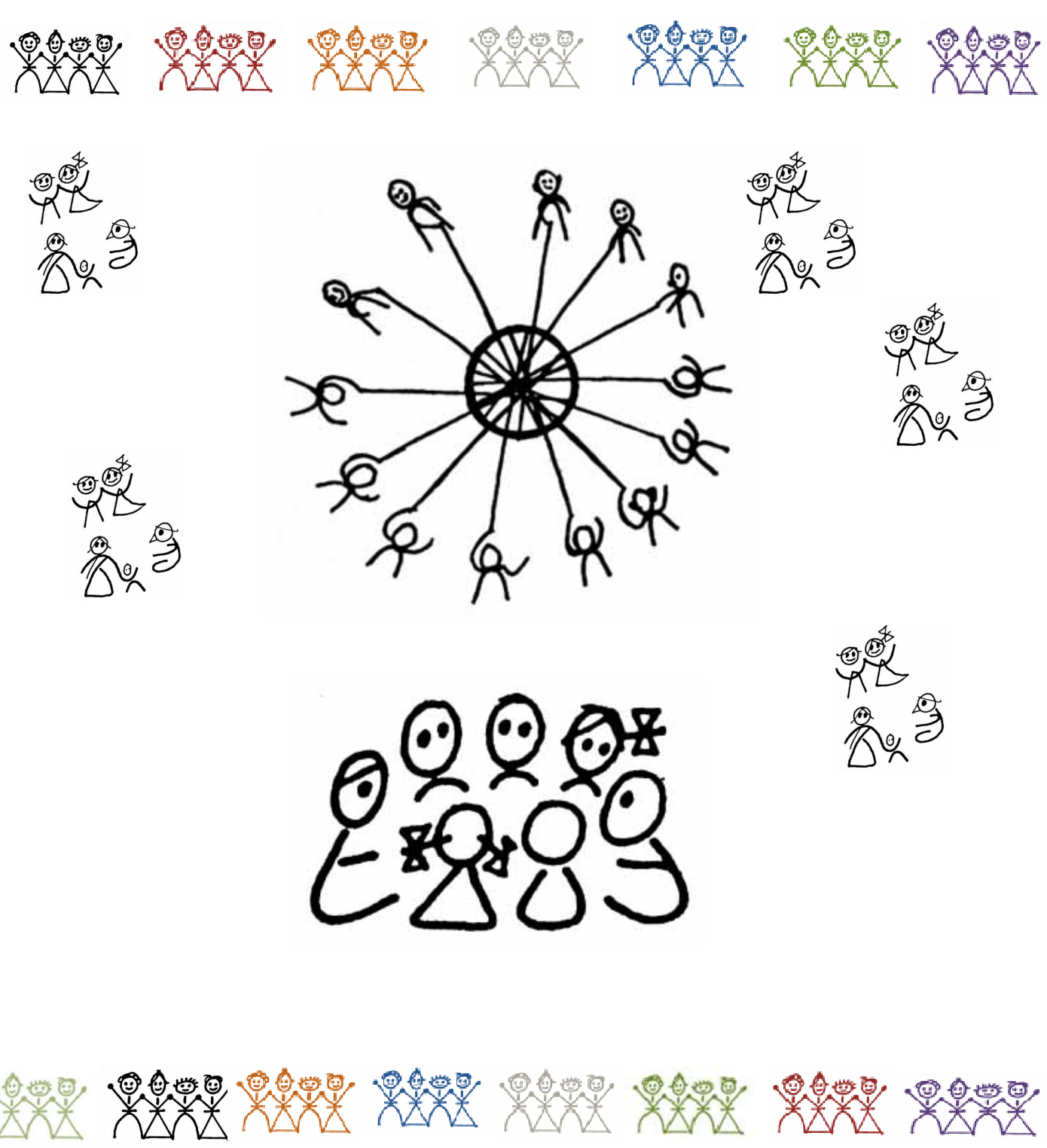
2014-2015

Community Health Learning Programme

A Report on the Community Health Learning Experience

Dr. Bharti Sahu



SOPHEA

sochara
building community health

2015

Community Health Learning Program

Dr. Bharti Sahu

SOCHARA

Index

-: Acknowledgement:-

I would like to convey my heartiest thanks to **The Director of SOCHARA, Dr. Thelma Narayan** for introducing this life changing fellowship for people who actually want to dedicate their work for community welfare

Dr. Ravi Narayan is a wonderful story teller which actually inspires people to think differently and do differently which mean a lot to someone who needs your help to make changes in their life.

Special thanks to **Mr. Prasanna** sir who mentored me for my research topic. I

would like to pay my sincere thanks to **Dr. Mohammad and Mr. Kumar** who always guided us in spite for being so busy in their work.

Thanks to **Rahul, Janelle** and **Sabu** for so much of support and guidance.

Tons of thanks to **Mr**. **Chander** who always motivated me and opened my eyes to see this world from another prospective when I was almost lost.

My fellows :- Jyoti lakshmi, Krishna, Amrendra, Tosif, Pawan, Rahul, Phoolsingh, Afsana, Ashma, Yashoda, Huntiful, Regina, Saraswati, Asma, Vishan, Anusha , Juliet who are now my family far away from home. All our enjoyment, laugh, secrets and all good times together we shared will be always into my basket.

Lastly Hari and joshep Bhaiya for the rejuvenating lemon Tea.

Me :--

I originally belong to Raipur Chhattishgarh. I am born in a service(middle) class family. Blessed to have such a caring parents and loving younger sister. I have a big joint family.

I am a dentist by profession. I have 1 year experience working “Healthcare magic” as a medical consultant and 1 year with “Mediassist” as a medical officer. I opted the paradigm shift from medical model to social model of Health Care.

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 equity 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.

This Fellowship had widened my lens from the prospective of community. I have also learned how to relate with the root aetiology of any disease relating it directly to the social cause rather than just medical cause of it.

For community work, remember “Chinese Proverb”.

I. Go to the people

II. Live with them

III. Learn from them

IV. Plan with them

V. Work with them

VI. Start with what they know

VII. Build on what they have

VIII. Teach by showing, learn by doing

IX. Not piecemeal, but a system

X. Not a showcase, but a pattern

XI. Not odds 7 ends, but a system

XII. Not to conform, but to transform

XIII. Not relief, but release

- Yen Tangchu

Boarded:-

During CHLP orientation reflection time gave enough opportunity for personal learning while activities like role – play made me part of the system and helped in realizing the situation. As I started learning the concept “Health as a Human Right”, I found that it requires enough resources from the society to reach individual potential in a dignified way. In this situation “Availability” of the resources is not enough, another important factor is the “Accessibility” and “Capability” to utilize these resources.

"Monsoon game" helped in understanding the web of causation through social, economic, political, and cultural (SEPC) analysis and the hard realities of farmers' life, the caste system, difficulties in loan repayment and other socio economic factors affecting their life. We understood the abstractness of the "society", where it is a stratified group of people, who have power dynamics (intellectual, financial, natural and physical), Determining use of resources (ownership, access and control).

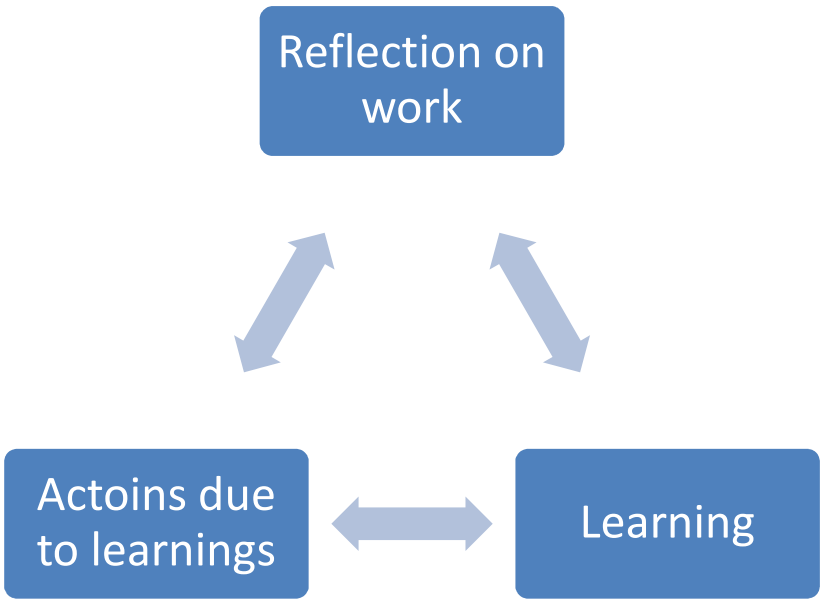
While finding the reasons how gender affects women's health, I found that so many factors work simultaneously and every factor is interlinked with each other. Following are the identified factors:

- Poverty
- Last priority in terms of health
- Social Control
- Empowerment factor of Women
- Discrimination of Women within their families
- Religious and cultural factors
- Restrictions in mobility
- Violence, overwork and stress

I observed that there are certain factors that make women more exposed to few diseases i.e. Sex/biology, gender norms and values, Government activities, access and control of basic amenities and resources. I figured out that getting same proportion and values of resources as compared to male gender is important but right to access these resources are essential part of community setting. How to cope up with the negative feelings and using them as change agents in society with proper integration with the policies and systems motivated me to work in this direction. The role play on "Alternative Paradigm in Community Health – a CHP perspective" helped in realizing how "individual specific care' works on social model and recognizes patient as people (more humane) and enable them at every step to move from disease to health.

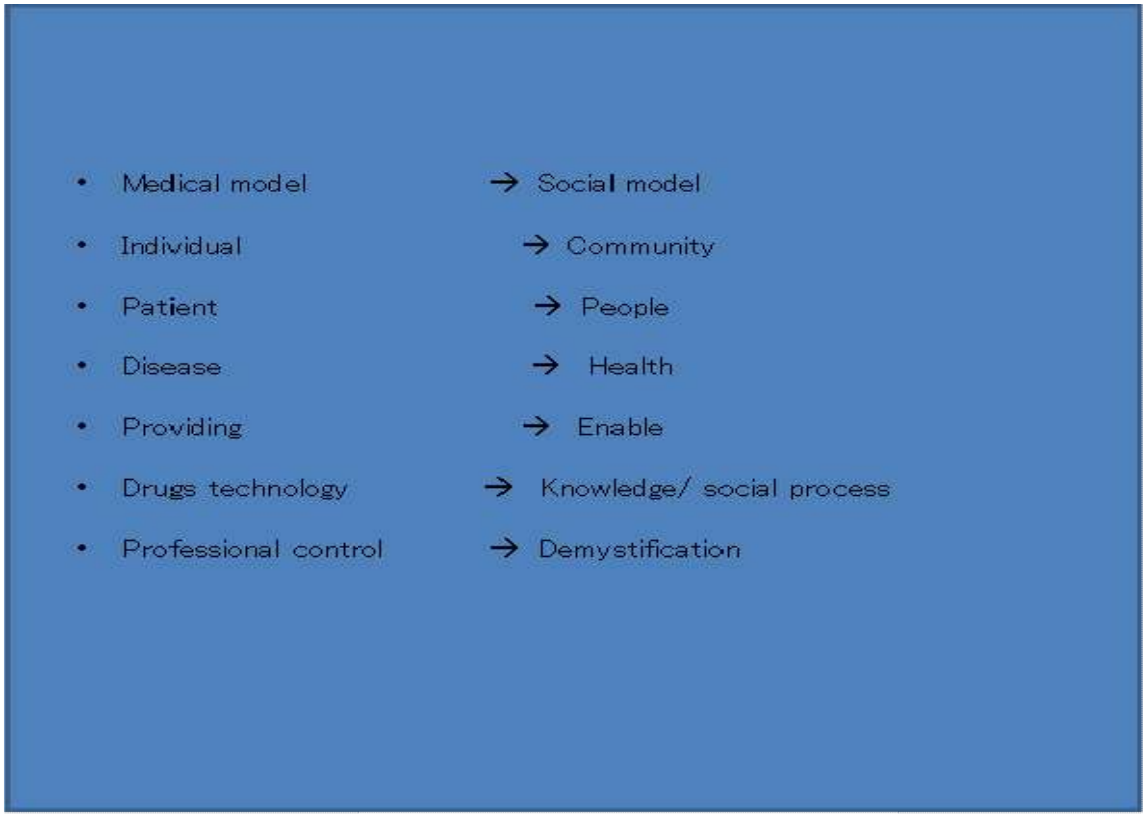
During my learning phase, I had many questions hovering in my mind about how to move ahead and how to handle the multidimensionality and

complexity of the health issues. My outcome to these thoughts was that when someone has focus on Research and learning, for finding a solution to a particular question, It is inevitable that one will encounter another set of intriguing question in the problem solving process. This helped me to understand the importance of “feedbacks” and “Reviews” in my problem solving methods, by this I understood that learning is a continuous phenomenon which reflects in to our future course of action. Blow flow chart shows the importance of learning which reflects the changes in work.



I learnt that committed leaders can provide the direction, inspiration, and will to bring together needed Partnerships and resources to ensure success. Leaders also can ensure that there is an active plan to sustain a community’s ongoing ability and commitment to work together to establish, advance, and maintain effective strategies that continuously improve health and quality of life for all.

Paradigm Shift:



Journey:

The session on globalization helped me understand following concepts:

- Globalization in its current phase has been described as an unprecedented compression of time and space reflected in the tremendous intensification of social, political, economic, and cultural interconnections and interdependencies on a global scale.
- Recent years have witnessed the emergence of new forms of global health care mobility, and increased popularity of existing forms due to processes such as the development of a globalized economy, establishment of international and bi-lateral trade agreements.
- Nongovernmental organizations (NGOs) have become increasingly important players in the realm of global health and development. They operate projects in low and middle-income countries (LMICs) throughout the world

- Commonly cited factor related to NGO distribution is the health and development needs of a population. Social and economic indicators of these needs include literacy rates, infant mortality rates, or life expectancy. Organizations whose objectives are oriented towards improving the well-being of neglected populations logically would target populations with serious needs according to health and well-being indicators.

The session on "Whatever happened to health for all by 2000 AD?" explained following key points:

- Primary health care was adopted as the policy model for global health. The outcome document, the Alma Ata Declaration, adopted this holistic approach, which emphasizes human rights and social and economic dimensions of health and well-being. It shifted the focus from cure to the prevention of ill health.
- The Alma Ata Conference took place in the political context of the New International Economic Order (NIEO), formally adopted by the 6th Special session of the General Assembly in April 1974. NIEO was a set of proposals developed during the 1970s by formerly colonized countries in the developing world. The main aim was to revise the existing international economic system to make it more favourable to the Third World countries, as they were then called.
- By 2005, implementation of the Global Strategy was still slow; the funding base decreasing rather than increasing.
- In the late 1990s, as the trend to public-private partnerships was becoming established, IBFAN-GIFA observed their formation and the development of the WHO Guidelines on Interaction with Commercial Enterprises.
- April 2008, GAIN introduced in India its Infant and Young Child Feeding (IYCF) program and proposed to launch officially an IYCF Alliance, which had been under discussion for some time. This effort met with strong protest from 19 national public interest organizations working in the areas of health, development, gender, education and nutrition, including Breastfeeding Promotion Network of India, Jan Swasthhya Abhiyan and All India Drug Action Network.

- The demonstrators protested against the increasing interference from manufacturers to influence policies on infant and young child feeding and nutrition.

The session on National Rural Health Mission – A nation's effort to strengthening of health systems and improve people's health" described the following points:

- **Major objectives of NRHM include the following** :

    - to raise public spending on health,
    - with improvements in community financing and risk pooling
    - to provide access to primary healthcare services for the rural poor, with universal access for women and children
    - Child health, Water, Sanitation and Hygiene
    - to see a concomitant reduction in IMR / MMR / TFR; to prevent and control
    - communicable and non-communicable diseases
    - to revitalize local health traditions

- **What is actually under new NRHM :**

    - Creation and upgradation (on infrastructure / human resource / managerial fronts using untied funding) of SCs, PHCs,
    - CHCs; Revitalising and mainstreaming AYUSH; Mission Flexible Pool untied funding; Janani Suraksha Yojana (JSY);
    - Accredited Social Health Activists (ASHAs); Involvement of community at decentralised levels through Hospital
    - Development Societies (HDS) or Rogi Kalyan Samitis (RKS) / Village Health and Sanitation Committees (VHSCs);
    - Converging health, nutrition, water, sanitation and hygiene activities through District Health Plans; Integration of vertical health and family welfare programmes at national, state, district and block levels; Fostering public-private partnerships while regulating the private sector; Instituting Indian Public Health Standards.

- **Issues and challenges for NRHM :**

    - LACK OF TRAINED PERSONNEL: Lack of trained personnel and infrastructure is a major concern for proper implementation of NRHM.
    - ORGANIZATION OF SOCIETIES: Implementation of NRHM in many states like Jharkhand is very challenging .These states lacks the basic infrastructures for implementation of national health programs and state health societies were not constituted here for long.
    - PARTICIPATION OF LOCAL SELF-GOVERNING BODIES: At present, the NRHM is being seen as a package of schemes but in reality it is a participative program of different stakeholders like Community, PRIs, government and non-governmental organizations in a well-coordinated manner.
    - CORRUPTION IN IMPLEMENTATION: There is possibility of corruption in the implementation of these programs.
    - UTILIZATION OF UNTIED FUNDS: Civil society engagement has not yet taken place at the state level.
    - PUBLIC-PRIVATE PARTNERSHIP: Public-private partnership processes should not encourage the privatization of health services. Financing should be from public funds so that universal access to services is ensured.

- The overall health status of the poor and socially excluded population is meagre in some states. The reasons for the poor health status of millions of people are not hard to find. Major factor hindering access to quality health services are lack of or non-existing inter-sectoral linkages between different stakes holders. This phenomenon is also found between different Government Departments. Here the role of panchayati raj institutions and civil society organizations becomes pertinent as one of the important stakeholder. There is also need of forging alliances with wider determinants of health. Existence of services in terms of structure will never ensure its utilization to fullest unless and

until there is proper channel between different stake-holders which can link people to these services.

Essential concepts: ----

Health

WHO says “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.
But as scholar activists the word health can be 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.

Community

A group of people having same identity living in a locality having a common interest looking for common goal.

Community Health

It is related with health of the community. A well-developed community should have proper drinking water, sanitation, nutrition, good environment, education, accessible to primary health care and so on.

Determinants of health:
Economical
Cultural
Social
Political
Environmental

Community health Axioms:

- Rights and responsibility
- Autonomy over health

- Integration of health and developmental activities
- Building decentralized democracy at community and team level
- Building equity and empowering community beyond social conflicts
- Promoting and enhancing the sense to community
- Confronting the biomedical model with new attitude skills and approach
- Confronting the existing super structure model of medical/health care to be more people and community oriented
- A new vision of health and healthcare not a professional package for illness
- An effort to build a system in which health for all can become a reality.

4 pillars of primary health:

- Appropriate technology
- Equity
- Community participation
- Inter structural collaboration

Four A's in health stream:

- Accessibility
- Affordability
- Availability
- Acceptability

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.

Health as a Right

When we talk about health as a right all those social, cultural, environmental, political, economic factors should be dealt at first then only the word HEALTH FOR ALL is achieved.

The **Declaration of Alma-Ata** was adopted at the International Conference on Primary Health Care (PHC), Almaty (formerly Alma-Ata), Kazakhstan (formerly Kazakh Soviet Socialist Republic), 6-12 September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health For All" but only in third world countries at first. This applied to all other countries five years later.

Useful parameters:-

Total fertility rate (**TFR**):

TRF of a population is the average number of children that would be born to a woman over her lifetime if:

- She were to experience the exact current age-specific fertility rates (ASFRs) through her lifetime, and
- She was to survive from birth through the end of her reproductive life.

Incidence: Occurrence of new cases of a specified disease in a specified community during a specified period of time

Prevalence: A measure of the total number of existing cases (episodes or events) of a disease or condition at a specified point in time. (If a period of time is specified, then the resulting disease measure is period prevalence.)

Morbidity: Any departure, subjective or objective, from a state of physiological or mental well-being, whether due to disease, injury or impairment.

Methods and formulae:

Incidence: [Number of new cases in a given time period] X100/population at risk in given time period]

Prevalence: [total number of new and old casesX100]/Population

Incidence rate: [Number of new cases in the given time period*1000]/Total person-time of exposure

For infectious diseases, it can also be expressed as:

Incidence: Number of episodes in a given time periodX100/Population at risk during the time period.

Proportion: Defined as the fraction a/ (a + b) for mutually exclusive groups with elements a and b.

(The *b* elements may belong to more than one group, each mutually exclusive of the group with the *a* elements.)

Rate: A measure of the "speed" at which events are occurring (for example rate of incidence of a specified disease is a measure of the "speed" with which new cases occur in the community).

Ratio: Defined as the fraction a/ b for two mutually exclusive groups with elements a and b (conventionally expressed as 1: b/a).

Crude death rate (CDR): [Total number of deaths occurring in a year x 1000]/Mid-year population. The adjective "crude“ refers to the overall death rate with no compensation for the effect of any associated factor, such as age, sex or race.

Perinatal mortality rate: [(Number of stillbirths) + (number of infant deaths in the first week after birth) in a year X 1000]/Total number of births in the same year.

Perinatal mortality ratio: [(Number of stillbirths) + (number of infant deaths in the first week after birth) in a year X 1000] /Total number of live births in the same year.

Infant mortality rate: [Number of deaths under one year of age in a year X 1000] /Total number of live births in the same year.

Maternal mortality rate: [Number of female deaths due to complications of pregnancy, or during child birth in a year X 1000] /Total number of live births in the same year.

Definitions of new terms and concepts in the context of health indicators:

(Health) status indicator:

An indicator of the level of the health phenomena of interest.
Example: Average annual number of cases (episodes) of diarrhea per child under five years of age

Feasibility:

The ability to obtain the data needed to compute the indicator.
Example: An indicator of fetal loss may not be feasible, since not all data on fetal losses are routinely collected.

Goal (of a health programme):

The ultimate aim of a health program.
Example: polio eradication.

Indicator:

A variable that helps to measure changes directly or indirectly and is used to assess the extent to which objectives and targets are being attained.
Example: see Handout 16.3.

Objective (of a health program):

A measurable state a health program is expected to be in, at a given time, as a result of the application of program activities, procedures and resources.
Example: An objective of an expanded program of immunization could be effectively to immunize at least 90% of the eligible children by the end of the current 5-year national health program.

Process indicator:

A measure of the extent, efficiency or quality of service performance.

Example: Proportion of pneumonia cases seen who receive standard case management at health facilities.

Proxy indicator:

An indicator used in place of a direct indicator which may be more difficult to measure or compute.
Example: School absenteeism may be used as a proxy indicator for general morbidity in school-age children.

Relevance:

The extent to which an indicator contributes to the understanding of the phenomena of interest.
Example: The proportion of preschool children (under 5 years of age) more than 2 SD below the median height-for-age of the WHO/National Center for Health Statistics reference population contributes to the understanding of childhood moderate and severe stunting.

Reliability:

The indicator should be reproducible if measured by different people under similar circumstances.
Example: Infant mortality is a reliable indicator of early childhood mortality in countries with comprehensive birth and death registration.

Sensitivity:

The degree to which an indicator reflects changes in the phenomena of interest.
Examples: The quantity of non-expired drugs by category at a health facility is a sensitive indicator of drug supply at the facility. In many developing countries, outpatient attendance rates at public health facilities are a sensitive (proxy) indicator of the supply of drugs at those facilities.

Specificity:

The ability of an indicator to reflect changes in only the specific phenomena of interest. Example: The amount of drugs dispensed daily at a health facility is not a specific indicator of drug supply at the facility.

Some of the indicators for monitoring the goals and targets of the World Summit for Children

Indicators of mortality

Infant mortality rate: the annual number of deaths of infants under one year of age per 1000 live births.

Indicators of childhood nutrition

Underweight prevalence:

Proportion of preschool children (under 5 years of age) more than 2 SD (moderate and severe) or more than 3 SD (severe) below the median weight-for-age of the WHO/National Center for Health Statistics reference population.

Indicators of water and sanitation

Proportion of the population with access to an adequate amount of safe drinking-water in a dwelling or located within a convenient distance from the user's dwelling.

Proportion of the population with access to a sanitary facility for human excreta disposal in a dwelling or located within a convenient distance from the user's dwelling.

Indicators of disability

Disability type-specific prevalence:

The total number of persons with disability, specifying the number having serious difficulty in seeing, hearing or speaking, moving, learning or comprehending, or having strange or unusual behavior, or other disability of

duration of at least six months or of an irreversible nature, in the following age groups: 0-4, 5-14, 15-19 and 20 and over.

Indicators of health and nutrition of the female child, and of pregnant and lactating women

Antenatal care:

Proportion of women attended at least once during pregnancy by trained health personnel.

Indicators of child spacing

Contraception: proportion of women of childbearing age (15-49) currently using contraceptive methods (either modern or traditional).

Fertility: fertility rate of women 15-49 years of age.

Indicators of immunization coverage

- Proportion of children immunized against diphtheria, pertussis, and tetanus (DPT, 3 doses) before their first birthday.
- Proportion of children immunized against measles before their first birthday.
- Proportion of children immunized against poliomyelitis (OPV, 3 doses) before their first birthday.
- Proportion of children immunized against tuberculosis before their first birthday.

Disease:

A disease is a particular abnormal, pathological condition that affects part or all of an organism. It is often construed as a medical condition associated with specific symptoms and signs.[1] It may be caused by factors originally from an external source, such as infectious disease, or it may be caused by internal dysfunctions, such as autoimmune diseases. In humans, "disease" is often used

more broadly to refer to any condition that causes pain, dysfunction, distress, social problems, or death to the person afflicted, or similar problems for those in contact with the person. In this broader sense, it sometimes includes injuries, disabilities, disorders, syndromes, infections, isolated symptoms, deviant behaviours, and atypical variations of structure and function, while in other contexts and for other purposes these may be considered distinguishable categories. Diseases usually affect people not only physically, but also emotionally, as contracting and living with a disease can alter one's perspective on life, and one's personality.

it can be broadly classified in two ways:

- Communicable
- Non communicable

Communicable d/s: A communicable disease such as a cold is a disease that spreads from person to person. Communicable diseases are diseases that you can "catch" from someone or something else. Some people may use the words contagious or infectious when talking about communicable diseases.

There are four major types of germs:

- Bacteria
- Viruses
- Fungi
- Protozoa

Hepatitis: Viral hepatitis is a major global health challenge. Viral hepatitis, which affects the liver, is a group of infections referred to as hepatitis A, B, C, D, and E. It is responsible for more than 1.4 million deaths annually, mostly in low- and middle- income countries. This public health threat rivals the number of deaths from HIV/AIDS (1.7 million), tuberculosis (1.4 million) and malaria (700,000).

One in three people worldwide have been infected with the hepatitis B virus at some point in their lives, and 400 million people live with chronic hepatitis B or C infection. Hepatitis B and C causes roughly 80 per cent of liver cancers, and are an important cause of cirrhosis (scarring) of the liver. A key concern about viral hepatitis is hepatitis virus co-infection among people living with HIV, which can increase the risk of both serious liver disease and more rapidly progressive HIV infection.

Close attention should therefore be paid to viral hepatitis as we implement global programs on HIV/AIDS such as the Presidents Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to fight AIDS, Tuberculosis, and Malaria.

Influenza: Seasonal Influenza (the flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness, and at times can lead to death. Some people, such as older people, young children, and people with certain health conditions, are at high risk for serious flu complications. The best way to prevent the flu is by getting vaccinated each year.

Polio: Polio, short for Poliomyelitis, is an infectious disease. It is caused by a virus that invades the nervous system. Less than 1 per cent of polio cases get to the paralysis stage, which is fatal when it reaches the muscles humans need to breath. Still, fewer than 10 per cent of polio cases that reach paralysis result in death. Polio is a horrific disease because it tends to infect children under five, causing lifelong crippling conditions. There is no cure for polio, but there are two vaccines, meaning the strategy to eradicate the disease is focused on prevention.

AIDS/HIV: Human immunodeficiency virus (HIV) destroys or impairs the immune system of the people it infects. As the immune system weakens individuals become more at risk to infections. As condition progresses, the immune system becomes weaker and the individual becomes more at risk to acquired immunodeficiency syndrome (AIDS), the most advanced stage of HIV. Because of advances in medicines called antiretroviral drugs, many people with HIV live for 15 years or more before symptoms of AIDS appear.

Malaria: Malaria is a preventable parasitic disease transmitted by mosquitoes. It is prevalent especially in sub-Saharan Africa and Southeast Asia.

According to WHO's World Malaria Report 2012:

- There were roughly 219 million cases of malaria in 2010
- There were an estimated 660,000 deaths from malaria in 2010
- Ninety per cent of all malaria deaths occur in Africa; many victims are children under five years old
- Between 2000 and 2010, more than 1.1 million malaria deaths were averted globally as a result of scale-up interventions

Because malaria is a global emergency that affects mostly poor women and children, malaria perpetuates a vicious cycle of poverty in the developing world.

Tuberculosis: Tuberculosis, also known as TB, is a disease caused by bacteria spread through the air from one person to another. Commonly, it attacks the lungs, but also other parts of the body. It is estimated that one third of the world's population is infected with TB, but it can lay latent, meaning not everyone develops the active disease. Persons with latent TB do not spread the disease unless it is active in the body. Of all TB cases in the world, 85 % occur in 22 countries. Of these 22 countries, 9 are in sub-Saharan Africa and over 1.5 million cases of TB occur in Africa each year. In Africa TB/HIV co-infection is one of the main causes of morbidity and mortality in Africa. A 3-5 drug regimen using Directly Observed Therapy – Short course (DOTS) over a 6-8 month period is the standard of treatment for TB. Treatment failures result in drug resistance including multi-drug.

Non communicable d/s:

A **non-communicable disease**, or **NCD**, is a medical condition or disease that can be defined as **non-infectious** and **non-transmissible** among people. NCDs can refer to chronic diseases which last for long periods of time and progress slowly. Sometimes, NCDs result in rapid deaths such as seen in certain types of diseases such as autoimmune diseases, heart diseases, stroke, most cancers, asthma, diabetes, chronic kidney disease, osteoporosis, Alzheimer's disease, cataracts, and many more. While

sometimes (incorrectly) referred to as synonymous with "chronic diseases", 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 transmittable infections. Chronic diseases require chronic care management as do all diseases that are slow to develop and of long duration.

The World Health Organization (WHO) reports NCDs to be by far the leading cause of death in the world, representing over 60% of all deaths. Out of the 36 million people who died from NCDs in 2005, half were under age 70 and half were women. Of the 57 million global deaths in 2008, 36 million were due to NCDs. That is approximately 63% of total deaths worldwide. Risk factors such as a person's background, lifestyle and environment are known to increase the likelihood of certain NCDs. Every year, at least 5 million people die because of tobacco use and about 2.8 million die from being overweight. High cholesterol accounts for roughly 2.6 million deaths and 7.5 million die because of high blood pressure.

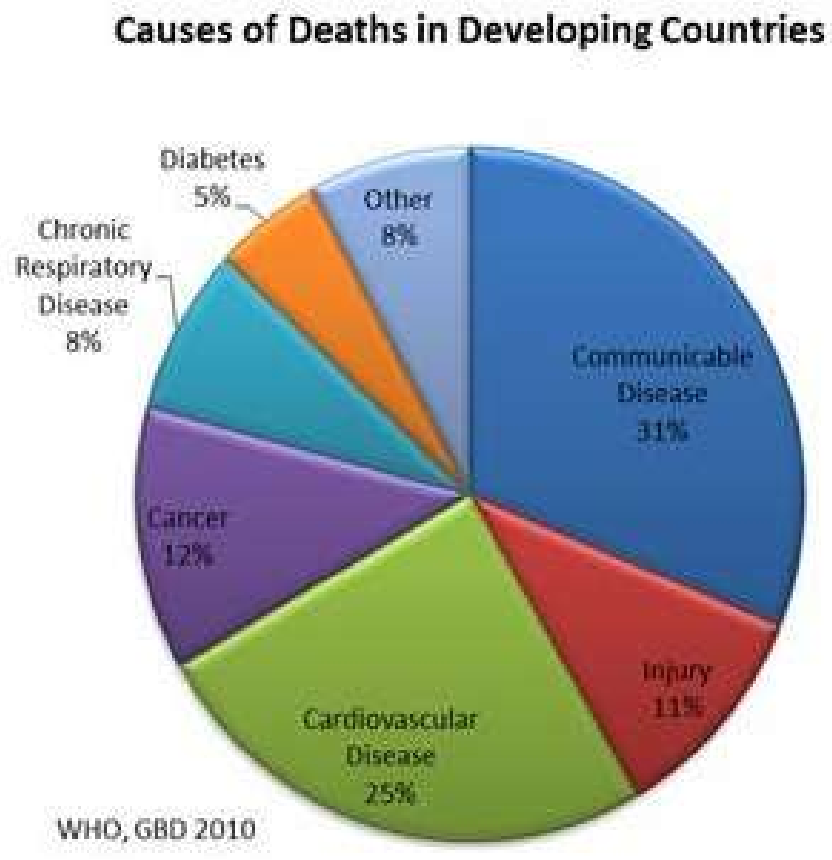
Types of NCDs:

- Cardiovascular disease (e.g., Coronary heart disease, Stroke)
- Cancer
- Chronic respiratory disease
- Diabetes
- Chronic neurologic disorders (e.g., Alzheimer's, dementias)
- Arthritis/Musculoskeletal diseases
- Unintentional injuries (e.g., from traffic crashes)

Importantly, deaths due to NCDs are becoming more common in low- and middle-income countries, where the majority of NCD deaths occur and where health systems are often not equipped to respond. The WHO reported in 2010 that 31% of deaths in developing countries are caused by communicable

disease, while the remainders of deaths are caused by these non-communicable diseases and injuries:

- Cardiovascular disease – 25%
- Cancer – 12%
- Injury - 11%
- Chronic Respiratory Disease – 8%
- Diabetes – 5%
- Other – 8%



Key NCDs:-

1. **Cancer:** For the vast majority of cancers, risk factors are environmental or lifestyle-related, thus cancers are mostly preventable NCD. Greater than 30% of cancer is preventable via avoiding risk factors including: tobacco, being overweight or obesity, low fruit and vegetable intake, physical inactivity, alcohol, sexually transmitted infections, and air pollution. Infectious agents are responsible for some cancers, for instance almost all cervical cancers are caused by human papillomavirus infection.

2. **Cardiovascular disease:** The first studies on cardiovascular health were performed in 1949 by Jerry Morris using occupational health data and were published in 1958. The causes, prevention, and/or treatment of all forms of cardiovascular disease remain active fields of biomedical research, with hundreds of scientific studies being published on a weekly basis. A trend has emerged, particularly in the early 2000s, in which numerous studies have revealed a link between fast food and an increase in heart disease. These studies include those conducted by the Ryan Mackey Memorial Research Institute, Harvard University and the Sydney Centre for Cardiovascular Health. Many major fast food chains, particularly McDonald's, have protested the methods used in these studies and have responded with healthier menu options.

3. Diabetes: Type 2 Diabetes Mellitus is a chronic condition which is largely preventable and manageable but difficult to cure. Management concentrates on keeping blood sugar levels as close to normal ("euglycemia") as possible without presenting undue patient danger. This can usually be with close dietary management, exercise, and use of appropriate medications (insulin only in the case of type 1 diabetes mellitus. Oral medications may be used in the case of type 2 diabetes, as well as insulin).Patient education, understanding, and participation is vital since the complications of diabetes are

far less common and less severe in people who have well-managed blood sugar levels. Wider health problems may accelerate the deleterious effects of diabetes. These include smoking, elevated cholesterol levels, obesity, high blood pressure, and lack of regular exercise.

4. Chronic kidney disease: Although chronic kidney disease (CKD) is not currently identified as one of WHO's main targets for global NCD control, there is compelling evidence that CKD is not only common, harmful and treatable but also a major contributing factor to the incidence and outcomes of at least three of the diseases targeted by WHO (diabetes, hypertension and CVD).CKD strongly predisposes to hypertension and CVD; diabetes, hypertension and CVD are all major causes of CKD; and major risk factors for diabetes, hypertension and CVD (such as obesity and smoking) also cause or exacerbate CKD. In addition, among people with diabetes, hypertension, or CVD, the subset who also have CKD are at highest risk of adverse outcomes and high health care costs. Thus, CKD, diabetes and cardiovascular disease are closely associated conditions that often coexist; share common risk factors and treatments; and would benefit from a coordinated global approach to prevention and control.

5 cs during delivery

Clean hands

Clean place

Clean blade

Clean stump

Clean thread

Health care expenditure:

- Total health expenditure

- Public health expenditure
- Private health expenditure
- Out of pocket health expenditure
- Per capita health expenditure

Public health expenditure is expressed in terms of % of GDP.

GDP= gross domestic production

(All incomes of the country including foreign income, donations, and funds + local income)

GNP= gross national product

(All domestic incomes, they don't include foreign revenue)

Total health expenditure of country = 5.8% of GDP

Public health expenditure= 1.1% of GDP

Private health expenditure= 4.7% of GDP

Therefore total health burden on public of their health is around 19%
(i.e. 5.8/1.1)

It indicates that out of 100 Rupees of health expenditure the government is putting only 19 rupees and rest is done by the person itself means out of pocket expenditure.

Unfortunately the 2nd biggest reason for loan in India is health expenditure.

4 principles of health financing in insurance

- Risk pooling
- Cross subsidy

- Solidarity
- Equity

Tax based insurance is the best health insurance system working in India. It is based on **Beveridge model** also called as National Health Service model.

Principle of public private partnership:

B--- Built

O--- Own

O--- Operate

T--- Transfer

But there are certain conditions for this partnership

- Provider should built the physical infrastructure
- Risk should be owned by the contractor.

In India there is no public private partnership which follows the above mention condition.

Mental health: burden of mental disorders had risen over last few decades. Mental health is 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 is able to make a contribution to his or her community. Major proportions of mental disorders come from low and middle income countries . There are lacunae in psychiatric epidemiology due to intricacy related to defining a case, sampling methodology, under reporting, stigma, lack of adequate funding and trained manpower and low priority of mental health in the health policy. Most common causes of disorders especially in adolescents could be depression, alcohol abuse, schizophrenia and bipolar disorders. Various studies had shown that the prevalence of mental disorders is high in female gender, child and

adolescent population, students, elderly population, people suffering from chronic medical conditions, disabled population, disaster survivors, and industrial workers.

women issues: The health of Indian women is intrinsically linked to their status in society. women's status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. There is a strong son preference in India, as sons are expected to care for parents as they age. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labor force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons. While women in India face many serious health concerns, this profile focuses on only five key issues: reproductive health, violence against women, nutritional status, unequal treatment of girls and boys, and HIV/AIDS. Because of the wide variation in cultures, religions, and levels of development. it is not surprising that women's health also varies greatly from state to state. I personally can say that until or unless we won't improve the status of women in society diseases like Anemia can't be just cured by distribution of iron and folic acid tablets in free of cost .Women need more high-quality nutrients when they are pregnant or nursing; however in some areas of India women typically eat last and least. More than half of all Indian women develop anemia due to lack of essential nutrients. While women's rights and professional careers have come a long way, there are still segments of Indian society where women are very much discriminated against.

Sanitation and hygiene : Access to improved water and sanitation facilities does not, on its own, necessarily lead to improved health. There is now very clear evidence showing the importance of hygienic behaviour, in particular hand-washing with soap at critical times: after defecating and before eating or preparing food. Hand-washing with soap can significantly reduce the incidence of diarrhoea, which is the second leading cause of death amongst children under five years old. In fact, recent studies suggest that regular hand-washing with soap at critical times can reduce the number of diarrhoea bouts by almost 50 per cent. good hand-washing practices have also been shown to reduce the

incidence of other diseases, notably pneumonia, trachoma, scabies, skin and eye infections and diarrhoea-related diseases like cholera and dysentery. India has the highest rate of open defecation in the world *(WHO-UNICEF, 2010)*. People who have their own land have space to practise open defecation. The poorest people, however, who own little or no land, often have to walk for miles each day to access relatively safe and private open space. At the very least, this is a huge waste of time, effort and human potential. For the more vulnerable members of communities (women, pregnant women, children, and sick, elderly, or disabled, people) fulfilling their basic human needs can be a dangerous and degrading ordeal. Defecation near water sources and where food is being grown can spread disease.

Privatization: India has achieved substantial improvement in its health indicators. Life expectancy has increased, infant and maternal mortality has declined, and the coverage of most of the National Health Programmes is better. However, this progress is uneven; there are large State-wide variations, and performance in some States is abysmally low. Lack of accountability is plaguing the Indian health system. The productivity of public health sector has been rather low, and it is often considered one of the 'sick unit.' A popular 'treatment' to this 'sickness' is public-private partnership (PPP), which has become a buzz word today. Although PPP does not imply privatization alone, it has many other options available; but it may lead to privatization in its current format. Providing land and infrastructure to private players and letting them operate the health facilities in their own way cannot be labeled PPP. Monitoring the regulation capacity of public health system is very much inadequate currently, without which PPP is not possible. At this stage, privatization means that around 20% of the people who are very poor and depend on government system will be left with no option. The term privatisation refers to the growth of the ‘for profit’ sector and its inter relationship with the public sector. It also includes the introduction of market principles in the public sector viz. user fees, contracting out and private insurance schemes. The trends in privatisation are analysed in terms of the increase in private institutions and beds relative to public provisioning across rural and urban areas and states. This trend is a result of states facing a fiscal crisis and therefore, opting for

loans and grants from multilateral and bilateral agencies that advocate policies to make the public sector generate its own resources. The net effect of such a restructuring process on the utilisation patterns for outpatient and inpatient care across states and income groups are analysed in relation to the structures of provisioning

Disaster management: India has been traditionally vulnerable to natural disaster on account of its unique geo-climate conditions. Floods, droughts, cyclones, earthquakes, and landslides have been a recurrent phenomena. We have no policy on systematic disaster Management. It is only after a disaster strikes that the wheels of the government, both at the centre and at the states, move and that too slowly. Despite the need to build up capabilities to meet the challenges of disasters, the thrust has unfortunately been on alleviation and relief. Even the relief has not been quick and adequate, as few disasters such as Orissa super cyclone, Tsunami of 2004, Gujarat earthquake etc are still in our mind. Not only this they need psychological support/ counselling as well which is usually being neglected. And the basic priority is only given to shelter, food and clothings.

Environmental pollution: One of the greatest problems that the world is facing today is that of environmental pollution, increasing with every passing year and causing grave and irreparable damage to the earth. Environmental pollution consists of five basic types of pollution, namely, air, water, soil, noise and light. Improper management of solid waste is one of the main causes of environmental pollution and degradation in many cities, especially in developing countries. Many of these cities lack solid waste regulations and proper disposal facilities, including for harmful waste. Such waste may be infectious, toxic or radioactive. Municipal waste dumping sites are designated places set aside for waste disposal. Depending on a city's level of waste management, such waste may be dumped in an uncontrolled manner, segregated for recycling purposes, or simply burnt. Poor waste management poses a great challenge to the well-being of city residents, particularly those living adjacent the dumpsites due to the potential of the waste to pollute water, food sources, land, air and vegetation. The poor disposal and handling

of waste thus leads to environmental degradation, destruction of the ecosystem and poses great risks to public health. Air pollution is cause by the injurious smoke emitted by cars, buses, trucks, trains, and factories, namely sulphur dioxide, carbon monoxide and nitrogen oxides. Even smoke from burning leaves and cigarettes are harmful to the environment causing a lot of damage to man and the atmosphere. Evidence of increasing air pollution is seen in lung cancer, asthma, allergies, and various breathing problems along with severe and irreparable damage to flora and fauna. Even the most natural phenomenon of migratory birds has been hampered, with severe air pollution preventing them from reaching their seasonal metropolitan destinations of centuries. Water pollution caused industrial waste products released into lakes, rivers, and other water bodies, has made marine life no longer hospitable. Humans pollute water with large scale disposal of garbage, flowers, ashes and other household waste. In many rural areas one can still find people bathing and cooking in the same water, making it incredibly filthy. Acid rain further adds to water pollution in the water. In addition to these, thermal pollution and the depletion of dissolved oxygen aggravate the already worsened condition of the water bodies. Soil pollution, which can also be called soil contamination, is a result of acid rain, polluted water, fertilizers etc., which leads to bad crops. Soil contamination occurs when chemicals are released by spill or underground storage tank leakage which releases heavy contaminants into the soil. These may include hydrocarbons, heavy metals

Collective session includes the self-refection for a proper paradigm shift to evaluate both the sides of coin. The people of BHARAT and the other side is the changes which is actually occurring at the cost of people's livelihood. Most of the development is pushed by World Bank and IMF. But we should realize it's not actually development it's just distortion of environment and the resources. Ultimately the poor people continue to suffer a lot.

Presentations:

There were few presentations which I prepared during my fellowship. It consists of the different topics.

1. **Challenges in domestic violence counselling---- by CEHAT**

Key Learning's:

- Counselling is a close relationship between counsellor and counselee.
- Counsellor has to make decisions as to what one should do or not to do in critical situations.

Ethical codes of counselling describe:

    - Rights and responsibilities
    - Standards of principle
    - Values
    - Conduct
    - Most importantly welfare of clients
- CEHAT has its collaboration with private hospitals for a counselling for domestic violence issues.
- Domestic violence has bought into public domain in india by Feminist moment 1980s.
- DILAASA – first public based crisis centre

Components of counselling at DILAASA:

- Counselling practise with a feminist perspective
- Response system to psychological and social needs
- Process of dealing with suicidal ideation

- Sensitisation of health care provider on DV so that could identify abuse amongst patients coming to them.

Ethics in counselling is concern:

- How should the counsellor act?
- How should the counsellor justify holding one set of moral values rather than the other?

Principles of counselling ethics:

- Autonomy—respect and protect right and dignity of the client
- Non maleficence—causes no harm to the client in particular and the community in general
- Beneficence—ensures positive contribution towards the welfare of clients.
- Justice—benefits and risk of any intervention should b fairly distributed amongst people.
- Fidelity—notions of loyalty and commitments towards client
- Self-respect—fostering the counsellors own knowledge and care of self.

Critical evaluation model in ethical decision making:

1. Identify the problem—therapeutically, legal, professional dilemma
2. Apply the codes of ethics
3. Determine the nature and dimension of the dilemma
4. Generate potential course of action
5. Consider the potential sequence of all options, choose a course of action
6. Evaluate the selected course of action
7. Implement the course of action

My reflections:

- By going through this book I have learned how one should control your own emotions as a counsellor when you are dealing with very much personal and saddest part of someone's life.
- There has to be a barrier not to involve yourself fully in the case mean while you should also think that what would you have done when you were placed in that particular scenario.
- To motivate the sufferer and to make the second backup for her life is really very much important.
- It is the basic job of a counsellor to make feel the sufferer secure emotionally and physically.
- Overall it was a guideline for me how to deal with the cases of domestic violence and the people who need support and help from us.

2. Verbal autopsies to study the gaps and causes contributing to child mortality in rural Chhattisgarh.

   District profile:

- At the time of the 2011 census, the population within the Municipal Corporation area of Raipur was 1,010,087.
- The Municipal Corporation had a sex ratio of 946 females per 1,000 males and 12.3% of the populations were under six years old. Effective literacy was 86.90%; male literacy was 92.39% and female literacy was 81.10%.

  Raipur has a tropical wet and dry climate, temperatures remain moderate throughout the year, except from March to June, which can be extremely hot.

INTRODUCTION

- The under-5 mortality rate is the number of children who die by the age of five, per thousand live births in a year.

- As per AHS Report 2012-13, total under 5 Child mortality rate is 60 per 1000 live births for Chhattisgarh, out of which it is 65 and 40 per 1000 live births for rural and urban population respectively (data for 2009 to 2011).
- As per World Bank's Report (2013), the Child mortality rate in India was 56 per 1000. As per NFHS-3, this rate was 74 for India.

There is a need to study the gaps that lead to such high levels of child mortality in rural Chhattisgarh so that steps can be identified for improving policy/programmes.

OBJECTIVES:

1. To identify gaps contributing to child deaths in Chhattisgarh in:

a. Health seeking behavior of the family

b. Access to referral transport

c. Provision of healthcare services

2. To identify probable medical causes of child deaths.

3. To compare the gaps and causes for districts showing different levels of child mortality in the state and to explain the reasons behind the extremely high child mortality rate seen in certain districts (Sarguja (93), Jashpur (87), Koriya (75) and Kwardha(74)). (Data source : AHS 2012-13)

4. Suggest a strategy to address the systemic gaps thus identified.

METHODOLOGY:

1. Study period: Child Deaths happening from January 2014 to December 2014

2. Sampling :

1. Mitanin trainers (MT's) fill up the death register during monthly VHSNC meeting which contains details about child deaths (under 5 years age). Efforts are made that recording of no deaths is missed in this register.

2. These deaths are further compiled at block level each month by MTs in a Block Death register

3. Out of this list, three child death cases are selected randomly every month for each block (145 blocks out of total 146). Around 5000 verbal autopsies of child deaths will be done during the study.

3. Method of data collection and tool:

- Verbal autopsy: A verbal autopsy is a method of finding out the cause of a death based on an interview with next of kin or other caregivers.
- A pre-designed questionnaire is used for recording the chronological events of child death.

Process of data collection:

1. Block surveyors (Swasth Panchayat Coordinators) are trained to conduct verbal autopsies and fill up this questionnaire. They have good rapport in community and are familiar with local context and dialect, terms etc. used there.

2. These questionnaires are then submitted to SHRC every month for analysis.

4. Analysis method

4.1 Every filled questionnaire is checked by a **Trained Reviewer** and discussion is done with each surveyor for getting complete information about the case.

4.2 Data from the questionnaire is entered in computer.

4.3 A descriptive Case Summary is prepared for every case by reviewers that capture the key events, gaps and medical cause/s.

4.4 Based on data on key variables, the reviewer interprets and enters the categories of gaps for each case (TABLE A: Interpretation Form – Neonatal Form, TABLE B: Non-neonatal Form)

4.5 Quantitative analysis of these entries is done.

Preliminary findings (Summary):

- **Sample analyzed till June end:**

- Child deaths – 400 (during January to March 2014)

CHILD DEATHS

- Neonatal- 269 (67%)
- Post – neonatal- 131 (33%)

CHILD DEATHS- GAPS:

DELAY AT FAMILY LEVEL

1	FAMILY LEVEL	ALL CHILD DEATHS (N=400)	NEONATAL (N=269)	POST-NEONATAL (N=131)
1.1	Family did not take preventive steps	24%	27%	17%
1.2	Family sought treatment with delay or did not seek any treatment.	38%	34%	44%
1.3	Family did not approach mitanin	32%	28%	38%
1.4	Mitanin did not give right advice to family	4%	5%	2%
1.5	Family sought healthcare from Inappropriate provider	57%	51%	69%
	Proportion of deaths involving delay at family level	**73%**	**69%**	**82%**

DELAY AT TRANSPORTATION LEVEL

2.	TRANSPORTATION LEVEL	CHILD DEATHS (N=400)	NEONATAL (N=269)	POST-NEONATAL (N=131)
2.1	Came late after call	2%	2%	2%

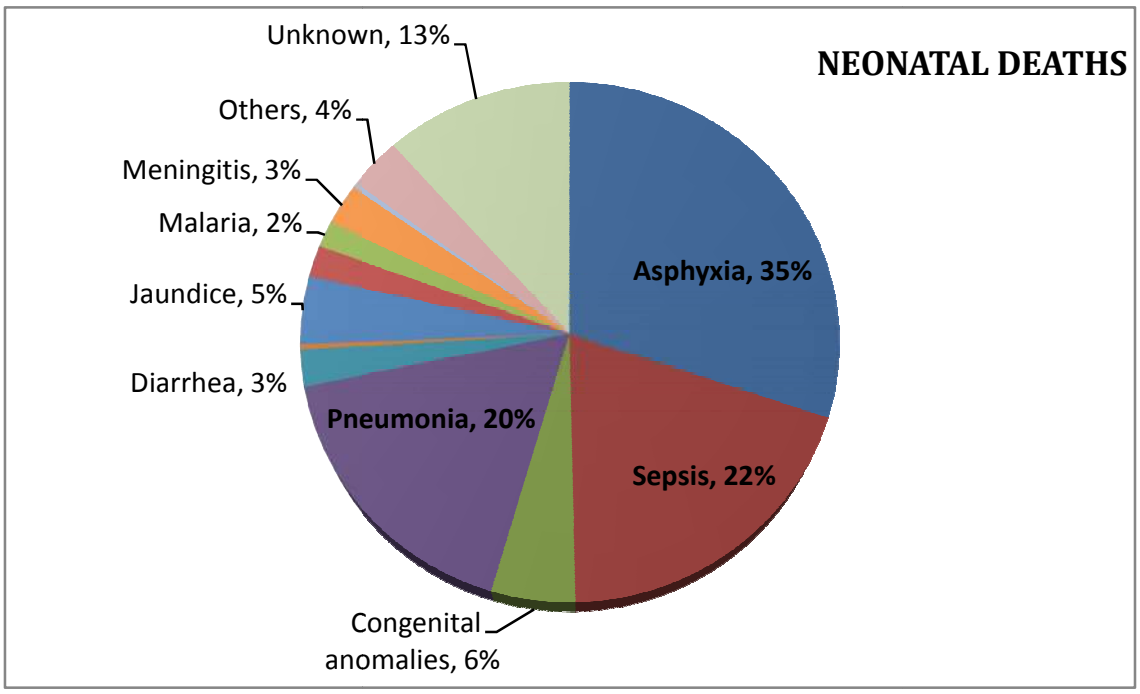
2.2	Did not come	2%	3%	1%
2.3	Did not pick	0%	0%	0%
2.4	No phone coverage	1%	1%	1%
2.5	Facility to facility referral support was needed but not arranged by health centre/ hospital.	4%	3%	5%
2.6	Money taken for transportation	2%	2%	1%
2.7	OTHER	1%	1%	0%
2.8	**Proportion of deaths involving delay at transportation level**	**10%**	**10%**	**8%**

DELAY AT HEALTH FACILITY LEVEL

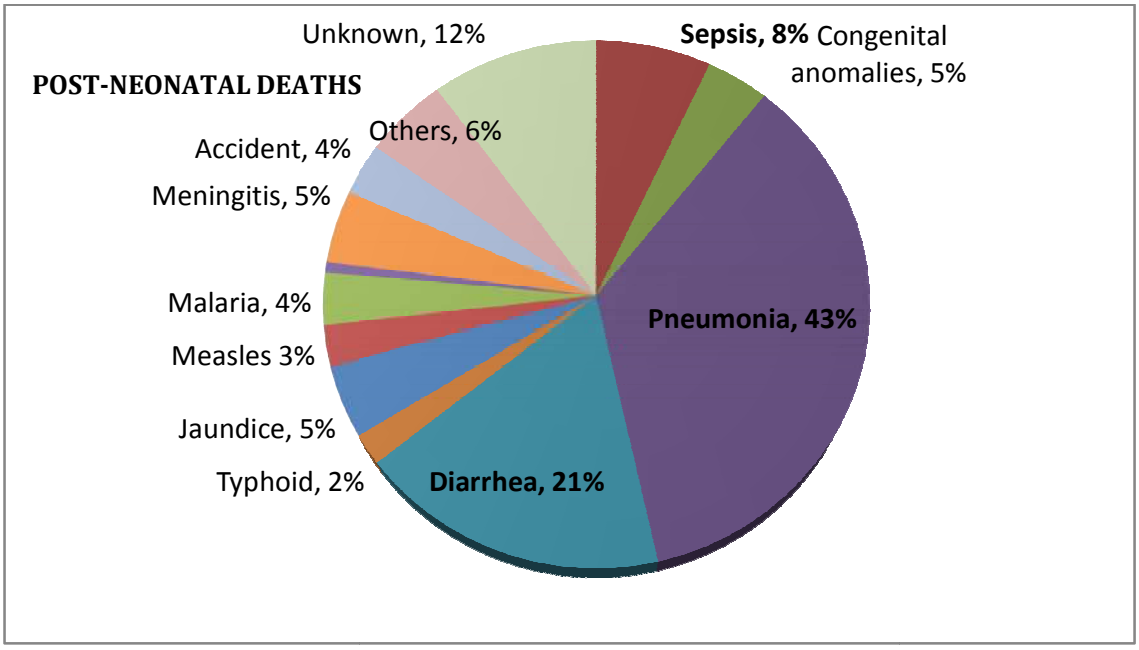
3.	**GOVT. HEALTH FACILITY LEVEL**	**CHILD DEATHS (N=400)**	**NEONATAL (N=269)**	**POST-NEONATAL (N=131)**
3.1	The required service/ procedure was not available at the appropriate level	24%	25%	24%
3.2	Money taken by the hospital (other than JDS charges)	5%	4%	5%
3.3	Delay in treatment	2%	3%	1%
3.4	Govt. facility Referred to private facility	11%	12%	8%
3.5	Family was sent back to home without proper treatment or did not pay attention during stay	19%	22%	13%
3.6	**Proportion of deaths occurring involving delay at Health facility level**	**44%**	**47%**	**38%**

NEONATAL DEATHS- MEDICAL CAUSES (N=269)

Discussion : above 3 table states that there is wide gaps when it comes to death of infants because of lack in awareness of the family. Effort has to be made for healthcare in people to make utilization of the fascility provided by government. Some how the family is not updated about the consequences of death. Basic health awareness is very much needed amongst the people. The next gaps lies in the sequence is gap in hospital facility . we should check the PHC and CHC whether they have full fascility as per their requirement or not because chhattissgarh consists of villages more than cities, so the village people should get the facility in PHC and CHC. And the last is because of transport. When it comes to reference it takes time to move from one hospital to other hospital which also add figures in mortality.



NON-NEONATAL DEATHS- MEDICAL CAUSES (N=131)



There were few presentations on mental health also which I would like to include in my report.

1. **Electroshock :the gentleman's way to batter women**

Introduction:

- From the perspective of most adherents to the medical model of psychiatry, electroconvulsive therapy (ECT) is a safe and effective treatment for severe and intractable depression.
- ECT is a psychiatric procedure which consists of passing sufficient electricity through the head (100—190 volts) to produce a grand mal seizure or convulsion—hence the term "electroconvulsive therapy".

- ECT is generally (although not universally) considered a valid, although relatively invasive, option for the treatment of major depression when all else has failed, especially when a patient is actively suicidal.
- Invented in fascist Italy, ECT was inspired by the sight of animals en route to the slaughter being rendered docile by an electrical cattle prod. The first human recipient was a homeless man who was dragged off the street and administered it against his will.

THE SCIENTIFIC FINDINGS: ECT AS DAMAGE

- Typically, a single ECT series consists of at least six to ten treatments.
- As early as the 1950s, animal experiments established that ECT causes brain damage.
- On the basis of observable brain damage (cell death and haemorrhages), with almost complete accuracy, he was able to identify which animals had been administered shock.
- To cite relevant research on human beings with respect to both unilateral and bilateral shock, Weinberger (1979) found more cerebral atrophy in the brains of “schizophrenics” who have had ECT than those that have not.
- Memory loss, intellectual impairment, and the creation of neuropathology are standard and well documented.
- Breggin’s extensive literature review (1998, p. 27) culminated in the following conclusion: “ECT causes severe and irreversible brain neuropathology including cell death. It can wipe out vast amounts of retrograde memory while producing permanent cognitive dysfunction.”
- In a rigorously controlled double blind study, Lambourne and Gill (1978) found that a month after shock and simulated shock, there was no discernable difference in improvement between the shock and control groups.

THE LATEST SIGNIFICANT PIECE OF RESEARCH

- Ross (2006) finding, the largest and most ambitious study in ECT history was concluded.
- It involved 346 shock recipients, used a barrage of different measures, and involved six month follow-up.
- The study established cognitive impairment, brain damage, and memory impairment to the level of statistical significance—moreover, a high level of significance—with respect to both unilateral and bilateral electroshock, and indeed, for every method of delivering electroshock, including the newest.

STATISTICS:

- 1974 study of electroshock in Massachusetts reported in Grosser(1975) revealed that 69% of those shocked were women.
- In Ontario in 1999—2000, 75% of the shock administered was administered to women.
- Another statistic that seems relevant is that approximately 95% of all shock doctors are male.
- The simple fact is that the people most damaged by electroshock (women) are administered electroshock two to three times as often as the people less damaged by it (men).

WOMEN IN SPECIAL JEOPARDY:

- Several of the populations of women at particular risk of being subjected to this medicalized assault are evident in the foregoing.
- They include: women who are distressed, abused women, women who are in conflict with others who hold power over them, women who have received ECT previously, women who have not “improved” on psychiatric drugs, women who present as “suicidal,” women who are depressed.

CONCLUDING REMARKS:

- Battery which is highly damaging and which is unleashed on women at their most vulnerable.
- It is a particularly insidious form of battery, more over, and one difficult to mobilize against because it is done in the name of help. What adds to the problem, it is committed by professionals; its victims are automatically defined as “not credible”; it is state-sponsored; it is seen as legitimate; it is underpinned by a huge industry with vested interests; it is routinely done with the cooperation of family members; and mere are no shelters to which its victims or potential victims may flee.
- It is beyond the scope of this article to provide detailed suggestions about what feminists can do about this form of woman abuse, though clearly, we have a responsibility here.

2. Adolescent mental health

Introduction:

- Adolescents aged 10–19 constitute about one fifth of India's population and young people aged 10 - 24 about one third of the population.
- The most common causes for adolescent deaths, worldwide, have been found to include communicable diseases such as HIV/AIDS, tuberculosis, and respiratory tract infections, and non- communicable diseases such as road accidents, self-harm, violence, substance abuse and early pregnancies.
- Over 35% of all HIV infections occur among young people 15-24 years of age and a large proportion of young women - around 16% of 15 to 19 year olds - have experienced pregnancy or childbirth.
- 15% of all deaths among rural women ages 15-24 years can be attributed to maternal mortality and morbidity.
- An estimated 10-20% of young people worldwide experience mental health problems, leading to related health and social problems such as adverse school performance, delinquency risky sexual behaviour and substance abuse with suicide being the third leading cause of death among young people.
- The suicide death rate in India is among the highest in the world with 40% of Indian suicide deaths among men and 56% among women occurring in the age group 15-29 years.
- 40% of adolescents start taking drugs between ages 15-20.

However mental health of young people is a neglected public health issue in low and middle income countries.

CorStone's resilience based work in India

- CorStone is a non-profit organization with the mission to provide evidence-based personal resilience programs to improve mental and

physical health and increase academic achievement among marginalized youth.

- Resilience has been defined as the ability to achieve positive life outcomes despite significant stress, challenge, or adversity.

  Recent research has shown that resilience can be developed or 'built' through interventions, and interest in resilience-based interventions for improving youth outcomes is growing worldwide.

  Outcome:

- Preliminary results including demographic covariates.
- Gender attitudes were measured through questions that asked about the rights of girls to attend school, bear a child before 18 years of age and their attitude about sanctions on violence.
- Similar results emerged for a number of mental, social, health and education outcomes in the Surat study.
- In the boys' cohort, we found that boys improved their emotional resilience, self-efficacy, school performance, and social well-being statistically significantly
- Girls were able to advocate to parents to stop their own and others' early marriages by using their persistence, emotional awareness, and assertive communication skills they gained through the resilience curriculum while communicating the facts about the dangers of early marriage to their parents using what they had learned in the Health curriculum.

Conclusion:

- Mental health promotion with a focus on building personal resilience among youth may be one key missing link in youth programs in India.
- We must consider strength-based mental health work as a core program that can lead to better outcomes not only in overall wellbeing, but also

in specific but related areas as in the field of health, education, and livelihoods.

- However, these attempts need to be reviewed and there is a need to build evidence on their effectiveness.

3. Grand Challenges to Global Mental Health

Introduction:

- Announced research priorities for improving the lives of people with mental illness around the world, and called for urgent action and investment.
- The largest ever international Delphi panel was assembled in a project starting March 2010 to formulate the "Grand" Challenges to Global Mental Health project.
- The panel consisted of a scientific advisory board from the US National Institute of Mental Health.
- The panel listed 25 grand challenges including biological, social and genetic factors that needed to be identified and tackled.
- They argued that MNS disorders constituted 14% of the global burden of disease surpassing cancer and cardiovascular.

The main framework for the project utilised a narrow "medical" model for understanding mental distress that emphasised treating mental, neurological and substance- use (MNS) disorders through improved understanding of the brain, its cellular and molecular mechanisms

The main problems with adhering to the Grand Challenges proposal:

1. Concerned about the approach of the Delphi panel. The data on which the Delphi panel bases its recommendations is also

questionable and could grossly exaggerate the global burden of mental disorders.

2. The focus on “molecular and cellular mechanisms” in the brain for the complex problems of living ignores the experiences of ordinary people and the different settings in which mental health problems manifest.
3. The recommendations overlook indigenous healing, social support networks, rights-based organisations and family support.
4. The assumption of a global norm for mental health and the idea that deviations can be subsumed within a simplistic biomedical framework is restrictive and disconnected from the real-lived experiences of potential service users.
5. Mental health services should not be dependent on funds driven by pharmaceutical, insurance and other industries with potential conflicts of interest.

4 **MENTAL HEALTH POLICY IN INDIA-** UNPACKING THE ‘RIGHT TO MENTAL HEALTH CARE’

Introduction

- This paper is an attempt to foreground the contradictions inherent in different policies related to mental health and promotion viz., the NMHP, the UNCRPD, the proposed National Health Policy (NHP) and the Mental Health Care Bill (2013). The paper is a call to shake this status quo by examining critically the continuing ‘medicalisation’ and ‘individualization’ of mental

illness whereby ‘distress’ is being continuously diagnosed as ‘illness’ stripping the ‘agency’ of suffering individuals.

National Mental Health Programme (NMHP):

- The first one to be rolled out in India was the National Mental Health Programme (NMHP) in the year 1982.
- The NMHP has failed to address the social determinants of mental health and illness through inter-sectoral engagements.
- There is little data on community mental health from a community or developmental perspective.
- Prevention and promotion’ of mental health has always been a policy objective through the National Mental Health Programme 1982, ground level practice has focused on mental illness and tertiary care treatments.

United Nations Convention on Rights of Persons with Disabilities (UNCRPD):””

- The UNCRPD adopted on 13 December 2006 at the United Nations is intended as human rights
- The aim of changing attitudes and approaches to the persons with disabilities.

Article 26 of the UNCRPD states that:

- “States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services”.
- Article 28 states:

- "States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability".

UNCRPD has thus brought about a social perspective about mental health replacing 'mental illness' with a forward looking term of 'psychosocial disability' drifting away from the earlier biomedical model of mental illness. Yet, how far it would be implemented in letter and spirit in India remains to be seen.

Mental Health Care Bill (2013):

- The Mental Health Care Bill, 2013 piloted by the Ministry of Health and Family Welfare, Government of India is intended to replace the Mental Health Act, 1987 to push forward reforms in the mental health sector.
- The Bill has narrowed down the scope of mental health care to merely increasing access and availability of psychiatric facilities and medicines free of cost.
- This is far from what is envisaged in the UNCRPD which exhorts mental health professionals to recognize and address the social barriers to wellbeing and to design disability-sensitive mental health programs
- The Bill further states that "Mental illness of a person shall not be determined on the basis of,—
- (*a*) political, economic or social status or membership of a cultural, racial or religious group, or for any other reason not directly relevant to mental health status of the person;
- (*b*) Non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person's community."

Draft National Health Policy (2015):

A preliminary survey of the proposed National Health Policy reveals that it has also not been able to conceptualize mental health in its psychosocial aspects; it is silent about addressing the root problems of social inequality, injustice and other deprivations that give rise to distress. The focus has been on telemedicine linkages, integration with primary health care, easy access to follow-up medications and increasing access to mental health care services by increasing the number of mental health professionals to fill the gap.

Medicalization and individualization of distress:

- "Mental illness is a brain disorder".
- The disadvantaged people's attention is deflected from the deprived socio-politico-situation in which they are in, towards their supposedly compromised brains.
- Every distress arising out of a person's compromised social environment is termed as illness and treated with psychotropic drugs reinforcing the false notion that pills can cure life's ills.
- Disability scholars like Mehrotra (2013) have drawn attention to the need for a social paradigm of mental health that frames distress as not just rooted in one individual but as affected by the micro and macro forces surrounding the person.
- Reducing discrimination against sex, caste, disability and socioeconomic status is an important aspect to reduce mental disorders.
- Poverty and unemployment are both causes and effects of disability. Pharmaceutical companies add to this by employing disease awareness programmes.
- All these studies draw attention to the need for a holistic approach which is rights based. For this to materialize there is a dire need to shift the lens to asocial model of distress and to redefine mental health as entirely different from physical health which cannot be simply reduced to the brain.

5. Mental Health services during Natural Disasters.

Dr. K. R. Antony

Background:

- A social activist was visiting a coastal village in Orissa post Super-cyclone in 1999.
- The level of depression any victim of Natural disaster can go into.
- Often it is unrecognized and not acted upon by the relief workers in many natural disasters due to low priority and due to lack of technical experts to intervene.
- These hysterical blindness and deafness can be considered an escape mechanism for a traumatised mind.

Facility:

- Relief Commissioners and their government staff as well as voluntary organizations get busy with setting up relief camps, telecommunication networks, power supply, approach roads, shelter camps, community kitchen and toilets. Provision of drinking water, food, medical aid and prevention of communicable diseases all get priority, but not mental health needs of the survivors and victims of disaster.

Lacking behind:

- Many of the states do not have even absolute minimum number of Psychiatrists and clinical psychologists in their government service. The nearest medical colleges also do not have enough persons on pay roll to satisfy even the MCI Inspection teams. No wonder mental health needs of displaced communities in relief camps are ignored or kept as last item in the priority needs.

The fundamental Principles of PFA:

Handbook of International Disaster Psychology-Practices and Programmes-Gilbert Reyes and Gerard Jacobs 2006" are as follows:

1. **Protection**
2. **Social support**
3. **Arousal reduction**
4. **Assisted Coping**
5. **Supervision**
6. **Helping the Helper**

Conclusion:

- Psychological needs of displaced communities in transient shelters and victims and survivors of natural calamities living in their homes are seldom addressed systematically by government or international donors.
- Often it gets low priority and last attention by relief workers and civil society organizations.
- This also reflects the extremely inadequate training in mental health given to undergraduates in the Indian medical curriculum.

6. **Pebbles from a lonely beach--** Jagannath Chatterjee

Introduction:

- What people with health issues go through has never been fully described in any medical textbook, cannot be mapped through clinical tests, is not subject to rational thinking, and does not limit itself to the label flung at the patient in the form of a diagnosis.
- Health depends upon how the authorities or experts understand it.
- If the understanding is correct it culminates in health and happiness. If the understanding is partial or improper suffering spreads like the plague.
- Can we separate health issues on the basis of which part of the body is affected?

Conclusion:

- We talk of the increasing incidence of mental illnesses and the need for infrastructure, trained manpower and policies to attend to those who are affected or who will be affected in future.

We talk of the increasing incidence of mental illnesses and the need for infrastructure, trained manpower and policies to attend to those who are affected or who will be affected in future.

7. **Response to Bagchi and Chaudhuri--** Suicide and the Law in India

Background:

- The current discussion of suicide in India arises amidst extensive social churning.
- The developments are of varied origin and come together in a period of rapid change.
- In two Hyderabad universities with a student population of under 3000, there have been 7 suicides of Dalit students over the past two years.

- Farmer suicides in Andhra Pradesh in the period 1999-2012 have been recorded at 35898.
- A total of 135,445 persons committed suicide all over India in 2012.
- Today, suicide is understood to be a response of protest and desperation against violence (familial, sexual, social or institutional); loss of respect and social discrimination; and falling prey to a debt trap.
- Pressing charges against a survivor of suicide is almost unheard of. But criminal investigations are often launched to probe the much more serious crime of abetment to suicide by those in social and familial relationships with the deceased (or survivor).
- When the bill, in its eagerness to ameliorate the patent injustice of charging a survivor with crime categorizes suicide as an act of a 'mentally ill' person, it undercuts the concrete social gains made by these movements.
- A blanket presumption of mental illness on suicide attempts will implicitly influence unreported cases of attempted but failed suicide, which may be 20 times the number of reported cases.
- In many cases familial and social relations that lead to the unbearable tension realign themselves to correct the situation and relieve the pressure.
- If social attitude follows the law, this will result in the suicide survivor being taken for psychiatric treatment and medication.
- On the one hand, the normal corrective process will be abandoned and the distress individualized as 'mental illness".

Current situation:

- They argued that MNS disorders constituted 14% of the global burden of disease surpassing cancer and cardiovascular.
- An estimated 10-20% of young people worldwide experience mental health problems, leading to related health and social problems such as

adverse school performance, delinquency risky sexual behaviour and substance abuse with suicide being the third leading cause of death among young people.

- The suicide death rate in India is among the highest in the world with 40% of Indian suicide deaths among men and 56% among women occurring in the age group 15-29 years.
- There are just 3,500 psychiatrists in India. Three psychiatrists per one million people in India compared to 100 in Australia or 150 in developed countries.

THE PROBLEM WITH SOCIETY:

- Stigma and discrimination because of mental illness are still major obstacles to the development of mental health services, to the rehabilitation of those impaired by mental illness, and to an investment into mental health research.

Conclusion:

- We conclude this response by simply pointing to the other side of the picture in jails, police and judicial custody, and unfortunately in mental health institutions too.
- There is a violation of the rights of inmates in cases where suspicious deaths are passed off as suicides.
- These institutional environments are sometimes known to drive inmates to suicide through physical torture, humiliation and loss of self-esteem, as a result of taunting, heckling, and inhuman treatment by other inmates or people in authority.
- Thus far these have been seen as a human rights violation, but they will become invisible if the law looks at all suicide as driven by mental illness.

8. Small steps - context, learning and models of community and primary mental health in North India

By Kaaren Mathias

Background:

- Mental health – both illness and wellness are too entangled and complex, to be tidily described with neat packages.
- The boundary between mental distress and a mental disorder is blurred.
- Country needs models of mental health care that are centred in communities, appropriate to cultural contexts, work actively to address mental health determinants such as employment and social inclusion, and emphasise psycho-social interventions which are more durable and have few side effects than drug therapy
- At the same time, perhaps 90% of people in India with mental disorders do not have any option of access to allopathic (bio-medical) care (World Health Organisation, 2011).
- People with mental distress (PWMD) in Low Middle Income Countries (LMICs) include mental health's low ranking in a hierarchy of needs among populations who don't have access to sufficient food, grossly under-resourced mental health services.
- The District Mental Health Plan (DMHP) launched in India in 1996, has been imperfectly and incompletely implemented across the country

PWMD:

- PWMD find social sanction, initiate further help-seeking and find support and healing in a supportive and non-threatening environment of some traditional healers and shrines.
- PWMD, particularly those with severe mental disorders experiences of social exclusion and live with significant stigma and discrimination.

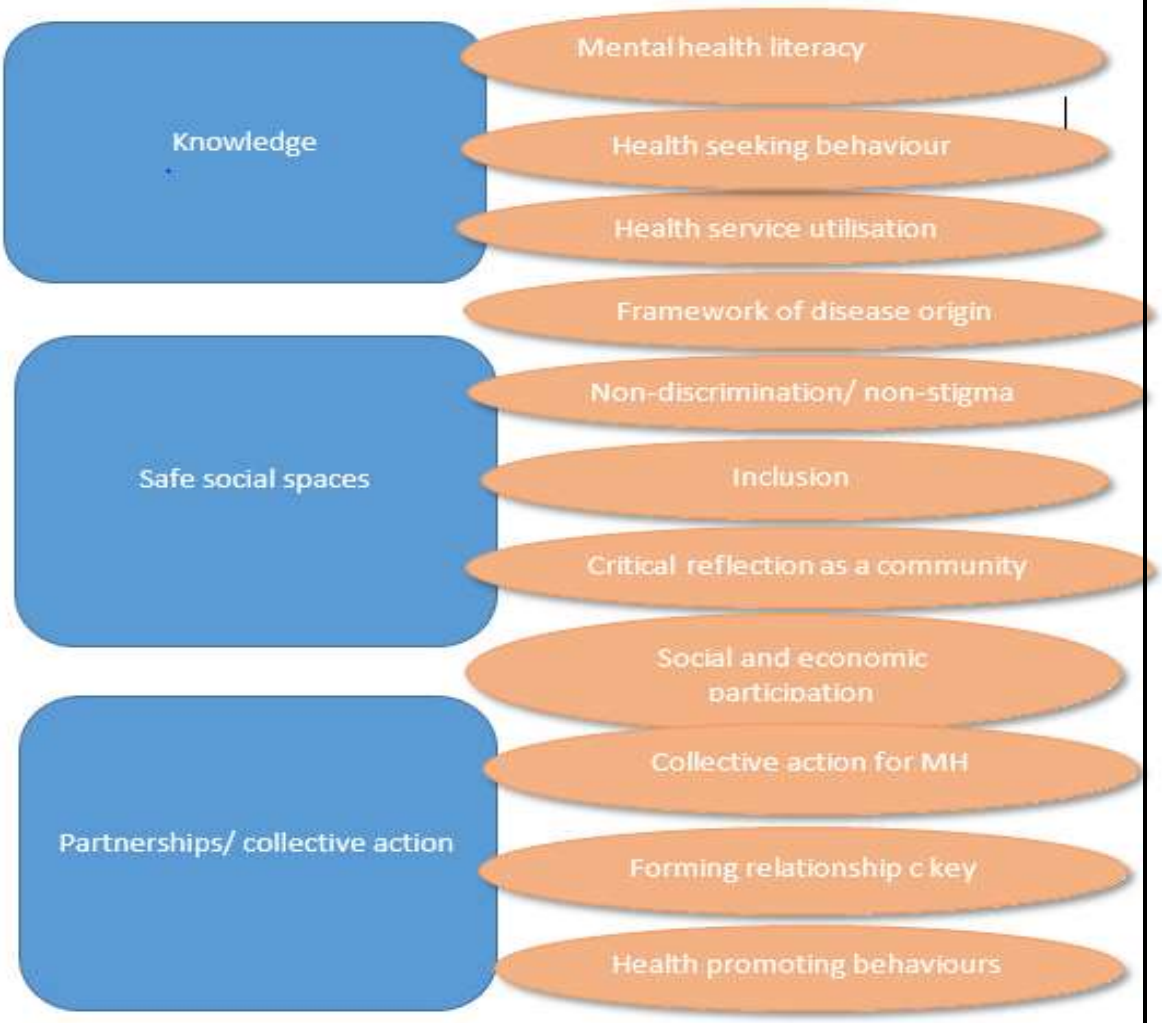
Emmanuel Hospital Association

- One of the largest non-profit providers of health services in North India.
- Framework for community health prioritises community participation and empowerment, and seeks to address health determinants using a rights based approach.
- Most deprived districts with 20 community hospitals providing clinical services and over 40 community health projects.

Context analysis:

1. Help-seeking efforts are monumental.
2. PWMD and their families are particularly vulnerable to the very worst of the Indian private medical system.
3. There is very little knowledge about mental illness. E.g post-partum psychosis may be understood by some as contagious, by others as a 'drama' to avoid work.
4. PWMD have a dominant experience of social exclusion which ranges from more subtle distancing and negative judgements to verbal violence.
5. PWMD have a hugely increased premature and preventable mortality.
6. There are millions of people in North and rural India with essential no access to mental health care.

Framework:



EHA - Model of care for people with mental distress:

Wellness skills

Self-care and agency

5 Kadam (steps)

Talking therapy - support group, therapeutic group, counselling and CBT, IPT

Medicines - needed for some people with common mental disorders and most people with severe mental disorders. Part of this step is acknowledging the power of Dua and Dawa (Prayers and Medicines) for many PWMD

5 steps to wellbeing :

Summary:

- There is huge capacity to bring healing and transformation for many thousands of PWMD and families who are currently isolated without care or support.

- There are also significant risks of doing harm if we use models of care that do not acknowledge the cultural context and promote mental health care exclusively dependent on pharmacology and Western biomedicine.

Learning from field visits:-

1. **SNEHADHAN:--** The main aim of SNEHADHAN is to provide needed care to the sick, with a preferential option for the people infected and affected with HIV/AIDS . It was establish on july 1997. 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 centres across the country. 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.

2. **VIMOCHANA:--** 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-àvis 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 policy. 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 counselling and if necessary go to the court for these women's issues. They teach them to be self-supportive and self-caring. 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.

3. Foundation of Revitalization Local Healing Tradition (FRLHT)

The aim of FRLHT is 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. 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, diarrhoea, 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.

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

Conferences/workshops:--

1. **NATIONAL BIOETHICS CONFERENCE:-**

   It was Fifth National Bioethics Conference.

   Theme: Integrity in health care practices and research.

Date: 11-12-13 December, 2014

Venue: St. John's Medical College Campus, Koramangala, Bengaluru

The conference aims to explore various sides of corruption and examines the limits and dimensions of integrity for health professionals and the health

system. In addition to the keynote addresses, there will be paper and poster presentations and workshops which will be selected by a scientific committee. There will also be screening of films centred around the conference theme. "The Dolls Speak" is a special exhibition at the conference which is guaranteed to enlighten and enthral. The theme of the Fifth NBC 2014 is "Integrity in health care practices and research, and would cover the following sub-themes:

a. Integrity and upholding trust of patients in medical care;
b. Ethical imperatives of integrity in public health practices and health systems;
c. Integrity in health care research (misconducts-plagiarism, data fabrication/ falsification, etc.)
d. Conflict of Interest in health care practices and measures needed,
e. Curricular frameworks in ethics to ensure integrity in healthcare, public health and research;
f. **International symposium** on December 13 on Corruption in health care and medicine.

Six plenary sessions, including those in the International Symposium will feature 18 keynote addresses and a panel discussion by well-known national and international experts on the theme and sub-themes of the conference. In each plenary session, sometime will be available for questions and discussion.

In addition, the Fifth NBC 2014 was also having scientific sessions where individuals and groups working in the field of bioethics was able to make presentation of papers (both oral and posters) and workshops on many relevant topic in the field of bioethics . There were Parallel group's sessions, presentations and workshops organised on the first two days of the conference and one joint parallel groups session for oral paper presentations and workshops was organised on the third day.

2. **Medico Friend Circle:**

It was held in Pune.

20th to 22nd February

Theme: **Mental Health Rights and Care**

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.

3. **Young environmental researchers meet:--**

   A national level meet was organised for early career environmental health researchers on the 29th and 30th of January, 2015 at Indian Social Institute, by SOCHARA, Bangalore. This unique event provided a platform for open discussion on the sector. Twenty six individuals representing 12 institutions from 8 states participated. Among those who were unable to attend, some created video-presentations to share their work and reflections in the field. The participants were identified through multiple methods such as snowballing, journals and institutional websites. The identified individuals interacted deliberatively as a group over emails to draft the agenda for the meet, which was broadly conceptualised as a space for sharing and reflection. Over two days, the participants presented about their research work and challenges, and also about larger environmental health concerns in their respective states. Top environmental health priorities included issues such as waste management, health impact assessment, sanitation, equity and sustainability-oriented developmental decision-making, environmental health officers (human resources), organic farming, environmental education, etc. The themes of research and action ranged from climate change and health systems, to silicosis, industrial pollution and sanitation. The presentations depicted an array of research methods and philosophies, and also a passion for translating research to action. It was

observed that some environmental health concerns are cross-cutting, such as air pollution, sewerage systems, and waste management which were affecting all urban areas, and poor access to water and sanitation which was affecting rural areas. Besides this, issues such as fluoride contamination of water were noted in Karnataka and Madhya Pradesh, silicosis was noted among some communities in Madhya Pradesh and Rajasthan, and pesticide associated farmers deaths was noted in Maharashtra, Andhra and Bengal. Issues related to inter-state migration which is affecting all areas were discussed as well. Policy provisions and constraints, and innovative community-led and government supported solutions were also discussed.

My Research study report:

To analyse the maternal health seeking behaviour

Aim: - Pre and post maternal population in medical college at Chhattisgarh state.

Objective**:-**

- Identify the reasons for registering late ANC healthcare at later stage.
- Identify the cultural practices related to pregnancy and deliveries.
- To document preferences for seeking healthcare for pregnancy and delivery issues from other systems of healthcare various health systems**.**

Background:-

India, which accounts for the largest number of maternal deaths in the world, is unlikely to achieve the fifth Millennium Development Goal of reducing maternal mortality to 109 per 1,00,000 live births by 2015. Only three states in India have so far managed to reduce maternal mortality rate to less than 109 deaths per 100,000 live births—a millennium development goal (MDG) for 2015. The recently released report of the Registrar General of India shows that India's maternal mortality ratio (MMR) decreased from 212 in 2009 to 178 in 2012. Assam recorded the highest MMR of 328 and Kerala lowest with 66. The MMR in southern states fell 17% from 127 to 105, closer to the MDGs. Assam and Uttar Pradesh/Uttarakhand were the worst performing states, with an MMR of 328 and 292, respectively. Kerala and Tamil Nadu have surpassed the MDG with an MMR of 66 and 90, respectively. Infant mortality declined marginally to 42 deaths per 1,000 live births in 2012 from 44 deaths in 2011. Madhya Pradesh registered the highest infant mortality at 56, and Kerala the least at 12. Among metropolitan cities, Delhi, the national capital, was the worst performer with 30 deaths per 1,000 live births in 2012. One in every 24 infants at the national level, one in every 22 infants in rural areas, and one in every 36 infants in urban areas still die within one year of life. There seems to be some good news for Chhattisgarh as the state has finally witnessed a steep decline in the infant mortality rate (IMR) and Maternal Mortality Rate (MMR). The IMR (per 1000 live birth) has been recorded at 48 and the MMR (per lakh

live births) at 263.

Introduction:-

The maternal mortality rate (MMR):The annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management

The MMR includes:

Deaths during pregnancy, childbirth, within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year.

MMR (per lakh live births) at 263 in Chhattisgarh: Wide gap in the maternal health seeking behaviour which leads to the huge number of mortality.

Study Setting:--

The place where the study has been conducted is Dr. Bhimrao Ambedkar Hospital .which is the with oldest medical college of Chhattisgarh state. It also consist of largest Gynaecology and obstetrics department in state. In this medical college more than 55 deliveries takes place on daily basis. It is a tertiary care unit. The Patient come for check - ups are usually belonging to low financial and literacy background.

Social demographic profile:-

The majority of women who came to hospital were of Low literacy level. Belonging to poor financial background Living in joint family and are dependent on husband for livelihood.

Situational Analysis:-

12% of women belong to 15-19 age group and they were already mothers. 4% of women belong to 15-19 age group were pregnant with their first child. In total, 16% women 15-19 have begun childbearing. Son preference, though reducing, still persists. 76% of women received two or more tetanus toxoid injections. Among women who received ANC. Less than two-thirds had come for their weight, blood, or urine taken, or blood pressure measured. Three-fourths had their abdomen examined in hospital. 36% were told about pregnancy complications. 56% of general population is married and 59% of pregnant women are anaemic. So, are pregnant women getting iron and folic acid (IFA) supplementation free of cost. Amongst the pregnant population 9% of live births in the past 5 years were delivered by C-section. 16% of first births are delivered by a C-section. Among women who received ANC. Less than two-thirds had come for their weight, blood, or urine taken, or blood pressure measured. Three-fourths had their abdomen examined in hospital. 36% were told about pregnancy complication. 56% of general population is married and 59% of pregnant women are anaemic. So, are pregnant women getting iron and folic acid (IFA) supplementation free of cost. Amongst the pregnant population 9% of live births in the past 5 years were delivered by C-section. 16% of first births are delivered by a C-section.

Birth intervals:

Research Design

Method opted – Mixed

Mixed methods research takes advantage of using multiple ways to explore a research problem.

Basic Characteristics

Design can be based on either or both perspectives. Research problems can become research questions and/or hypotheses based on prior literature, knowledge, experience, or the research process. Sample sizes vary based on methods used. Data collection can involve any technique available to researchers. Interpretation is continual and can influence stages in the research process.

Data collection:--

Sampling

Random selection for case history process. The Sample size is 60. And from that 60 women there is filtered group of 14 women who were taken personal interview which was purposive in nature.

Purposive Sampling (Selection) Benefits :

Wide range of qualitative research designs . Range from homogeneous sampling through to critical case sampling, expert sampling, and more. Provide researchers with the justification to make generalisations from the sample. Useful in these instances because it provides a wide range of non-probability sampling techniques for the researcher to draw on

Data Collection

Data for Quantitative analysis :

Patients Records from the medical college

Data for Qualitative analysis :

In-depth interviews of 14 women who came to medical college for ANC. set of questionnaires . lots of personal information came through interview

key findings :--

Reasons for late ANC

Majority of women said that getting ANC from somewhere else. Some women also said that they were busy. Some came with saying that their live far away. Few women said they were lazy to travel and come for such a small thing like ANC when they don't have any problem associated with pregnancy. Few said they Did not know where the ANC clinic is located. Some She had children before so they couldn't leave them and come . few said Doctors and nurses don't pay attention when early when they came to them. Few said that they Got tired of ANC during past pregnancies. Some women said that they feel this was the right time to come.

Analysis - Cultural practice related pregnancy care:--

previous delivery details : reflect the consciousness of the women regarding conception and family planning

ANC care

Home deliveries: Distance and cost to the health facilities matters for them. Need for women to be close to their other children and the housework. Few said the wish to follow traditional birth practices. Attitudes, quality of care and care practices at the health facilities. Few had problem with Episiotomies, lack of privacy and the presence of male staff

Hospital deliveries

Women feel secure and safe in case of emergency with presence of trained doctors. Emergency care system are available within instant such as ventilators etc.

Analysis:--

- **Experiences of seeking health care from other systems of medicine:**

    - By doctors for 72%
    - By ANMs and other health personnel by 20%
    - By dais or TBAs by 8%
    - For only 20% of home births was there any postnatal care.

No significant difference between participants living in rural and urban communities

- **Reasons for not having sufficient access to health care** :
    - Transport/distance to health care facilities
    - Financial constraints
    - Problems with the service
        - Provision and availability of medication
        - Number and quality of the staff,
        - Facilities (including equipment)
        - Hours and capacity to attend patients
- Urban and rural participants preference differed significantly for a health care provider

Urban Participents	Rural Participents
Private medical doctor (No money and transportation constraints)	a health clinic
financial constraints and to the expertise of the health care provider	treatment (availability and quality) and financial constraints

Discussion *:* Maternal mortality is unacceptably high in developing countries including India. Death of mother is a tragic event. In practical life, it has a severe impact on the family, community and eventually, the nation. The young surviving children left motherless, are unable to cope with daily living and are at an increased risk of death. Reduction of maternal mortality is the objective of MDGs, especially in low income countries, where one in 16 women die of pregnancy related complications.There are certainly need for improvement. Simply by building hospital wont work at all.untill or unless you wont make people awre about their health. Some how the people are not analysis the heath conditions or the health factor is not 1st at their priority list. As a developing state chhattishgarh have got still bulk of people who are poor so the trasport and treatment fare they cant effort also. Being a tertiary care there is more load of poatient coming for small issues which can be taken care at the level of PHC or CHC.

Conclusion: The MMR in our study is higher than the national averages. Most deaths could have been avoided with the help of good antenatal, intranatal and postnatal care, early referral, quick, efficient and well equipped transport facilities, availability of adequate blood and blood components, and by promoting overall safe motherhood. To reduce the maternal mortality and morbidity the main thrust should be on implementing basic and comprehensive emergency obstetrics care. Analysis of every maternal death

through maternal death audit, either at community level (verbal autopsy) or at the institutional level should be carried out. It will help in identifying the actual cause of maternal deaths and deficiencies in health care delivery system that might contribute in formulating preventive measures to reduce pregnancy related deaths.

Recommendations are formulated for :

Infrastructure investments in rural communities. Quality of health care and its perception. Improvement of household socio-economic status . Further research on the consequences of delay in health care seeking behaviour.

References:-

http://nrhm.gov.in/images/pdf/media/publication/Annual_Report-Mohfw.pdf

http://health.cg.gov.in/ehealth/NFHS3_DLHS3Report/DLHS-3Chhattisgarh.pdf

http://health.cg.gov.in/ehealth/CRMReport/Chhattisgarh2ndCRMReport.pdf

SHRC

Thanks

Community Health Learning Programme is the third phase of the Community Health Fellowship Scheme (2012-2015) and is supported by the Sir Ratan Tata Trust, Mumbai.

School of Public Health, Equity and Action (SOPHEA)
SOCHARA
359, 1st Main,
1st Block, Koramangala,
Bangalore – 560034
Tel: 080-25531518; www.sochara.org