















COMMUNITY HEALTH LEARNING PROGRAM

2012-13

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SOCHARA

-: Acknowledgement:-

I would like to thank Community health cell for conceptualizing and setting up the unique community health learning program. **"Sir Ratan Tata Trust"** for funding it, every member in CHC team has taken time out of their busy schedules to advise Encourage and support us.

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Dr. Ravi Narayan has been an inspiration to my life.

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My sincere thanks to the Administrator, the staff and supportive staff without whom my learning would not have been happening, I shall miss my lemon Tea of SOCHARA.

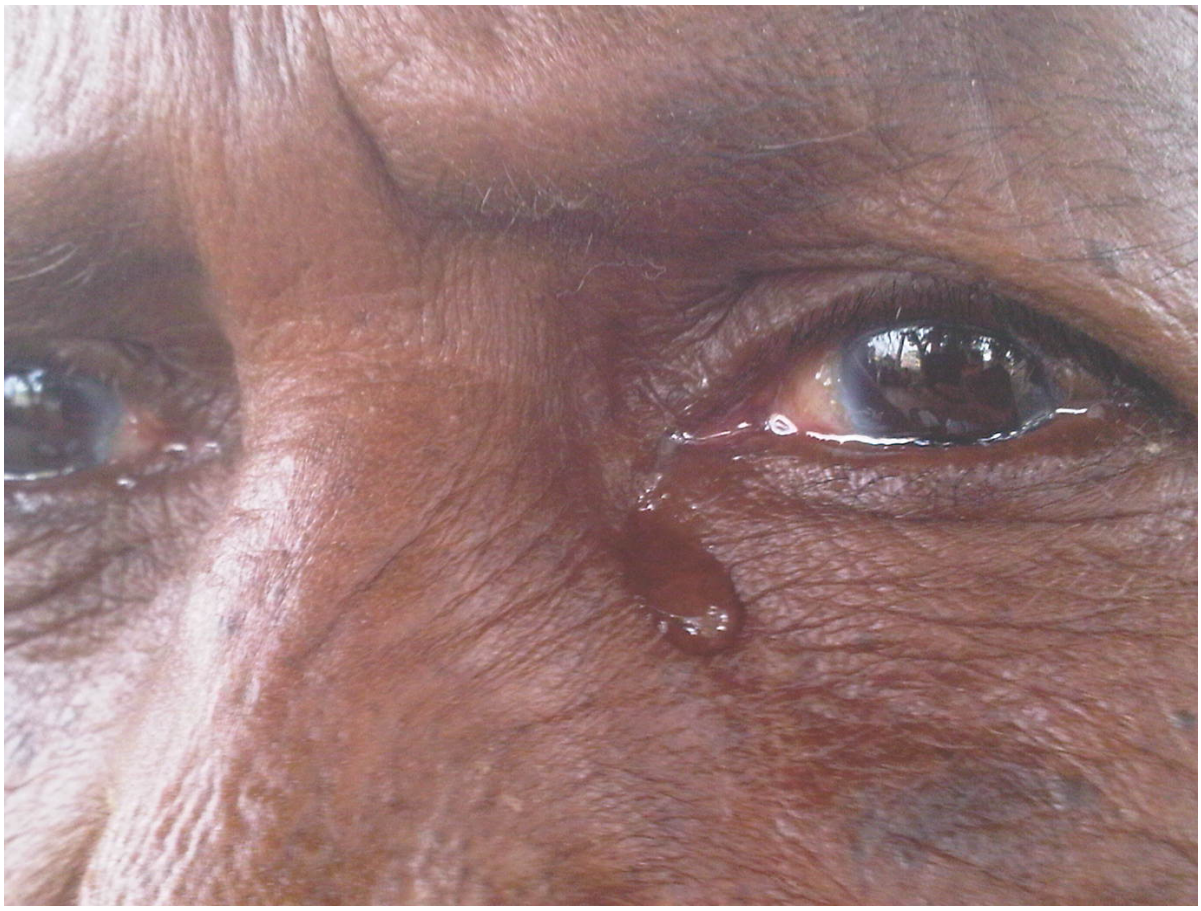
-:About me:-

Basically I belong to an ordinary Agricultural family, coming from northern part of Karnataka. I have more responsibility at home. Due to lack of water we are struggling to survive, and this part of the region is a draught prone. My family has spent for me their time and money to build me of what I am today. I am a curious as well as very accommodative and sensitive. I am fascinated of social issues and its impacts on the society that is why I took this fellowship programme.

This has been a significant turning point in my life, after this I started reflecting about health of common people and their struggle in life to reach an available, accessible, affordable, and quality treatment.

I have a passion to learn about many things which would help me to widen my knowledge on any issues especially the struggle of the people who are marginalized. It is a reason why I have selected the issues related with senior citizens.

I am on the strong belief that they should be taken care at home because at one point they were at their best. The modernization of today's world put this people on the periphery of the society and they are a burden to the community. Are they responsible for this?



CONTENT LIST

WHY I JOIN CHLP:-

I am basically coming from Middle of the Karnataka stae, Davanagere district, Harapanahalli Taluk and the Village name is Punabhagatta. My family is basically poor and illiterate. I spent my Childhood in my village and I completed my primary education in the village and after that high school education in other village which is 3 km away. Every day I used to walk 6 to 7 kms and did not have any means of transport. Because of some other problems I had many challenges in life to face. I also had health issues like scabies, chicken pox, and diarrhea. We did not have any sanitation facilities and no drinking water. I did my higher education at the block level which is 40 kms away from my village. After graduating I joined in an NGO, HEERA as a Janitor. It was my first job and I was very happy because I got a job. Unfortunately i did not get what I wanted because I thought of working with health issues. For me this job meant to do with dirty job but thought to myself that instead of wasting my time it is better that I continue this job. After two months I was promoted as a Outreach health worker, and because my abilities I was promoted as a Counselor, and later on as Project Coordinator, from 2009 -2013. During this period I started to reflect on many issues like Education, health, family, and how to support people who are infected/affected with HIV/AIDS. One day I met Dr. Yuvraj and he shared about SOCHARA, and requested if I knew some people who are interested to work with the community level in related to health issues would be welcomed to join SOCHARAs program. Then suddenly I cheeked the website of SOCHARA, I got some information. I was confused, should I continue my present job or join SOCHARA knowing that I had my limitations of English. After consulting Dr. Yuvraj I decided to join this fellowship program.

My objectives were:-

- I want to learn about the grass root level of work in the civil society and how to involve with the people.
- I want to know the schemes available for the community.
- I want to know about the NRHM and ASHA.
- I want to learn various aspects of NGOs responsibility in the civil society and their involvement in developing a community.
- I want to learn about health and health systems in the district as well as state level.
- I want to improve my English knowledge.
- I want to learn how to write a project proposal.

Learning objectives:-

To understand

- **The community/public health systems**
- **Senior citizen's health issues and their situation**
- **The institutionalized care to senior citizens**
- **The various aspects of NGOs**
- **The tribal community, their life style and health status**
- **How to do research in health field**

Introduction :-

Health:-

Before joining Community Health Learning program I was unaware of health and its issues. I thought that Health is only connected with the common diseases. I never thought that health has to do with social physical mental and spiritual well being. I thought when ever people visit to the hospital they are sick if not they are well.

After joining SOCHARA in Community Health Learning Program I understood that Health is a fundamental right and all need health. It is not only the responsibility of the medical people but also the responsibility of people who are involved in the well being of the population. Even a health worker can also take health in to his hands through scientific knowledge and transmit this knowledge to others.

WHO says “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. we can also add one more sentence to this WHO definition that Health is “Health is a state of complete physical, mental social and spiritual well-being.

Community:-

A group of people having same identity living in a locality having a common interest looking for a goal. Sometimes they will have the same culture, language, and same religion.

Community Health:-

It is related with health of the community. A well developed community should have proper drinking water, sanitation, nutrition, good environment,(no pollution) education, accessible to primary health care and so on.

How a healthy community should be:-

In the healthy community people should have more information regarding health status, easily accessible to the health care, affordable, available and appropriate. People should have drinking water, Environmental sanitation, good nutritious food, good education and healthy habits.

Alma Ata declared the eight components of the primary health care and the principals like Equity, Community participation, appropriate technology, intersectoral coordination, by promoting, preventing, curative, and rehabilitative, way the health can be achieved by all.

Learning from collective sessions:-

- **Participatory Rural Appraisal**

It is to make the people to take part in the well being of the community. To find out what are the basic needs of the community and how to prioritize the need. It is a Participatory action of the people, by the people, and for the people.

Any NGO before going to the field should do this PRA in order to find out what are the expectations of the people. One can't play the fool with the people because they are very sensitive to such problems.

- **Communicable and Non Communicable disease**

Communicable Disease:-

Communicable diseases are those that are transmissible from one person, or animal, to another. The disease may be spread directly, via another species (vector) or via the environment. Illness will arise when the infectious agent enters the host, or sometimes as a result of toxins produced by bacteria in food. The spread of disease through a population is determined by environmental and social conditions which favour the infectious agent, and the relative immunity of the population. An understanding of the disease and the measures necessary for its containment and management is therefore important. And so many types of communicable disease I learn in this collective session like Respiratory Infection- Tuberculosis, Diphtheria, measles, pneumonia, Polio, Cough etc. Intestine infection- Cholera, diarrhea, Viral Hepatitis, poliomyelitis, Typhoid, Hook Warm, Amoebiasisetc. Arthropod Disease- Malaria, Dengue, Filariasis, Chikungunya etc. Zoonosis-kfd, rabies, yellow fever, J.E. etc. Surface Infection-trachoma, tetanus, Leprosy, STD. this all types of problem and disease we learn in this collective session this is very useful for me.

Non Communicable Disease

A non-communicable disease is a health event or disease which is non-infectious and non-transmissible among people. NCDs may be chronic diseases of long duration and slow progression, or they may result in more rapid death such as some types of sudden stroke. They include autoimmune diseases, heart disease, stroke, many types of cancers, asthma, diabetes, chronic kidney disease, osteoporosis, Alzheimer's disease, cataracts, and more. NCDs are distinguished only by their non-infectious cause, not necessarily by their duration. Some chronic diseases of long duration, such as HIV/AIDS, are caused by transmissible infections. Chronic diseases require chronic care management as do all diseases that are slow to develop and of long duration.

In the whole week I learnt about the communicable and non communicable disease and this collective session was very useful for me because we don't know about the communicable and non communicable disease and how to manage and what are the features and what are the symptoms of the disease. I learnt about the disease they have their own symptoms and value.

National Rural Health Mission

Background

The National Rural Health Mission was launched by the Government of India to carry out necessary architectural correction in the basic health delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health, such as water, sanitation, nutrition, and safe drinking water. It also looks at mainstreaming Indian Systems of medicine to facilitate health care. The goal of the mission is to improve availability and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

Reflection

NRHM is a very good concept to improve access to health care for rural communities, especially women, children, and disabled people while promoting accountability, equity, and affordability. And some goals of NRHM include the reduction of IMR and MMR by half, universal health care access to public health, prevention and control of communicable and non-communicable diseases, population stabilization, revitalization of local health systems, and promotion of healthy lifestyles. These are to be accomplished with the help of ASHAs, and ASHA recruited to local ladies only this is very strengthening of sub-centers, PHCs & CHCs, creation of district health plans, integration of sanitation & hygiene, public-private partnership, health financing mechanisms, reorienting medical education, and strengthening of disease control programs. Community monitoring is an important component and can be accomplished through a People's Health Watch. And they approach to lead in healthy life and base on working with primary care level

ASHA is very useful to community because they are chosen by the community and it is their duty to identify the health issues which are in the community and bring in to the notice of the health system. They are given charge of thousand populations and given a small remuneration. They are supporting the ANMs, looking after DOTS, keep in touch with pregnant mothers and looking after immunization part.

Monsoon Game

Monsoon game is a way of teaching learners the Agricultural situations of the Indian society and the nature is very important for Agriculture like water, fertilizer, supplementary food for the plants to grow. This game shows the importance of the nature and the role of the money lender. In India 80% of the population lives under poverty and they depend on crops. The game shows the role of money lenders and how they exploit the poor formers. If the weather is good then the crops are better and vice versa. Thus the money lenders take advantage of the poor situation and exploit to the poor. Sometimes the government helps the farmers by providing financial loans which sometimes need to pay back. If the crops are good payment is easier but if not the money lenders have to be approached. They ask high interest which the Agriculturists are unable to pay thus the land is mortgaged by the poor in order to meet the debt. This game was and eye opener for me to reflect on the issues of the farmers of India and how they struggle in their life

Mental health

Mental Health is considered as one of the most complicated structure of Health of human in society. It is considered “Health is not everything but everything without health is nothing and absolutely there is no health without mental health”. According to World Health Organization, mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". It means a normal and healthy person can deal with problem and situation of life and able to take decision. He can communicate effectively and contribute the society with their custom, traditions, and other events and also can love and harmony with every individual and society. Mental wellness is generally viewed as a positive attribute, such that a person can reach enhanced levels of mental health, even if the person does not have any diagnosed mental health condition. This definition of mental health highlights emotional well-being, the capacity to live a full and creative life, and the flexibility to deal with life's inevitable challenges.

Health problems at community level

Health problems at community level is a very big issues because now a day’s community faces health related problems very grievously. We look at the health problems facing at the community like communicable and non communicable diseases, short time and long term diseases, curable and non curable diseases, preventable and non preventable diseases. Personal hygiene is very important for the community and the community health depends on how people live healthily in a society.

Health Economics

Health economics is part and parcel of health. For any infrastructure economy is a must for eg. You need building for a hospital for which you need labour who need wages and one needs to give salary for the health workers.

Two principles applied to help this decision making Efficiency and Equity. In efficiency there are two, Productive and Allocative efficiency.

All the activities need financing and where money is involved economic principles apply.Since there is a need to manage the money for health care; there is also the need to pool the revenues for the distribution of health care. There are three steps in Health financing. Revenue generation, pooling the resources, provider payment – payment for the services.

Human Rights and Health

There was International Health Conference, New York from 19 June to 22 July 1946, attended by 61states/countries and they felt that health is a human right. Thus they signed a declaration “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social

condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States."
Everyone has the right to a standard of living adequate for ... health and well-being of himself/herself and his/her family, including food, clothing, housing, medical care and the right to security in the event of sickness, disability, Motherhood and childhood are entitled to special care and assistance.

- **What is the Human Right and Health Right?**

Every woman, man, youth and child has the human right to the highest attainable standard of physical and mental health, without discrimination of any kind. Enjoyment of the human right to health is vital to all aspects of a person's life and well-being, and is crucial to the realization of many other fundamental human rights and freedoms.

- **The Human Rights Issues**

To physical and mental health, including reproductive and sexual health, to equal access to adequate health care and health-related services, regardless of sex, race, or other status, equitable distribution of food, to access to safe drinking water and sanitation, to an adequate standard of living and adequate housing, to a safe and healthy environment, to a safe and healthy workplace, and to adequate protection for pregnant women in work proven to be harmful to them.

Reflection

Health is a right for each individual and the state has the right to protect it the main issues of the human rights are gender bias, poverty and health, malnutrition, environment, education, employment, and medicinal drugs.

- **Health Policy in India**

According WHO "a national health policy is an expression of goals for improving the health situation, the priorities among those goals and the main directions for attaining them."
In India we have two national policies:-

- National Health Policy (NHP) 1983 & 2002
- National Population Policy (NPP) 2000

It means that the people should have the opportunity to participate and to access health care freely.
Challenges and Barriers:-Social inclusion/exclusion; ability to pay, Political choice, negotiation, contestations, Peoples' participation, perceptions, beliefs and experiences, War, violence, conflict, natural disasters.

Health system

According to WHO "a health system comprises all organizations, institutions and resources devoted to producing actions whose primary intent is to improve health. Most national health systems include public, private, traditional and informal sectors. The four essential functions of a health system have been defined as service provision, resource generation, financing and stewardship**."**

Health system in India is in the hands of the rich and the poor has known approachability to get any health facilities unless one needs to corrupt. The idea of health system is to enable any person in India to get health where ever he/she is, what kind of job he/she does and so on. If people have the possibility of health insurance then a great worry of the people well is removed.

The main components of health systems are the following:-

- Financing- public, private, out of pocket
- Organization of health care systems
- Governance & accountability mechanisms
- Implementation issues
- Quality of care
- Outcomes and impacts, including equity
- CPHC approach to health system development
- Health systems as a health determinant

Traditional medicines

The tradition of India believes strongly on local health, traditional healers and herbal garden medicine. We should encourage the people to get in to this tradition and 70% of the treatment can be dealt with locally. The following are the available health traditions in India.

Mrga Vaidya (Veterinary), Visha Vaidya (Poison Specialist), Dais (Traditional Birth Attendants),Bone-setters, General Herbalists – Marma chikitsa and Kannu vaidyam

Some issues which the community needs to be dealt with. Community Knowledge, Family / Household Traditions, Kitchen Herbal Garden, and so on.

Traditional medicines are codified into two such as Codified and non-codified

Codified :- Ayurveda, Sidha, Tibetan, Unani and Homeo

Non-codified:- Traditional bone setting, Poison healer, Birth attender, General medicine and Others

Environmental Sanitation

The sum total of all surroundings of a living organism, including natural forces and other living things, which provide conditions for development and growth as well as of danger and damage see environmental factors.

Environment is very important for us to have a good health for a healthy life environment plays a great role if the environment is corrupted then whole health system gets affected. Environment means free from any hazardous of climate, air, waste disposal, any sort of pollution.

Sanitation means cleanness of anything which is preventing well being of a person. Sanitation is very important for human beings. It also indicates of all pollution free.
Sanitation generally refers to the provision of facilities and services for the safe disposal of human urine and feces. Inadequate sanitation is a major cause of disease and improving sanitation is known to have a significant beneficial impact on health both in households and across communities. The word 'sanitation' also refers to the maintenance of hygienic conditions, through services such as garbage collection and wastewater disposal.

How we build at the sanitation in the community level with environmental friendly

Community Involvement, is changing the mindset of the Community, it cannot Focus on one community (Focus should be on whole village), importance of Health in Sanitation, motivating local Leaders, involving Govt. Officials, involving NGO's, SHG's, Youth groups

Learning from field visits:-

- **Basic Needs India : Mental Health**

Background

It was the first time that I heard about mental health and my visit Basic Needs India has opened my eyes. I have been a couple of times to basic needs and had interaction with the staff. They have opened my eyes to believe that in India there is a great number of people with mental illness.

Basic Needs India is nonprofit and non government organization working with people who are mentally sick and mentally retarded. If the community help them to start a living after they have been treated, they can become part of the community. The organization works with communities to overcome stigma and abuse. Their work strives to make mentally ill people self-sufficient and independent.

Mental health appears to be better addressed in the southern part of the country, especially Karnataka, Kerala, Andhra Pradesh, than in the northern states. This is partially attributed to the presence of the National Institute of Mental Health and Neurosciences [NIMHANS] in Bangalore. Basic Needs in India is based in Karnataka and therefore has a strong presence in the urban poor communities here.

Reflection

Meeting Dr. Mani Kalliath at the Basic Needs office in Banaswadi was an impacting and personal experience. My first visit to Basic Needs it was to learn more about Mental Health in Karnataka. However, the conversation I had with Mr,Guru and BNI team took a turn in a more interesting direction. Our discussion gravitated towards the state of the Indian government and its impact [detriment] on the people of India.

On a more personal note, Mr. Guru, Dr. Mani and team emphasized the importance to examine [everything] objectively and also maintain a sense of balance and humor in my work.

Reflection on Slum Visit [Basic Needs]

I visited a slum on where Basic Needs works to raise mental health education and awareness.
Basic Needs and other partner organizations like Association of People with Disability [APD] work together within an urban poor community to facilitate the identification of people with mental illnesses, provide access to resources and support systems, and raise awareness with community members about mental illness. A voluntary community health worker [CHW] from the slum is chosen from a self –help group to work with the community to achieve the goals. The CHW serves as a go-to person for people who have questions about symptoms they are experiencing or for information about what to do when family members are experiencing other mental health symptoms. The CHW is effective in dispelling fears and stigma about mental health in a community. The individual identified with mental illness has a caretaker from within the

family to ensure treatment adherence and attendance of general visits at NIMHANS. Additionally, the identified mentally ill and their caretakers have a support network, which meet periodically to discuss relevant challenges and methods.

Our visit to the Shivaji Nagar slum was coordinated by Guru of Basic Needs and fellow of SOCHARA . From 10am to 1pm and we divide 3 group per group one house hold one patient we stopped at 3 households, where an individual with mental illness resided. Shivaji nagar slum is diverse in religion and socio-economic status. Christians and Hindus are segregated and some houses are larger than others.

- **Case study:-**

At the first home my team met a 41 year old woman, who has postponed her marriage to care for her younger brother afflicted with schizophrenia. She decided to defer her marriage till her brother becomes better established and self-sufficient through work and treatment. The sister stated that there has been a vast improvement over the past few years in how community members treat her brother. Prior to Basic Needs' presence in the community, he was taunted and mocked by children throwing stones at him. After raising awareness about mental health through self-help groups, groups for young children, and painting projects of murals, people have started to understand his situation as an illness. The stigma within the community is also disintegrating as community members are realizing that is not contagious. Currently, the brother earns money through his work at a factory. A few of his co-workers also live in the slum and he travels with them to go to work every day. The sister recalled there are still a few worries that she faces. She recalled one disturbing incident when her brother was found at a liquor shop with other men from the slum. Following the incident, the other men had to be educated that it was not safe for the brother to mix alcohol with the medication that he was taking. This intervention by the organizations was constructive and did not place blame; rather it was conducted in a manner that encouraged openness and questioning. In regards to the treatment, the medication is provided free of cost by NIMHANS during periodic check-ups. The cost of transportation is provided for by the partner organizations. Additionally, the sister actively participates in caretaker resource meetings, which offer her support and guidance.

- **Foundation of Revitalization Local Healing Tradition (FRLHT)**

Vision: To revitalize Indian Medical Heritage. The Vision of FRLHT is to enhance the quality of medical relief and healthcare in rural and urban India and globally by creative application of our rich medical practices, action oriented research, education, training and Community services based on India's Traditional Health Sciences.

FRLHT are basically acting on few themes which are given below:-

- Conservation of natural medicinal resources
- Information technology and traditional knowledge
- Bridge between traditional knowledge and science
- Scientific repositories of natural resources
- Revitalisation of folk healing systems

- Research hospital
- A herbal public ltd company owned by rural women and small farmers
- Botanical repository
- Rural health security
- Scientific research
- Rural livelihoods
- Clinical services
- Literary research
- Educational Innovation.

Reflection

I spent two days at FRLHT where the focus was on AYUSH. I learned how important is the local herbal medicine and in India we have such a strong feeling towards the herbal treatment to which even foreigners are attracted to. One can treat almost 70% of the disease with the herbs. In a family some herbal plants can be planted and this can be a source of remedy for some disease like could, stomach pain, vomiting, diarrhea, skin problems, diabetes and so on. We don't have any written evidence of how these medicines are used and these medicines are known as grandmother medicines. It would be good if this information can be shared with local people especially traditional healers so that this could be an alternative way of treatment. Each family could also have a small herbal garden in their own homes.

- **APD -Association of People with Disability**

The Association for People with Disability (APD) is a Bangalore based organization working since 1959 for children, youth and adults with various types of disabilities — primarily those with physical disability, cerebral palsy, spinal cord injury, development delay, and speech and multiple disability. Our coverage extends to Tumkur, Kolar, Koppal and Haven i districts. We have linkages with voluntary organizations across south India and work with poor communities in and around Bangalore.

Association of People with Disability Vision and Mission is 'Equality and Justice for People with Disability to enable and empower all stakeholders'

With an estimated 70 million persons with disability in India, APD is among organizations that are at the forefront of the urgent, nationwide movement to overcome the growing challenge to support, rehabilitate and include people with disability into mainstream economy and social life

Reflection

Being able person one cannot do much but looking at Miss Hema Iyengar I was stund to see with such a sever handicap she was able to build up such a big organization were 28000 persons with disability were given rights in Equality and Justice by providing care to themselves. There is a need for such persons and organizations for providing support and help to the Handicapped.

SNEHADHAN

Background:-

Snehadaan was inaugurated on July 14, 1997, and has been involving in care giving for infected affected people with HIV/AIDS, and support and training of the family members to care for their loved ones who are sick. Snehadaan currently has the capacity to provide in-patient care for 52 people. The outstanding infrastructure and service delivery of the multi-disciplinary team have been duly acknowledged by the, National Aids Control Organization (NACO), Karnataka State Aids Prevention Society (KSAPS), and Karnataka Health Promotion Trust (KHPT). It also provides training for Doctors, Nurses, Health Care Workers, Social Workers and Medical Students on management of HIV/AIDS. The best service delivery practices Snehadaan developed have been replicated in many care and support centers across the country.

Vision

To provide quality and comprehensive health care to the sick, with a preferential option for the people infected and affected with HIV/AIDS

Mission

To be a positive force in addressing the comprehensive needs of PLHIV, ensuring their dignity and overall quality of life, by motivating, caring, supporting and rehabilitating them, with a priority for the palliative care of those who are in the end stage of the disease.

Reflection

At Snehadhan all the components of health are met like Nutrition, socio psychological support, family support, treatment of ART, provide Medical and nursing care, outreach programme, job placement, networking with other NGOs and care centers, and Physiotherapy & Personal Care. This is a tertiary center was people are brought in for a human dignity and eventually ends up their life over there.

There is also a center for the children who are infected or affected with HIV/AIDS. Due to discrimination these children are kept there for Education and Care, and some children are according to the need other activities are given.

Swasthya Swaraj. Kalahandi Orissa

I had a chance to visit Swasthya Swaraj at Kalahandi. It is started by Dr.Aquinas who is a General Physician along with other two sisters. Ms.Palak Agrval is coordinating this programme. It is the programme for the Tribal people of Kalahandi to focus on components of health. It is a registered NGO. These four daring women have undertaken a huge challenge and are working tirelessly to achieve health for all. We were over whelmed by the complexities of this project and the simplicity of these women. Kalahandi has the most beautiful landscape I have ever seen. The environment is serene, lush and filled with enormous riches of vegetation and minerals. However, the plight of health care facilities in the area like PHCs and CHCs are almost non-functional. People have heard of ASHAs but have seldom seen one in their own village. District Hospitals do provide some healthcare but most of the villages are about 70-90 kms away and then they don't even have connecting roads! Therefore, villagers live without minimal health support, depending

only on their traditional medicine, or ignoring their illnesses. Women deliver alone or with the help of their mothers if available. Even "dais" is not present in tribal villages. Kalahandi district has 16 blocks and out of these, Thaumul Rampur block is considered the most backward. Swasthya Swaraj team is currently initiating health related activities in 4 Gram Panchayats of Thamul Rampur block. The panchayats are Gunpur, Kerpai, Kaniguma and Thamul Rampur. The team is based at Bhavanipatna and thanks to their vehicle they are able to reach these places.

They run weekly clinics in the gram panchayats. The current focus is on identifying one village health worker "Swasthya Sathi" from each village, and arranging for their training along with weekly clinics in different gram panchayats. They have managed to select about 50 Swasthya Sathis at present, a tremendous achievement for a project which was started just about 8 months ago. Clinics are also gaining popularity among the locals. They see about 30-50 patients per day, arrange for onsite necessary lab investigations and medications, all free of cost. The myriad of diseases is extensive with tuberculosis and leprosy being very rampant, scabies is almost everywhere in Kuniguma block.

- **VIMOCHANA**

Vimochana**,** meaning liberation, was initiated in 1979 by women and men from within the Centre for Informal Development Studies (CIEDS) collective that had come together in 1975 to seek a just, humane and creative society rooted in transformative politics. Vimochana grew out of the need for a public forum that would stand for organized resistance to the increasing violence on women and would be assertive in challenging the pervading apathy to the problems of women in the context of larger structures of violence and power.

Vimochana is to strengthen women's resistance to violence both within the home and within communities, cultures and politics. To make families, communities and the state responsible for and responsive to the growing violence against women. To create alternative spaces and for a public debate and dialogue to bring about attitudinal and institutional changes in our society vis-à-vis discriminatory attitudes towards women. To make visible the deeper connections between increasing violence in the personal sphere of the home and the increasing brutalization of the larger public polity

Reflection

There is a Gender bias against woman in the society and they are the victims of physical violence, (dowry, and sex abuse, ill treatment at home). Burnt cases are often neglected even in the hospital wards, no proper treatment is given and normally they end their life at the hospital. Vimochana is fighting against such atrocities against women.

They also give counseling and if necessary go to the court for these women's issues. They teach them to be self supportive and self caring.

Seminars / Conferences/workshops attended:-

- **National workshop on Social Justice in Health: Research, Advocacy, Training and Action on Realizing Health Rights**

On the 10th and 11th of September, 2013 at St John's Medical College, Bangalore, I attended a seminar on "Social Justice in Health Research, Advocacy, Training and Action on Realizing Health Rights." It is an initiative taken by SOCHARA in order to create awareness on social justice in health. The deliberations included both theoretical and historical reflective discussions, as well as a focus on certain specific themes such as urban health, mental health, environmental health and privatization of health care which were otherwise inadequately reflected in the current UHC debate. The multiple approaches and pathways that have been used to address the social determinants of health in different parts of the country were discussed, and provided a framework for initiatives and action at several levels from individuals to families, communities and at a larger policy level. Eighty seven participants from health sciences and social sciences background participated at this workshop. The response very positive useful experience and are keen to work with others in the field towards Health for All

- **State level Consultation on Ban on Tobacco Advertising Promotion And Sponsorship**

Tobacco is a "communicated" disease. Due to tobacco there are 25 major diseases. According to global youth tobacco survey 2003- 04, the point prevalence in 13 – 15 year olds is 4.9% and national average is 17.5 %. There is a gap between the knowledge and community action, for this the families need to be supportive and aware. Tobacco epidemic is preventable. The livelihood of farmers also needs to be considered by introducing them to cultivation of alternative crops. The FCTC clearly states that sale of tobacco products among minors is illegal, of which India is a signatory. According to a study done by NIMHANS, youth belonging to the age groups of 12- 15 years received information about tobacco via print media. Karnataka is the second largest tobacco growers in the country. Globally 63% of all deaths are caused by NCD's with tobacco as the greatest risk factor. In the world 40% male and 9% female smoke, 6 million people die due to tobacco out of which 1.5 million are women, Advertising is a very powerful media that is difficult to curtail but with public pressure it definitely can be overcome.

- **2ND INTERNATIONAL CONFERENCE ON HEALTHY AGEING IN THE CHANGING WORLD 2013"**

"The conference would be an ideal opportunity for health care providers from all disciplines and professionals interested in the field of ageing and seek clinical information about geriatric issues. Population ageing is the most significant emerging demographic phenomenon. Asia has the largest number of world's elderly (53 per cent), followed by Europe (25 per cent). Population of elderly in our country has increased exponentially from 77 million at the beginning of last century

to around 100 million now, forming 9% of total population of the country. Thus, the country has become a 'graying nation.' The impetus behind this conference is the issue of ageing and its associated medical, social, and ethical problems. As we already know ageing is inevitable and unavoidable; however, modern science and medical technology are trying to understand the process of ageing and its slow impact on human body through continuous research. To a large extent, medical science has helped in understanding how to slowdown ageing, to avoid many diseases typical of old age and be able to enjoy life.

- **Tropical Medicine Course for Danish Doctors at MITRA**

The Goal of this Programme:-

- To provide visiting General practitioners from Denmark with an exposure and orientation to the signs and symptoms, diagnosis and management, epidemiology and prevention of tropical disease, so as to equip those to better serve the members of their communities who travel to distant lands or come from tropical countries.
- The India beyond the touristic view
- To live and work in a remote mission hospital in India, the similarities and the differences in practice.
- Issues in health and health care, the under currents that determine who falls sick, where, when and why.

Proceeding of the course:-

The 6 days Tropical Medicine course was started with we welcome and self introduction. The course sessions was conducted as per the given schedule.

Introduction to Tropix 2013	Dr.johny Oommen
Status of Health – India, Orissa, Rayagada, Bissamcuttack.	Dr.johny Oommen
The CHB history	Dr.Johny Oommen
Visit to CHC Bissamcuttack	Dr.Johny Oommen and Team
Mobile Clinic to MITRA project area	Dr.Johny Oommen and team
Lecture 1: Perspectives of Health in Developing Countries	Dr.Johny Oommen
Lecture 2: Indian health system	Dr.Sara Bhattacharji
Lecture 3: Culture and Communication Health and Health Care	Dr.Johny Oommen
Lecture 4: Understanding on Malaria	Dr.Johny Oommen
Lecture 5: Other vector-Borne disease Dengue, Chikkengunya, Japanese, Rickettsial infections	Dr.Sara Bhattacharji
Lecture 6: Communicable disease	Dr. Suranjan Bhattacharji
Lecture 7: Diarrhea and dysentery	Dr. Pragya
Lecture 8: Non communicable disease	Dr. Suranjan Bhattacharji
Lecture 9: Intrudes on Anthrax	Dr. Johny Oommen
Lecture 10: MMR in India Orissa and Bissamcuttack	Mrs. Mercy John
Lecture 11: Status of Health - India & Denmark SOWC	Dr.Johny Oommen

Reflection

This training programme was completely different from others which I attended ever before. This programme gave me an opportunity to learn about the various tropical diseases, especially the poor and marginalized. All through the programme was completely medical model and the sessions were highly technical. The social aspects related to the diseases were discussed. It helped me to understand the future of different diseases specially seen in India by which many poor and marginalized are suffering clinically and also socially. In this training programme one special session was taken by Dr.Johny on Aboriginal peoples who helped us to understand in detail about them of different country and their problems and the effort made by different peoples and organization for the upliftment of them.

- **Mental Health dialogue Gulbarga**

Dialogue on Integrating Mental Health with Primary Health Care. I was able to profit the maximum, because it was in Kannada and I understood the Mental Health scenario in Karnataka mainly in the northern part.

Reflection

1. Aware of the existing facilities on mental health at the district level.
2. Every person has sometimes some signs of mental depression.
3. Signs and symptoms of mental health and how important it is the early detention.
4. Sanitation has a great role in mental health.
5. The importance of the Family support for a mentally ill person.
6. It is a curable disease and they can have a normal healthy life.
7. Learned how to organize, to conduct and co-ordinate.
8. Networking with other Government and NGOs.

- **Medico Friend Circle New Delhi**

Background

MFC is a non funded group of members from various backgrounds from across the country –
Public health professionals, medical doctors, nurses, health activists, researchers, students and others. Annual Meets of MFC have contributed to many debates and discussions on a range of health related issues, for example, primary health care, universal health care, nutrition, occupational health, communicable and non communicable diseases, women's health, medical education, etc. MFC (Medico Friend circle) initially started with people who were of medical background.
But later on people of different background also joined this group thus a variety of social and health interests were added to it.
The main topics of discussions were Gender, Class, Caste and Religion. I was in the group dealing with Class. The main the discussion were on upper class and lower class, how the lower class is exploited, the attitude of the medical professional at the hospitals. Indian society is very much colored by the Class system; even it is very much available at the beurocratic level.

Example -if a person is on the level of secretary then he will be considered as high class while under secretary is of lower class (it's all depends on the scale of salary)
When it comes in to caste, Indian society is divided. These cast system are human made errors, what is very important is respect for each individual. There is a fight in all aspects of our life when it comes in to caste. I think the more we believe in caste the more difficult will be in the future of the country.
The MFC is a platform for the following

- MFC is a safe space to share without amusement and act upon resources.
- Then MFC is a togetherness for peoples issue,
- Get together to analyze medical education for peoples issue,
- Late 1980's ie., Formation of govt. groups to deal medical conflicts, right to health and human rights, violence initiated that time,
- MFC took birth. Non-monopoly in nature.
- Privatization, water resource activism, research, changing yearly meet and convener.
- Community inside community model.

Learning from field Experience:-

FEDINA

Foundation for Educational Innovations in Asia (FEDINA)

Background of FEDINA

FEDINA was established in 1983 with the objective of reaching out to the poorest of the poor and the marginalized, in order to improve their livelihoods. Though it was established with the idea of 'empowering' people by enabling them to access their rights, we invariably stepped back from building political consciousness among people and focused more on welfare. This was due to the political situation at that time, given that it was not too long after the emergency.

During those days, the suppression of the people had strengthened the Naxalite movement, and the government came down very heavily on Naxalites. Therefore NGOs were overcautious and did not want to be identified with the Naxalites. There was so much fear of the state, that any activity that came close to empowerment or rights, were withdrawn. Partly because of NGO intervention, many groups that were militant became less militant. People's movements were diverted, consciously or unconsciously, due to fear of the state.

Over the years, FEDINA has evolved gradually from Welfare to Rights and now our approach is almost fully rights-based.

IN the late 80s and early 90s, FEDINA was mainly involved in forming Self Help Groups, promoting income generating activities and conducting informal literacy classes for adults and drop-out children. We worked mostly with tribal's, dalits and senior citizens.

Over the subsequent few years, we began to focus more on rights of the marginalised people, and also started working on women's issues. In 1996 FEDINA consolidated a loose network of rights-based groups in South India, which later came to be called Network of Social Action Groups.

Work since 1996 can be divided into two phases. In the first phase, we worked broadly on human rights of dalits, tribals, women and informal sector workers. Later, as the groups interacted and worked with each other, we asked ourselves if we should have specific priorities under the broad framework of human rights. We realised that what really kept the tribals and dalits marginalised and poor is the fact that they were either unemployed or underpaid. So logically the priority had to be labour rights and unionization.

At this point we started looking at dalits more as workers with labour rights, and not just as a structurally marginalised and discriminated group. It took a few years for all the groups to make this shift from general human rights to labour rights. Now, the main priority of most of the groups in the network is labour rights.

Objective:-

General objective: empowerment of the marginalized/exploited communities: informal sector workers, Tribal's, Dalits, and women.

Specific objective: Strengthening and forming new unions. Extending and strengthening agricultural workers unions (as against caste organizations).Creation of informal workers, retired unorganized sector workers, domestic workers and agarbathi workers. Empower women's groups to fight domestic and social violence.

Reflection

Community based rehabilitation, use of modern technologies in the field of their work (pourakarmikas). Giving awareness of the existing government schemes, senior citizen pension scheme, domestic workers issues, organization of unskilled workers, dalit/ tribal issues and their rights.

KARUNALAYA

Karunalaya It is a senior citizen home with 18 beds for the women in the outskirts of Bangalore city and it is run by a group of and the inmates take part in all the activities of the house like Cleaning, cutting the vegetables, helping at the kitchen, keeping the surroundings and watering the flower garden. It is started in 2006 and they can accommodate 2 more making it to 20. The sisters are trained nurses thus they take care of the ordinary medical issues. Religious sisters it is a home for the destitute (Taken from the Roads) it has a homely atmosphere

Services

It has a family spirit and the elderly persons receive every day Joy and love, friendship in a relaxed and peaceful way. Each person is very important and great attention is given individually. Meals are prepared according to regional customs and standards, also taking into account special diets as advised by the doctor.

Reflection

Homely atmosphere, personal care is given individually, emotional and psychological support, timely treatment, their personal needs are taken care, and respect is given to each individual who ever it may be.

-:*LITLE SISTERS OF THE POOR*:-

April 30, 1900 – the first two Little Sisters of the Poor arrived in Bangalore. On May 2, the first poor elderly person presented himself to be cared by them. He was received with open arms and many were soon to follow. By May 18, there were nine residents – six men and three women. This house is meant for the poor elderly people who have no one to take care at home and they give more priority to most needed people who deserve. The Little Sisters as they do in all homes soon began collecting funds. As Fr Cabard didn't want them walking in the heat, he gave them a horse. A benefactress, Mrs Bride, donated a cart. Thus they went begging even to distant places and markets. Many people voluntarily offered little gifts, particularly rice.

Facilities

The Little Sisters of the Poor strive to achieve a family spirit in their Homes for the Aged. In this home Elderly persons receive every day Joy and love, friendship in a relaxed and peaceful way. Each person is very important and great attention is given individually. Meals are prepared according to regional customs and standards, also taking into account special diets as advised by the doctor.

Medical treatment is also given according to each person's need, and the staffs are qualified medically in order to reach in time of need.

The facilities available are Occupational therapy, Entertainment, spiritual counseling, emotional support, and homely care.

Reflection

Homely atmosphere, personal care is given individually, emotional and psychological support, timely treatment, their personal needs are taken care, respect and dignity for each person is given, who ever it may be.

MITRA

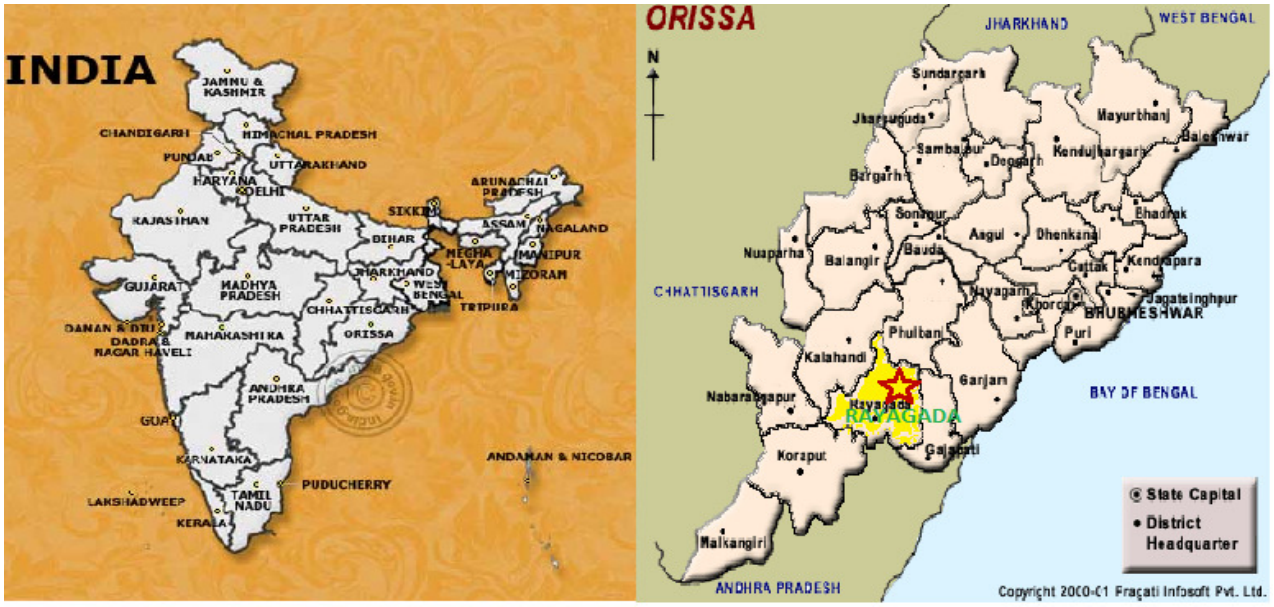
CHB

Madsen Institute for Tribal Rural Advancement(MITRA)

Background of CHB MITRA

Mitra means friend. Mitra also stands for Madsen's Institute for Tribal and Rural Advancement, which exists within the Community Health Department of the Christian Hospital Bissamcuttack (CHB) in India's state of Orissa.

Bissamcuttack is a small town of about 10,000 people in the hill district of Rayagada in Orissa. The Bissamcuttack block has about 315 villages and 85,000 people. Of these, 62% belong to the Adivasi (indigenous) community, and another 17% are Dalits. Therefore, the vast majority of our people belong to historically oppressed and vulnerable communities.



CHB is a 200-bedded mission hospital founded in 1954 by Dr Lis Madsen from Denmark. At that time, people in this remote and mountainous area had practically no access to health care. Dr Madsen began her work by seeing patients on the veranda of the local church. Then, she established a small dispensary, and trained locally recruited staff. CHB grew out of these small beginnings, and today is the main contributor to people's health in our area; the other nearest referral centers are over 200km away. From the beginning, Dr Madsen, who had a deep-rooted commitment to marginalized people, was convinced that it was necessary to go out to people in their communities. She began community-based health care on a small scale, and thus laid the foundations for Mitra. Today, Mitra consists of three pillars, viz. the Mitra Project, the Mitra Residential School Kachapaju, and the Mitra Training and Resource Unit.

The Mitra Project

The Mitra Project works with about 12,500 people in 53 predominantly Adivasi villages. Our approach is to be with the people, and allow their agenda to emerge in the context of this relationship. By the late 1990s, we had grown disillusioned with the traditional models of

community health and development, with their goals and objectives and log-frame-approach grids. From these more or less vertical approaches, we moved to what we would describe as community dreaming sessions and appreciative inquiry. We wanted to know about our people's real desires, and for them to become agents of change instead of objects of others' activity. What emerged from this fundamentally different approach was a four-fold Mitra dream that we still use as a reference point. It is the dream that "**one day our people will enjoy health for all, education for all, economic security for all, and social empowerment for all"**. Each of these dreams has simple components, and indicators that we use to measure whether we are getting closer to or further from the dream. Every element of our approach does not take place in all villages, and nothing must happen unless the village decides and asks for it; we work to the maxim, 'No demand, no supply'. All Mitra decisions are team decisions, with the monthly staff meeting being the centre of discussions, learning and planning. An informal council of tribal leaders evaluated our work in 2005 and, based on their own dreams for their people, provided further focus and direction for the next phase of Mitra's work.

Health for all

Six community health nurses spearhead our health-for-all work, and do so with the help of 48 village-level Swasthya Sevikas,(Health Worker) who are women chosen by their villages to serve each community's health needs. The primary health care model we employ follows the World Health Organization's 1978 Alma Ata concept of primary health care, which is based on the values of equity, social justice, universal access and solidarity. Our health-for-all programme includes mobile clinics, antenatal care, community, obstetrics, nutrition, health education, immunization, malaria control, and health information management systems. Over the last decade, we have seen a halving of the local infant and child mortality rates but there is still a long way to go before we can achieve our dream indicators.

Education for all

Over the last 25 years, we have pursued our dream of education for all in multiple ways. We began with adult education in the 1980s, moved to non-formal child education in the 1990s, and on to formal education initiatives in 1998. At present, our primary focus is an initiative that we call AQTE (Adding Quality To Education). This helps communities improve their government schools by appointing educated, motivated Adivasi young people as village tutors in order to help Adivasi children catch up by teaching them in their mother tongue. This began as an experiment in one village school; the immediate and visible impact created an upsurge of demand for more tutors. Now, there are 19 such teachers serving about 615 children from 22 villages.

Economic security for all

Mitra teams have facilitated the setting up and nurturing of over 50 self-help groups to help provide economic security for their members. Most of these groups consist of 15 to 20 women from a village, who save money together and provide each other with microcredit loans in times of need. Some women have also joined income-generating programmes, while others have chosen

to stay with those that offer credit security. In one of the groups, and assisted by Mitra, people set up a community-based health insurance programme.

Social empowerment for all

The concept of social empowerment for all is at the heart of what Mitra does and stands for. All our work has to enhance empowerment and discourage dependence. Mitra has chosen to stand alongside the Adivasi people; about half of Mitra's full-time staff comes from the Adivasi community. The preservation and promotion of the Adivasi **Kuvi** language and culture is at the core of the way we work. Thankfully, the community sees Mitra not as an outside agency but as an insider.

Nurturing value-based leadership skills is also part of our work. Over the years, a number of Mitra's paid staff and volunteers have gone on to assume leadership roles in local societies.

New initiatives towards improving health

Mitra is like a churn in which action and reflection, and rootedness and exposure constantly interact with one another. This process constantly throws up ideas and possibilities that are scientific and strategic as much as they are locally rooted and participatory. Some of the new initiatives that have taken off in 2008 and 2009 include:

• A malnutrition reduction strategy that focuses on malaria prevention as its prime thrust; Chloroquine malaria prophylaxis seems to help people put on weight more than food itself.
• Ageing with dignity is a community-based programme for the elderly in 16 villages; it uses a club membership approach, and is managed by village committees;
• Living with sickle cell anemia (SCA) is a small, self-help-group approach for people with SCA in 50 Mitra villages; this initiative seeks to enable people have dignity and health through awareness and understanding, socio-medical inputs, and health insurance.

Mitra Residential School, Kachapaju

In 1997, a community dreaming session in the hill village of Kachapaju led to the vision of an Adivasi school of our own, where children could grow up within an ethos that reflected their own culture in order to be equipped to lead their community as educated adults.

Mitra and a cooperative of 16 hill tribe villages jointly envisioned this school, and worked together on a plot of land in the middle of the forest to make their dream come true. The school opened in July 1998 with 31 children. Today, the Mitra Residential School, Kachapaju, which is also lovingly called "Mrs K" after its acronym MRSK, is an Adivasi school providing education from grades 1 to 5; it has 143 children and nine staff. The school aims to offer its children the best possible education in an atmosphere that reflects the culture and wisdom of the Adivasi community. We begin by teaching in Kivu; gradually we introduce the children to Oriya and English, and even some spoken Hindi. The school follows the government curriculum but education at "Mrs K" overflows far beyond the walls of the classrooms to include topics such as nature, health, drama, crafts and much more.

The Mitra Training and Resource Unit

In 1997, we stumbled across an innovative way of controlling malaria that evolved from our struggle with this one disease that accounted for one-third of the deaths in our area. Before we knew it, we were inundated with requests from action groups and non-governmental organizations (NGOs) in Orissa and beyond for assistance and training. This led to the formation of the Mitra Training and Resource Unit by a community health nurse in 2000. The unit takes lessons learnt from the field, and shares them with other groups and individuals through training, consultancy and publications. Over the years, we have shared our expertise in primary health care, malaria control, HIV and AIDS, epidemiology, reproductive health and other subjects with governmental and the non-governmental groups. At present, we are part of a technical think tank that the government has set up to look at issues related to health sector reforms.

Mitra: a way of life

Mitra is an experiment in evolution, with one foot in the grassroots reality of village life, and the other in the world of science, health, education and development. We are constantly brainstorming, dreaming and reflecting, and out of this melting pot come ideas and programmes. Many dreams never translate into action; most often we are disappointed with ourselves and fall short of our own expectations. We are conscious that what we do is minuscule compared to what needs to be done, and even what we should be doing.

However, through all the years of Mitra's existence, we have been confident that it is the people of the villages themselves who have the solutions to their problems. We believe in these people and their strengths. At the core of Mitra is our relationship with the 12,000 people living in 53 villages around us; this is the foundation of all we do. Together, we are able to unearth issues and needs, and discuss possibilities. Then, we act together. The action and reflection that takes place during this process feeds back into our relationship, and we all grow together. Our work is our life. For us, Mitra is much more than a programme; it is a concept, a philosophy, and a way of life.

Towards Health for All

Primary Health Care

- Mobile clinic: 50 per month
- 50 Swasthya Sevikas – village health workers
- Community Health Insurance
    1. M – CHIP, Dakulguda
    2. Swasthya Paanthi, MAS
    3. Swasthya Paanthi, DSH
- 2 Nurses-run Sub-Centres at P Dakulguda & Kachapaju
- Health Education
- Mitra Nutrition Programme
- Mitra Malaria Control Programme

1. Medicated mosquito nets
2. Neem – based repellants
3. "MAL MAL" camps
4. Treatment & referral

- Special Initiatives
    1. Sickle Cell Anemia Group
    2. Geriatric care
    3. Hypothyroidism Support
    4. School Health Programme
- Management information system
    1. Village Swasthya Patta
    2. Data Analysis & Feedback

Towards Economic Security for All

- SHG Programme
    1. Over 50 Self – Help Groups
    2. Credit & Saving Programme
    3. Income Generation Programme
    4. Health Insurance programme
- Agricultural Initiatives
    1. Discussion forum for farmers

Towards Social Empowerment for All

Programmes for

1. Youth: on leadership, HIV – AIDS etc
2. Women: Exposure Programmes, Leadership Training
3. Mitra Volunteers: Training & Exposure Programmes

- Ageing with Dignity
    1. A support programme for the Elderly
    2. 500 subscribing members
    3. Health & Social Support Initiatives

Towards Education for All

- **The MKB Initiative**("Milla Kahini Basa" or Children's Play Place)
    1. 11 Centers
    2. 11 shishu Didi's
    3. 177 Children

- **AQTE Initiative ("Adding Quality to Education")**
  Catalyzing Quality education in Govt. Primary Schools
    1. 17 Teachers

2. 612 Student

- **High School Kids Camps**
  1. Coaching camps in English, Maths & Science
  2. Exposure to computers
- **Nancy Henry Scholarships for Higher Education**
- **MRSK(Mitra Residential School, Kachapaju)**
  1. an adivasi primary school, kuvi – cum – odiya medium
  2. jointly managed by Mitra & the people of 16 hill – tribe villages
  3. 155 children – 50% boys & 50% girls; 12 staff
- **Old student Follow – up Programme**
- **Post – Matric Scholarships**
- **Teacher Training for AQTE Volunteers**
- **Education Consultancy**
- **Kuvi Sanskriti Kendra – an initiative to preserve, celebrate and nurture the Kuvi Language and Culture.**

My Research study report

An Exploratory Study to Understand the Physical and Emotional Problems Experienced by the Elderly in Old age Homes in Bangalore

Introduction

What is 'old age'?
According to the World Health Organization (WHO), most countries have selected an arbitrary **chronological age** of 60 or 65 as a definition of 'older person'. This age is chosen simply because it tends to be the age when most (but not all) people retire – that is retire in developed countries. [1]

In recent years, there has been a sharp increase in the number of older people worldwide[2] and more old people are active nowadays than at any time in history.[3] India is the second largest population of elderly (60+) in the world.[4]As per the 2001census, the number of older persons were 70.6 million (6.91%) and projected to grow to 94.8 million (8.3%) in 2011, 118 million (9.3%) in 2016 and in 2026 it is expected to touch 173 (12.4%) million. [(5)]

In today's world the family is becoming more and more nuclear and the old system of the joint family is disappearing. So there is isolation for the elderly from the present family set up. Though people retire at 65 years they remain healthy and productive but due to demand and competition they are unable to find employment. This leads to unemployment and a feeling of wastefulness among the senior citizen.

Ageing of the population along with changes in the family structure and shifts in intergenerational relations has brought into focus issues pertaining to the elderly in India. In the early times the elderly people somehow managed to keep themselves busy by either taking care of the grand children or doing odd jobs at home like shopping, taking the grand children to school and spending time with them. With decreasing size of the family and migration to the cities senior citizens are finding it difficult to keep them occupied.

The growing visibility of old age homes in India points to the needs of elderly, which were not recognized earlier. Old age homes have sprung up to cater to the needs of the elderly from different socio-economic backgrounds. The interests of the elderly to spend their old age in sacred places, the migration of children in search of employment opportunities, their maladjustment in family and poverty of the elderly are the major reasons for the Indian elderly to shift to old age homes. The busy life of the city and its challenges which make the senior citizen unwanted is also another reason for the senior citizen opting for such homes. However in recent times, as a result of demographic transition, rapid pace of industrialization and urbanization, disintegration of joint family structures into nuclear ones, increasing participation of families in non-agricultural labor force, the older people have become more vulnerable. The lack of familial support made elderly resort to old age homes run by private and or voluntary organizations for their care and support.[(6)]

There are two types of Old Age Homes in India. One is the "Free" type which cares for the destitute old people who have no one else to care for them. They are given basic necessities like

shelter, food, clothing and medical care. The second type is the "Paid" home where care is provided for a fee. Such "Retirement" homes have become very popular in India and they are well in demand.

Today, the old age homes are indispensable as they are needed to take care of the lonely and forsaken elderly in the evening of their lives. Whenever the family does not provide full protection and security to the aged, the society has to share the burden of looking after them. Nowadays, old age homes are established to take care of the old. This idea of "institutionalization" of the aged has largely been borrowed from the western countries. In the context of the dynamic changes taking place in Indian society, the problem of the aged has assumed importance. There is a gap between the needs of old people and the availability of health and social service in these institutions. There is much research on the problem of the institutionalized old people abroad but in India, very little organized information is available about the problem of the aged living the families and in old age homes. Thus this study is being conducted to understand the reasons for moving into old age homes, their health problems and the issues faced at the old age home to understand the relationship between staying in an old age home, health status and the issues faced by senior citizens.[7]

Objectives

1. To understand the reasons for elderly people coming to the Old Age Homes
2. To understand the problems faced by the Elderly in Old Age Homes.
3. To understand major health problems of the Elderly at the Old Age Home.

Material and Methods

Study area- The study was conducted in Bangalore urban district.

Study population- The study population consisted of elderly population of an old age home located in central Bangalore.

Study duration- during the period of Sept and Oct-2013

Study design- A qualitative study design was used since to answer the research question and to achieve the objectives there was a need for in-depth understanding required which would not have been possible if a quantitative study design was used.

Sample- A total of 6 residents of the old age home were selected and interviewed out of one hundred and twenty residents in the old age home.

Data collection – Data was collected using in-depth interviews and observations. In-depth interviews were conducted using an interview guide and recorded using a voice recorder. The interview guide was prepared in English and then translated into Kannada. Observations were made using a checklist.

Data analysis – Data was transcribed from the audio recordings then translated into English. Translated data was entered into and analyzed using NVivo Version 10.

Consent- I have got consent from the respondents after having explained to them my intention of doing a study on them. Also I explained to them in no way it will do harm to them and it is strictly kept confidential, though I have used some of the group photos in my report but I have not disclosed their names.

Description of old age home

The Little Sisters of Poor, home for the aged is situated near Johnson Market, Hosur Road, Bangalore Karnataka. It is run by Little Sisters of Poor and provides care for senior citizens and destitute.

It currently provides stay for one hundred and twenty residents with separate sections for males and females. Majority of residents were brought by family members and a small percentage by voluntary organizations. The people brought by these organizations are the ones who are abandoned by family members or found on streets. The cost of maintenance of these people is borne by the old age home itself along with financial contributions from many organizations and local community mobilization.

Medical services are provided by a medical college and hospitals in Bangalore with a physician visiting the home once a week and a psychiatrist once a month. There is a separate room for medical checkups and visiting doctors. Separate medical records and medication kits are maintained for each resident. A permanent trained nurse regularly checks vitals and dispenses medications. In case of any emergencies residents are shifted to the St. Johns Medical College Hospital where a separate geriatric OPD is available and provides treatment at concessional rates.

Routine activities of the residents include prayer, reading newspapers, watching TV, chatting, helping in making beds, serving and cleaning. Residents are taken for religious activities on a regular basis. They are allowed to visit their relatives for a day or two with permission and similarly visits from family are also encouraged.

Results and discussion

Table 1. Demographic characteristics of respondents at old age home

Sl.No	Demographic Variable	Frequency
1	**Age(in years)**	
	71-75	1 (16.66%)
	76-80	1 (16.66%)
	81-85	0%
	86-90	2 (33.33%)
	91-95	2 (33.33%)
2	**Sex**	

	Male	3 (50%)
	Female	3 (50%)
3	**Religion**	
	Hindu	3 (50%)
	Christian	3 (50%)
4	**Caste**	
	General	1-M
	Scheduled Tribe	2-F
5	**Education**	
	Illiterate	3(50%)
	Primary	0 %
	High school	1(16.66%)
	College	2(33.33%)
6	**Number of Children**	
	0	2(33.3%)
	2	1(16.6%)
	4	2(33.3%)
	7	1(16.6%)
7	**Current Occupation**	
	Not working	6
8	**Previous occupation**	
	Not working	1(16.66%)
	Daily labor	3(50%)
	Regular work	1(16.66%)
	Business	1(16.66%)
9	**Current Income**	
	Nil	6
10	**Previous Income per month (in rupees)**	
	0 - 1000	2 (33.33%)
	1001 - 2000	1 (16.66%)
	2001 - 3000	1 (16.66%)
	3001 - 4000	0
	4001 – 5000	1 (16.66)
11	**Duration of living in the old age home (in years)**	
	00-04	3 (50%)
	04-08	1 (16.66)
	08-12	1 (16.66)
	12-16	1 (16.66)

The study was conducted in the one old age homes of Bangalore. Out of total 6 respondents, the distribution of respondents on age, gender, religion, caste and educational qualification, men and women living in institutions settings is presented in table above below. Fifty percent of the

respondents were men and the other fifty percent were women. Religion of the respondents is that fifty percent are Hindu and fifty percent are Christian. Fifty percent of respondents are illiterate and the rest fifty percent are educated high school and above. Two thirds of the respondents were above 86 years of age and the rest above 70 years but less than 80 years.

Reason for coming to the old age home

The main reason for elderly people coming to the old age home is poverty. Residents come from a rural setup and half of them did not have any basic education because of which they were not able to secure jobs and they migrated to urban are a sin search of jobs which they found the in unorganized sector and as a result did not have any job security. Work was available on a daily wage basis and women worked as domestic help in various households. Their income was low and they had large families to support. As they became older they had difficulty finding work and also were not able to undertake manual work. They did not have and currently also do not have any social security and coming from poor background they do not own land. This meant that they did not receive pension nor had other alternative sources of income as a result of which they did not have any income and were forced to come to old age homes. Poverty however did not act in isolation and interacted with other factors including ill-health which further worsened the financial status, and maltreatment and negligence of family members partly due to lack of earnings by those interviewed.

"Yavude vidyabyasa agilla yakendare akaladalli namage sariyagi vyavaste iralilla kshta andre kasta namage 5 mandi iddaru kelasa illa karya illa vyvasaya madidaru adaralli Adaaya illa eallarannu kastadinda saktaa idde kuli madiye jeevanana desabekittu illaandare hotte tumbuvadu tumba kasta agutitu yavude sarakar ikelsailla enu illa yava muladinda namage Adaaya brutiralilla ella kuli madiye jivana nadesabekittu" (Male 92 years old)

The second reason for coming to the old age home is ill-health. According to the respondents as one grow old health problems increase and also the body moves slowly. Due to lack of Education they are unaware of health issues and how to adjust such issues at their age. This was further compounded by lack of care at home and also negligence of family members. And since they did not any source of income they were unable to seek health care and this along with poverty and lack of care led the respondents to the old age home.

"nanage aareetia samashyegallu enu illa bayi vanaguvudu aste matte ivag nanage kivi sariyagi kellisalla sumaru ondu varshadinda kadime agide nanage sugar ide mai mele gayavagide kai mtte kalian beralluglu setiyuttave jothege selleta ond ekade kullitukollalu Aguvudilla nanage kalian himmadiyalla nadiyuvaga novu barutte idannella torisidaga sugar tablet swalpa kadime madu jasti madu anta heli hogtare adaralle kala kalitaidini." (Male 75 years old)

The third reason is negligence of the family. The respondents felt that due to their inability to earn money they were not taken care of the family and that if they were taken care by their family they would not have come to the old age home. They feel that they are a burden to their families and

that they are ignored in their homes. They think that if they were earning or were receiving pension then they would have been taken care of at their home. Due to lack of care they are not able to meet their needs including receiving medical care. This has forced them come to the old age home and also the mental stress resulting from lack of care has contributed to them deciding to come to the old age home. .

The last reason is lack of care givers at home. The needs of a senior citizen are multiple. At old age people have many health issues, they need affection and concern, but often this is ignored by the family.

Problem faced in Old age home

The respondents feel that at the old age home they face many problems including torture,, discrimination taste of food, verbal and non verbal abuse, work load for old people.

The main problem according to the respondents is discrimination. Those who are the running old age home have appointed staff but some staff is not caring all the residents. The discrimination is in form of preferential treatment in form of provision of good service, quality food, hot water, good medication to those who are cooperating with the staff and those who are not cooperating with the staff do not receive good services

"Avaru maduva kelasakke nanu jagalla maduttene nyayavagi ellarigu nodikoda hage nmmannu nodikolluvudilla ellarigu kottahage koduvudilla adkke nanu jagalla maduttene yarigadaru novu adare aspatrege kallisuttare nange enadru novu adre aspatrege hogu anta helodilla. E Ashramadalli paravagilla channagi nodkotare aadre ello ondu kade nammannu sariyagi nodikolluttilla taratmya madutiddare anta namge anisuttide." (Female 86 year old)

The second problem is the respondents face is with the food at the old age home. At the old age home two types of food is prepared one is for the staff and the other for residents of the old age home. Respondents say that the food prepared for staff is tasty but the one prepared for them not tasty and also food quality was poor. Though a facility for hot water is available the respondents tell that they are not provided with the same. The respondents are of the view that food supplied to them from outside is tasty compared to what is cooked at the old age home. Respondents tell that when they take food provided they are facing more health problems.

"Enu nodkotare hagene illi innen sigutte illi uta kodtare tindi kodtare adu uppu khara enu iralla kelavomme ruche irode illa illi bisi neerina tondare ide adannu bittare channagide adre kelvondu bari namage uta ruche anislla" (Female 86 years old)

In the old age home the residents face abuse which they consider to be a major problem. The residents face two types of abuse namely, verbal abuse and physical abuse. Verbal abuse is more than physical abuse at the old age home. Respondents tell that staff shout at them and use bad words. One of the reasons for which respondents face verbal abuse is regarding them not being provided free food and the threat that they have to work otherwise they will not be provided food.

This leads to mental stress and respondents think at such instances that it is better to go back to their homes because of all these issues that they face at the old age home.

Another problem faced by the respondents is that they are unable to carry out heavy work but staffs give them heavy work and when they undertake such work they face health problems such as joint pain, body ache, headache, and fever. The staffs do not understand about their problem and give them target of work which they are not able to finish. This results in the respondents comparing their homes and the old age home since that such kind of work they have to do or were doing at their homes. They also think it is better to go back to their homes because due to such work at home they have shifted to the old age home and them facing the same problem at the old age home too.

"Namage summane kullitukollalu aguvadilla hogi snna putta kelasa gallannu maduttene adaru saha idan madu adan madu anta kriyuttare nanna kaiyali astondu kelasa madalu aguvudilla namma kasta arta madikolluvude illa namage adannu madu anta tumba vattaya maduttare kelavaru hage tondare kodutta iruttare innu ullidavaru channagi nodkottare." (Female 80 year old and 86 year old)

According to the respondents though they and the staff stay in the old age home, the staff do not speak to them properly and do not behave well with them because of which the senior citizens are sad. They also tell that not having access to newspaper and television makes them sad. Since they do not have any care givers they are ready to face the problems at the old age home but even in the old age home no one takes care of them or cares for the problems faced by them.

Health Problems in Old age people

As human beings get older they start facing a lot of problems of which health problems are a major issue. The health problems faced by the elderly at old age homes are similar to those experienced by those staying at home however certain differences do exist. The health problems faced by the respondents include Communicable disease, Non communicable disease, mental health problems and Physical health problems.

1. Communicable diseases which are seen among the respondents include skin problems, cold, cough, fever, eye problems, headache and diarrhea. (Figure1).

"Nange kannugalu sariyagi kanuvudilla operation agide matte nanna kivi sariyagi kellisuvidilla kaikalunovu mutte selleta nidde sariyagi barilla enu saha sariyagi nenapuiralla ellamaratbidtini nanna kainail bhara yattuvudakke agalla nange tumba dura nadkondu hogalu aagalla idellasamasye ide ivag naragalu sakastu tondare koduttade adakke sister matrekoduttare adallade nange maikadita jasti adakke matrekodtare adre idella novige nange nidde sariyagi barodeilla." (Female 86 years old)

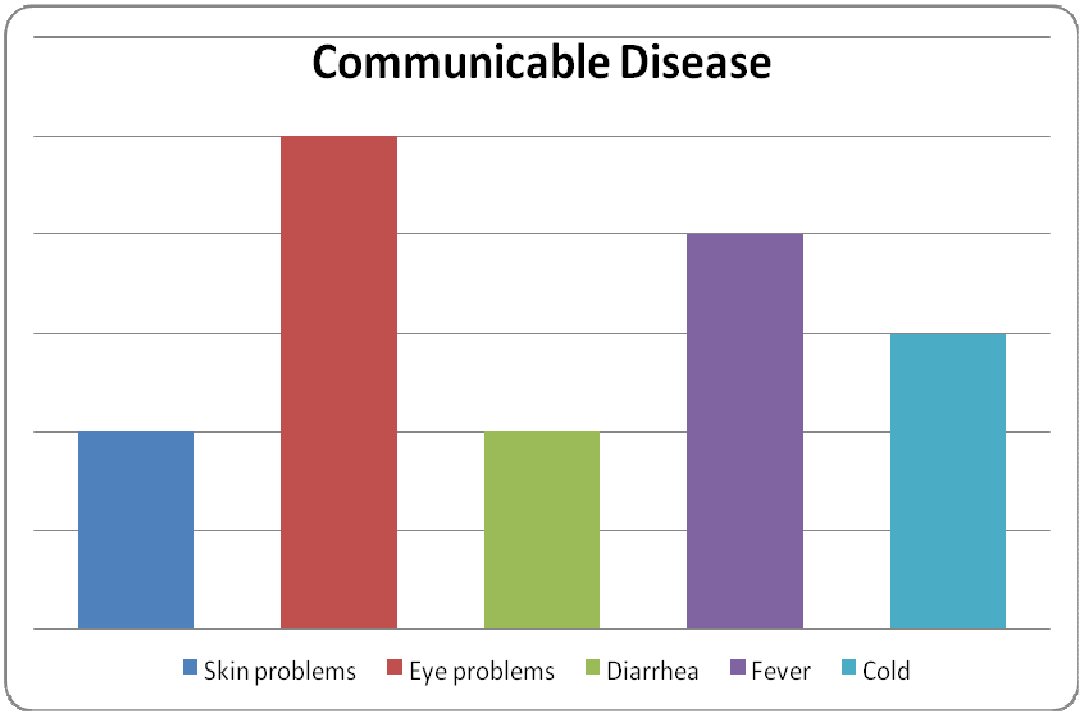


Figure 1: Communicable diseases faced by respondents

Non Communicable disease:-

The chronic illnesses faced by respondents include diabetes, asthma and those related to the prostate gland.(Figure 2) These illnesses required old term care and usually do not have a cure.

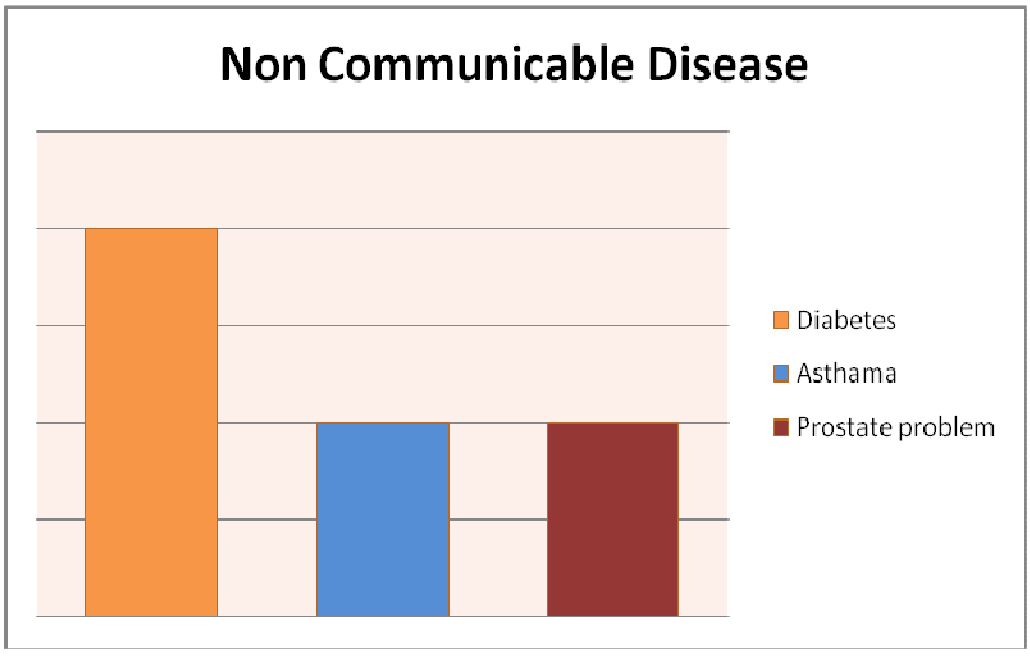


Figure 2: Chronic illnesses faced by respondents

Mental Health:-

Mental health issues at the old age are a common problem which usually manifest in the form of memory loss, loneliness, sleeping disturbance, sad movement, depression, anxiety. These problems are faced the by respondents also and figure 3 below shows the pattern of the mental health problems faced by the respondents.

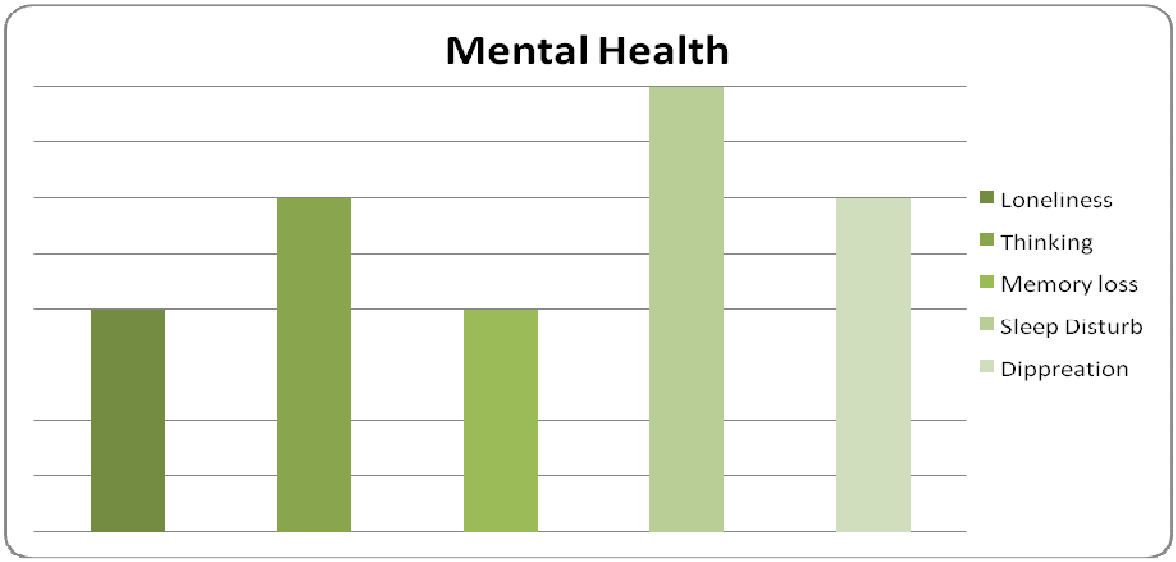


Figure 3: Mental problem faced by respondents

Physical Health:-

The physical health problems faced by the respondents include joint pain, hearing loss, tiredness, sweating, dry mouth and loss of hair.(Figure 4)Some of these problems are linked to the poor nutritional status of the respondents.]

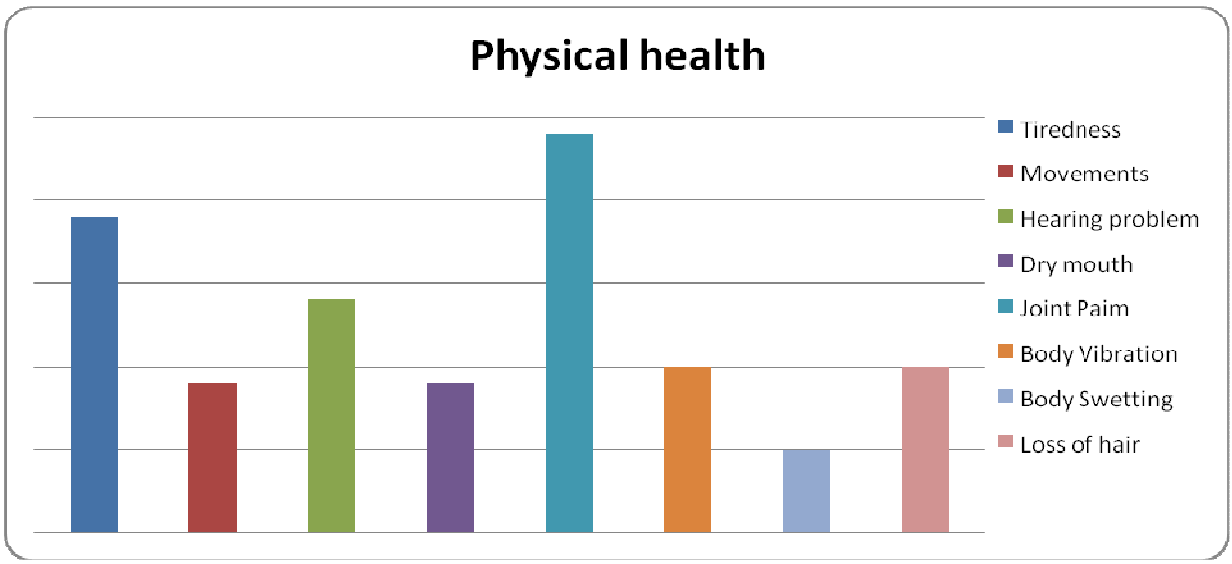
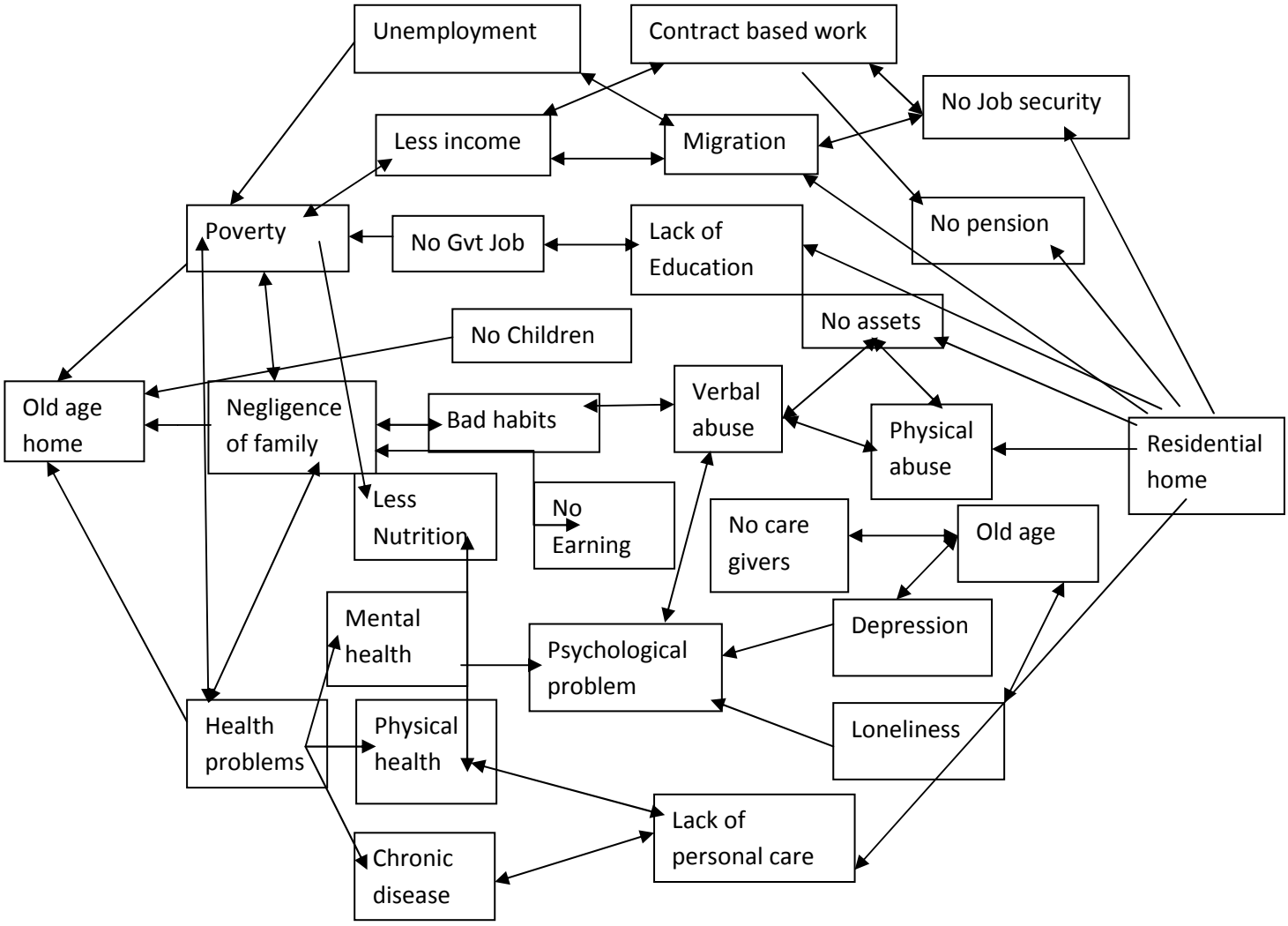


Figure4: Physical health problem faced by respondents

"Nange mai kai ella jibi jibi annuttade ega nanage buja kai kalian kandagallella tumba novu baruttade matte nanna kai kalian beralugallu setiyuttave jotege selleta onde kade kulitukollalu aaguvudilla nange kalin himmadigllella nadeyuvaga tumba novubaruttde idella vayassadmele sahaja ankondu kalakalita idiniaste." (Male 75 years old)

Links the problems at old people



Conclusion

An attempt was made to study the relevance and usefulness of old age homes in Karnataka, with the objective to find out the reason for coming to the old age home, their level of satisfaction about the conditions and life in the home and health problems in old age of the inmates. Six inmates of an old age home in Bangalore urban, Karnataka were selected for the study. Information regarding the reason for the coming to the old age home, health problems in old age home and problem faced in old age home, was collected from the respondents using an interview guide.

Major findings revealed that the majority of the inmates joined the Old Age Homes due to family problems like poverty, ill health and absence of caregivers. Poverty however did not act in isolation and interacted with other factors including ill-health which further worsened the financial status, and maltreatment and negligence of family members. Elderly people has some problems in old age home as they face many problems like torture, discrimination, lack of tasty food, verbal and non verbal abuse from inmates as well as staff and work load. And the health problems are like communicable and non communicable disease, mental and physical health problems. Communicable diseases include skin problems, cold, cough, fever, eye problems, headache, joint pain, and diarrhea; chronic illnesses like diabetes, asthma and those related to the prostate; mental health problems like dementia, loneliness, sleeping disturbance, depression, and anxiety; and physical health problems like joint pain, hearing loss, tiredness, sweating, dry mouth and loss of hair.

Based on the research findings the following recommendations are being given:

Recommendation

1. Educate personal and community on aging and problems of elderly and remedies.
2. Provide group therapy like counseling and family intervention.
3. Since the families are nuclear in size there is a need for institutionalized old aged home
4. The existing government facilities like old aged pension, senior citizens card, free treatment facilities at government hospitals, supplement of nutritious food and club for senior citizen.
5. At institution provide quality care and psychosocial support.

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   *Help Age India – Research and Development Journal.***14(3),** 8-18 **(2008)**

Over all learning

- Faith in myself and others
- Self Confidence
- Love and respect for each other
- Communication skills
- Dedicated to work in the community
- Time management
- Patience
- Respond to communicator
- Learnt about communicable/ non communicable disease
- Learnt about the exiting health systems of the Govt and the Different way of Pvt/Public hospital functioning.
- Learnt little of Odiya (Language of Orissa State)
- How to get involved in the community.
- Learn the culture / habits of the Tribal belt
- Apprehension about working in Tribal areas has disappeared.
- Love for nature.
- Value of relationship
- Trust
- Empathy
- Documentation skills
- Reporting skills

Conclusion

Health for all is a subject very dear to me since I was unaware of it from elsewhere except SOCHARA. Me coming from a normal family I was introduced to universal health and its components which has become a challenge to me personally. The experience which I have after in contact with senior citizens has personally questioned me ***"what is wrong with the society."*** My involvement with Adivasi tribal people in Orissa has been an eye opener to the values which they cling to their daily life. They taught me self respect, self confidence and how to be in friendly with the nature. Yes, I have become ***"a lover of the nature".***

I am convinced that ***"Health is a challenge for us today"***

Reading list

- Health status of the urban elderly- Siva Raju, S
- Qualitative Methods in Mental Health Research-Kapur, R L Ed.
- Caring for Elderly People in the Community 2nd -Williams, Edrs
- Bharata samajakarya viswakosha. Vol. 1-Marulasiddhaiah, H M
- Janarogya- Arogya Hakku
- Health Status of the Urban Elderly - A medico social study-Siva Raju, S
- Psychology Part - 1: Textbook for 1 year PUC-Nataraj, P
- Mental Retardation - A manual for village rehabilitation workers-NIMHANS
- Health action – Oct-2013
- Karnataka towards Equity, Quality and Integrity in health – Task force on health and family welfare government of Karnataka-2011.
- Research method knowledge base-Trochim, William M K
- Population Ageing and Health in India – S Irudaya rajan.
- Active Ageing a policy framework
- Che Guevara Reader. 2nd edn - Deutschmann, David
- Anand for newsly married couples-Invally, Prasanna
- When a lawyer falls in love- Amrita Suresh
- An Agenda for Caring – Interventions for Marginalized groups – Harsha Mander and Dr. Vidya Rao

POETRY:-

Saaviraru Janagalle Bandu Seriri Ondagi Indu Samudayavannu Kattuvirindu Seveya Padeyalu Endu ॥ 2॥	**S**–ಸಾವಿರ ಸಾವಿರ ಜನಗಳೆ ಬಂದು ಸೇರಿರಿ ಒಂದಾಗಿ ಇಂದು ಸಮುದಾಯವನ್ನು ಕಟ್ಟುವಿರಿಂದು ಸೇವೆಯ ಪಡೆಯಲು ಎಂದು ॥ಪ॥
Ondondu Kaiyannu Hididu Indu Swabimanadi Baduki Endu Samatheyannu Saralu Neevu Ondagi Banni Ellaru Endu ॥2॥	**O**–ಒಂದೊಂದು ಕೈಯನ್ನು ಹಿಡಿದು ಇಂದು ಸ್ವಾಬಿಮಾನದಿ ಬದುಕಿ ಎಂದು ಸಮತೆಯನ್ನು ಸಾರಲು ನೀವು ಒಂದಾಗಿ ಬನ್ನಿ ಎಲ್ಲರು ಎಂದು ॥2॥
Chadurida Janagalle Neevu Hedaradiri Endendu Kuggadiri Nanna Sodhar Sodhari Sahakara Sigalilla Endu ॥2॥	**C**–ಚದುರಿದ ಜನಗಳೆ ನೀವು ಹೇದರದಿರಿ ಎದೆಂದು ಕುಗ್ಗದಿರಿ ನನ್ನ ಸೋದರ ಸೋದರಿ ಸಹಕಾರ ಸಿಗಲಿಲ್ಲ ಎಂದು ॥2॥
Hakkugallannu Padeyuvadu Namma Aajanma Sidda Hakku Maretu Hogadiri Bandugalle Idu Nimmaya Kartavya Endu ॥2॥	**H**–ಹಕ್ಕುಗಳನ್ನು ಪಡೆಯುವುದು ನಮ್ಮ ಆಜನ್ಮ ಸಿದ್ದ ಹಕ್ಕು ಮರೆತು ಹೋಗದಿರಿ ಬಂದುಗಳೇ ಇದು ನಿಮ್ಮಯ ಕರ್ತವ್ಯವೆಂದು ॥2॥
Arogya Namma Ellara Hakku Uchitavagi Adu Sigutirabeku Sarvarigu Sama Ballu Sarvarigu Sama Palu ॥2॥	**A**–ಆರೋಗ್ಯ ನಮ್ಮ ಎಲ್ಲರ ಹಕ್ಕು ಅದು ಉಚಿತವಾಗಿ ಸಿಗಬೇಕು ಸರ್ವರಿಗು ಸಮ ಬಾಳು ಸರ್ವರಿಗು ಸಮಪಾಲು ॥2॥
Rajiyagdiri Kutantra Janarige Lancha Kodadiri LanchaBakarige Ramanagiri Nambida Janarige Ravanna Patra Dharisadiri ॥2॥	**R**– ರಾಜಿಯಾಗದಿರಿ ಕುತಂತ್ರ ಜನರಿಗೆ ಲಂಚ ಕೊಡದಿರಿ ಲಂಚಬಾಕರಿಗೆ ರಾಮನಾಗಿರಿ ನಂಬಿದ ಜನರಿಗೆ ರಾವಣ ಪಾತ್ರ ಧರಿಸದಿರಿ ॥2॥
Andada Nadu Nammadagalu Namma Hakkanu Kellalu Mareyadiri Nambugeya Samudaya Kattalu SOCHARA Samstheyu Mareyadiri Bandugalella Ondagi Nava Samaja kattalu mareyadiri ॥2॥	**A**–ಅಂದದ ನಾಡು ನಮ್ಮ ದಾಗಲು ನಮ್ಮ ಹಕ್ಕನ್ನು ಕೇಳಲು ಮರೆಯದಿರಿ ನಂಬುಗೆಯ ಸಮುದಾಯವ ಕಟ್ಟಲು **SOCHARA** ಸಂಸ್ಥೆಗೆ ಸೇರುತ್ತಿರಿ ॥2॥ ಬಂದುಗಳೆಲ್ಲ ಒಂದಾಗಿ ನವ ಸಮಾಜ ಕಟ್ಟಲು ಮರೆಯದಿರಿ.
Saviraru Janagalle Bandu Seriri Ondagi Indu!!! Seriri Ondagi Indu!!!!! Seriri Ondagi Indu!!!!!!	ಸಾವಿರ ಜನಗಳೆ ನೀವು ಸೇರಿರಿ ಒಂದಾಗಿ ಇಂದು!!

A Celebration at Home for the Aged

Lunch at mid day

Senior Citizen Group discussion

Sharing with Senior Citizens

Team at Bissamcuttack Orissa

My tribal family at Dharasing Orissa

My learning's

Thank You AEI for Dignity