2014-2015

Community Health Learning Programme

A Report on the Community Health Learning Experience

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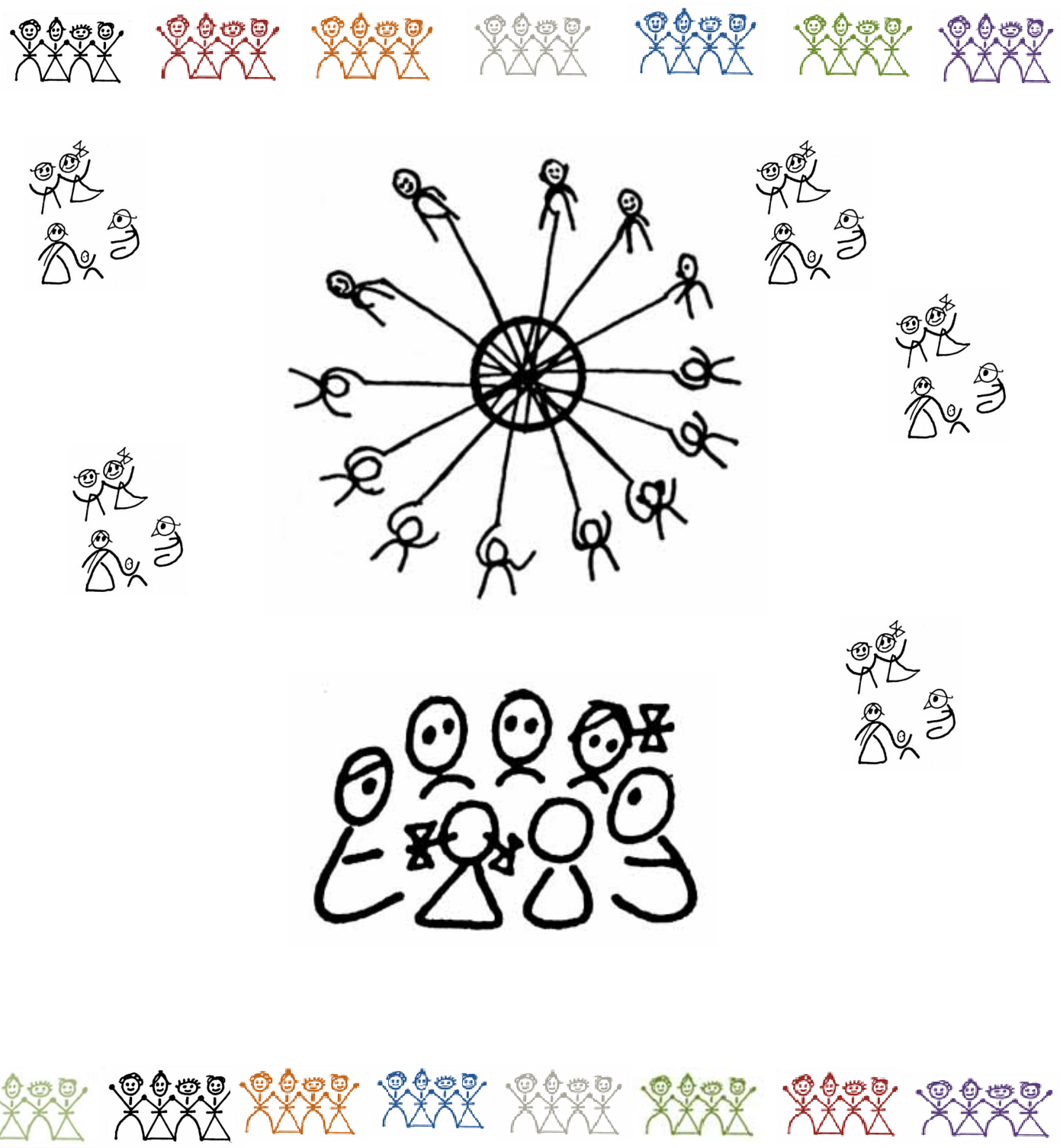

SOPHEA

sochara
building community health

COMMUNITY HEALTH LEARNING PROGRAMME

REPORT

SOCHARA SOPHEA

2014 – 2015

ASMA . S

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2. Acknowledgment

I say to thank my dad and mom, for letting me chance my dreams and their unconditional love and support and who have helped me in every sense of the term throughout.

In my journey through the wisdom in community health at CHC, I would like to thank first of all Dr. Thelma Narayan, a successful woman in public health, her in-depth analytical and intellectual lectures were extremely helpful to think through myself during the fellowship.

I would like to thanks Dr, Ravi Narayan for his commitment, humbleness and openness to learn and to make me learn. Truly he is an inspiration to continue the journey with confidence.

I would like to thanks my mentor Mr. Prahlad for his commitment, passion and his support in the fellowship.

I would like to thanks Mr. Mohammad, Mr. Chander, Mr, Kumar K.J, Dr. Rahul, Mr. Sabu to make me learn and their support in the fellowship.

Overall, I am thankful for all the resource people, which the CHC team worked hard, bring to share their experience with the one year of us. Such a rich experience sharing and wisdom is difficult to get even if one is ready to spend any amount of resources.

I would like to thanks MY Field mentors Dr. Manohar Prasad from SVYM organization & team and Dr. Bagyalakshmi Sakhi Trust during my field work for giving me the wonderful opportunity to spend 6 months with them and to learn from their organization and their personal experiences. Their dedication, innovativeness, hard-working nature, approach and simplicity were truly inspiring and encouraging to me. I thank them for the time and comfort they gave me and will carry with me the wonderful memories and learning's I got from there.

Another learning experience by observation is the staff of SOCHARA truly I saw an invisible structure without any hierarchy. I would sincerely thank all the staff at CHC who helped me feel friendly and comfortable during the course of the learning program.

I am indebted to thank my fellow friends each one of them from different background and experience shared so much of knowledge and a true friendship helping me to realize 'together we can'.

I also acknowledge and thank all the directors of the projects I visited and the time each one took to share with me their immense knowledge and experience in the field they are.

I would like thank to my field mentors, the organization and the staff of that I visited for giving me the opportunity to learn.

3. Why I wanted to do the Community Health Fellowship

My academic background is a MSW (Master of Social Work) which I completed in 2011. My first two years of experience in Bellary after college gave me the confidence that I can work with communities. Being part of a grassroots organization (ST. Mary's Hospital) that gives to care and support for People Leaving with HIV . I learnt about the complex challenges in PLHIV and began to understand how health care could be one of the leading causes of debt among the PLHIV

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

4. My Learning Objectives

To understand and learn Right to Health. Right to health care and approaches to it.

1. To understand the various strategies for realizing health rights. (With people's Health movement)
2. To understand/critique the NRHM from an entitlement/rights perspective
   A) How Health entitlements /Rights has been incorporated in NRHM
      - Policy
      - Implementation
      - People's perspective
   B) To understand the limitation of health entitlements Health entitlements/rights within the NRHM.
   C) To identify opportunities for enhancing Health entitlements/rights within the NRHM

Learning objectives	**How**	**Why**
1.To learn and understand Right to Health	Reading, to attend training program, placements, involving with community to understand their needs.	To become a trainer in health rights and work community to realize their rights.
2.Various strategies for realizing health (special study of PHM)	Meeting PHM activities, going through literatures review, books/ journals, previous works, placements.	To be a health activist and understand the role of movement in realizing health rights and entitlements.
3.Understand /critique the NRHM as entitlements/rights	Meeting people working with the policy formulators, organization placement, research work training, Advocacy training, Engaging in policy-making activity.	To understand the intricacies of policy making, it's shortcomings, To lobby with governments to take people's perspective while policy formulation.

5. Learning from collective teaching sessions and field visits

Orientation

The six months orientation period for the Community Health Learning Program 2014 was technical, pragmatic, and theoretical but above all dangerously thought-provoking. These new points of view were refreshing, disturbing and guilt-inducing, recurrently jolting me into a state of mental and physical paralysis. Why? Because at times the scale of poverty, the complexity and depth of suffering and the dearth of visible change can be that disillusioning. In some ways I was left feeling 'what can one individual really do when the rules of the game are inherently inequitable'? Nonetheless, it built a strong frame of reference, a value system if you will, that I will hold steadfast. Below I highlight the broad concepts that impacted me the most.

Health

Health is a state of complete physical, mental and social well being and not merely the absence of disease. – Alma Ata Declaration, 1978

Physical Health

Physical health is an essential part of Community. The overall health which includes everything ranging from physical fitness to overall wellness which makes an individual mechanically fit to carry out his daily activities without any problems.

Mental Health

Mental health is a sense of well being, confidence and self – esteem. It enables us to fully enjoy and appreciates other people day to day life and our environment. When we have mental peace we can:

- Form positive relationships
- Use our abilities to reach our potential ……..???
- Deal with life's changes

Social health:

Social health is your ability to create and maintain healthy and flourishing relationships with other people. Healthy relationships are based on respect, mutual trust and equality.

Spiritual:

- Generally Is something everyone can experience
- Helps us to final meaning and purpose in the things we value
- Can brings hope in times of suffering and loss

- Encourages us to seek the best relationship with ourselves, others and what lies beyond

Confronting the existing super structure of medical / health care to be more people and community oriented.

The community health approach evolves action from the community outwards and upwards confronting the various components of the existing superstructures of health services.

Ex – PHC, Hospitals, teaching & research institutions.

- Medical, nursing, public Health teams & professional trainings
- Health programmes & health institutions under government or NGOs.

1978 – ALMA ATA DECLARATION

- Health for all
- Primary Health Care
- Health is a Fundamental Human right
- Equity
- Appropriate Technology
- Inter – sectoral Development
- Community participation

After ALMA ATA

G – Growth monitoring

B – Brest feeding

I – Immunization

F – Female Education

F – Family Planning

O – Oral Rehabilitation

8 Components of Primary Health Care

- Adequate Nutrition
- Water and Sanitation
- Health education
- Prevention of endemic diseases
- Mother & child health
- Immunization
- Treatment

- Essential medicines

What is Community Health?

"Community Health" as I have understood from the orientation programme and from the placement is empowering people to have the power to demand their right and it involves community participation, community mobilisation and community involvement in reaching this goal as very important components. More to my understanding on community health it is more than just "medical" everything that comprises the well being of a community is health. Again "wellbeing" i.e. "health" should come to a community through all dimensions of their daily life. This is what I feel is community health.

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

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

Quite Often, the health of an individual suffers because of a societal structure or norms. For example a woman's nutrition can also affected by her social status in that society and therefore is an issue of gender inequality reasons why she's malnourished.

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

B) Awareness, Availability, Access, Affordability and Capability

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

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

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

The importance of the public sector:

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

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

The growing solidarity of the people's Health Movement and its specific country chapter plays a key role in bringing health back to public agenda. On a national level the introduction of the National Rural Health Mission promises involved community in its planning monitoring and evaluation. For the government to mandate this, at least in theory, is promising. Further, hearing about lessons from some pilot states for community monitoring proved that inroads are being made to strengthen the health system from within.

Ultimately, no NGO or numerous networks of NGOs or other private actors can make themselves accessible to over 500.000 villages. The government is the primary and the largest service provider. Efforts to support and improve public system are the only sustainable option to improve the health of this country.

Globalization is really making the poor poorer:

The role of international institution in regulating national government cannot be emphasized enough. And it wouldn't be reductionist to say that their function is more exploitive than beneficial.

Structural Adjustment Programs (historically) and their failures

The stipulations of the World Trade Organization and its direct effect on farmers and other small stakeholders

The establishment of New Institutions in governance that private's basic amenities on the basis of efficiency but deny universal access

International targeted/vertical funding interventions that don't improve the overall health of communities

The monopoly of allopathic and the lobbying power of the pharmaceutical industry

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

Balance between theory and practice:

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

My inner learning's from CHLP

- Communication and participatory skill with Community
- Stage fear decreased
- In the beginning I was so scared while talking English with everyone, now I improved English speaking
- I gained more knowledge about health
- learned new Software applications in Research I learnt about cultural differences between states

Group Learning

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

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

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

You are mentally ill – if you are "CASTE" bound

I acknowledge and appreciate such powerful words from Dr. Ravi, "You are mentally ill – if you are CASTE bound". I could experience his words in many humiliating instance i personally see in the lives of my friends who belonged to SC community. And during orientation of CHLP, we also witnessed the same in our field visits to villages in Raichur District.

NIMMA – NAMMA Test

People have to experience you in the community as someone belonging to them. For instance if we say we are community worker, the community that we work with should say he/she is OUR person and not the NGO's staff or person. This is a crucial and strong lesson that I have learnt, but truly to express sometimes I have reverse discrimination for being negative to work among HIV positive people's networks. But still, it's important for me to be unequal to be equal to all.

Vimochana

We visited to Vimochana (a women's rights organization that primarily deals with domestic abuse) and better understand how organization can impact matters in the private spere of women's lives. We spent one day in Vimochana learning about their interventions.

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

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

Seva-in-Action

Seva-in-Action is a voluntary organization working since 1985, towards developing an inclusive society which value the abilities and potentials of persons with disabilities and consider them as contributing members of the society. SIA is working with Community Based Rehabilitation program, Integrated and Inclusive Education program, Training in disability areas and inclusive education besides working with government system.

SIA's mission is to develop an inclusive society through inclusive education. SAI believes in empowerment of with disabilities and its families and ensure their human rights. To achieve this, the organization works with parents association of children with disabilities, persons with disabilities, persons with disabilities, community members and the government system.SIA has three pronged activities: firstly the direct services and through resource centers in rural and urban areas, skill development, secondly capacity building through various training programs and thirdly working with the government system through National Trust and Education sector to reach out to unreached in Karnataka.

KAIROS

(Kannur Association for Integrated Rural Organization and Support)

Kannur Association for Integrated Rural Organization and support (KAIROS), a Registered Society under Society Registration Act XXI of 1860 is the Social work department of Diocese of Kannur. KAIROS was unofficially wing of Calicut Diocesan Social Service Society. It started its independent involvement in 1999. The area of operation covers the northen civil district of Kerala i.e., Kannur and Kasargod. KAIROS is working with Dalits, Fisher folk, Marginal farmers, Agricultural laborers, Women, Children, Tribal & HIV/AIDS infected and affected.

KAIROS collaborates with many development agencies through planning and extension of various programmes of Government and Panchayath Raj Institutions.

VISION: Create a society of justice and peace based on true human values.

MISSION: The mission internalized by KAIROS is capacitation of the people in all aspects to generate and carry out development at their own level in a participatory and sustainable manner.

SHANTHI PAIN & PALLIATIVE CARE SOCIETY

HISTORY:

- A registered charitable society established in June 2004.
- An organization of medical professionals and volunteers dedicated to the community based palliative care.

MISSION:

- We believe that individuals and families coping with life-threatening illness such as Cancer, paraplegia, HIV+, PVD, CVA, Psychiatry, Kidney and old age ailments deserve efficient access to services that are designed to enhance their quality of life and also enable them to receive care in the setting of their choice.
- The society endeavors to popularize the concept of palliative care in this part of the world

HOME CARE:

- The society has established home care services for chronically ill, bed ridden and incurably ill patients in partnership with family and local organizations.
- Our community palliative care staff provides help, support and advice about their illness in the comfort of their own home.
    - This could be one visit or several over a period of time whilst they need our support.
- This one-day per week 'Home Care Program' became operational in June 2004.
- The society has three teams
    - One led by a doctor
    - The other by nurses and volunteers
    - And the third by community volunteers

Out Patient Clinic

- The society runs an outpatients clinic at the Kalpetta since 2004
- Patients with curable and incurable conditions like cancer, HIV – AIDS, PVD, CVA, psychiatric problems,
  Kidney diseases, old age and chronic pain are attended to.
- The clinic not only provides medical treatment for but also extends social psychological and economic care.

Community health and working with communities

Community as a source of knowledge

I learnt that to work communities one must begin with humility and the sensitivity to acknowledge that you may come with formal education but not the wisdom and experience the community has. Distinguishing between harmful traditional practices and practices that can be

harnessed and developed for the community is valuable. There has to be a mutual exchange of knowledge and skills and drawing and building on their on their existing knowledge rather than replacing it with completely new forms is crucial. My decree is to not go in with all the answers, and accept that learning more about the community will incite more questions.

Social illness

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

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

Process enabling

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

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

6. Learning from field work [Case Studies / Reflections

Swami Vivekananda Youth Movement (SVYM) Organization – Mysore

Swami Vivekananda Youth Movement (SVYM) is a registered, Non Government Development Organization started in 1984 by a group of medicos inspired by the teachings and nationals ideals of Swami Vivekananda. It is working in the sectors of Health, Education, Community Development, Training, Research and Advocacy & Consultancy Services. It is engaged in building a new civil society in India through its grassroots to policy-level action in Health, Education and Community Development sectors. Acting as a key promoter-facilitator in the community's efforts towards self-reliance and empowerment, SVYM is developing local, innovative and cost-effective solutions to sustain community-driven progress. SVYM is also rooted to its values of Truth, Non-Violence, Renunciation and service, Which is reflected in its program design and delivery, transactions with its stakeholders, resource utilization, disclosures and openness to public scrutiny. Buying in support from the community, working in healthy partnership with the government and corporate sectors and sharing its experiences with like-minded organizations have been the hallmark of Swami Vivekananda Youth Movement.

The organization has about 50 projects in the sectors of health, education, community development and training located in all the districts of Karnataka state. It runs two hospitals (80 bedded and 15 bedded) for rural and tribal people in H.D.Kote taluk, a mobile health unit tribal's, and various tribal, rural and urban development projects focusing on housing, hygiene, sanitation, microcredit, community based health, education & rehabilitation, governance and human rights.

The organizations innovativeness in initiation & execution of the programs have been recognized and appreciated by Governments & Non-Government agencies.

Vision:

A caring and equitable society, free of deprivation and strife

Mission:

To facilitate and develop processes that improves the quality of life of people

Core Values:

- Satya - Truthfulness
- Ahimsa - Non Violence
- Seva - Service
- Tyaga – Sacrifice

CHA – Community Health Activities

The health intervention focuses on providing an interdependent and complementary community based and institution based services. The community based services focuses on awareness generation, community mobilization, preventive and primitive health with home-based follow up care for curative health. The institution based services (Vivekananda Memorial Hospital, Saragur) focuses on 24*7, guaranteed backbone for early detection of health concerns, patient and family counseling, institution based high quality comprehensive curative treatment and personalized prevention and rehabilitation measures.

Objectives

- ☐ Address the unmet health needs of the community
- ☐ Familiarize the community with the range of services offered by the health centers
- ☐ Enhance community participation
- ☐ Establish efficient healthcare network and referral mechanism

Projects

- ☐ Outreach activities
- ☐ Field based maternal and child health program
- ☐ Community based rehabilitation of persons with disabilities
- ☐ Water and sanitation
- ☐ Community based diabetes program
- ☐ Mental health initiative

"Health for All – Health Everywhere"

Community based primary health care its essential for the community members, health awareness about catching disease, environment and individual clean, safe drinking water, nutrition food, minor disease of treatments, family welfare, women and child services these are main components for primary health care.

Sub centers:

Basic health facilities for all people, from women and child welfare office 4 to 5 thousand populations or 4 to 5 villages 1 sub center facility is there, in this sub center 2 staff like 1 female and 1 male health workers is there.

Primary health care:

Primary health care for 20 thousand populations one PHC is there, in this PHC duty doctor, lab facility, deliveries room, emergency ward facility compulsory, so in this PHC give the services like Preventive & Health Promotion. In Taluk and district levels hospitals provide the curative services.

Health organizations in Karnataka:

- Above 8,870 sub centers
- 2,310 primary health centers
- 326 community health centers

NRHM Program:

The **National Rural Health Mission** (NRHM) is an initiative undertaken by the government of India to address the health needs of underserved rural areas. Founded in April 2005 by Indian Prime Minister Manmohan Singh, the NRHM was initially tasked with addressing the health needs of 18 states that had been identified as having weak public health indicators.

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

GOALS

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

Objectives:

- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Human resource support and management
- Basic infrastructure for sub center, PHC etc.
- Economic Decentralization

- Community participation and accountability
- AYUSH services for PHCs.

NRHM Programs:

- ❖ Janani suraksha yojane (JSY)
- ❖ Madilu kit program
- ❖ Prasuti aaraike
- ❖ Taayi bhagya
- ❖ Janani - shishu suraksha yojane
- ❖ Taayi bhagya plus

Janani Suraksha Yojana (JSY)

JSY aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme cash assistance is provided to eligible pregnant women for giving birth in a government health facility. Large scale demand side financing under the Janani Suraksha Yojana (JSY) has brought poor households to public sector health facilities on a scale never witnessed before.

Janani suraksha yojana:

- ❖ Regarding this program, for home deliveries they will provide 500/-
- ❖ For urban living women's, from health institutions will give 600/-
- ❖ For rural living women's, from health institutions will give 700/-
- ❖ Registered and sesirien deliveries in private hospitals for them 1500/-
- ❖ For this facilities Adhar card & bank Account it is necessary

Prasuthi bhatya:

- ❖ For 4 to 6 months pregnancy women's 1000/-
- ❖ After delivery 300/-
- ❖ For urbans 400/-
- ❖ This scheme not include in kolara & dharawada district.

Madilu kit:

Who will take the delivery in government hospitals for them they will provide the madilu kit. These kits will mainly helping for mother and child, in these kit 19 things is there.

Beneficiaries:

- BPL/SC & ST
- Deliveries in government hospital

- Only for 2 children's
- Who have mother card

Taayi bhagya yojana:

- ❖ After delivery when delivery patient will go to the home at that time they will give the 250/-
- ❖ For helpers 75/-

Taayi bhagya plus:

For rural pregnancy patients they will register in the government hospitals and they will get the delivery in that government hospitals for them they will provide the 1000/- regarding this scheme.

Accredited Social Health Activists

Community Health volunteers called Accredited Social Health Activists (ASHAs) have been engaged under the mission for establishing a link between the community and the health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHA Program is expanding across States and has particularly been successful in bringing people back to Public Health System and has increased the utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient care.

ASHA Program:

For 1000 population 1 ASHA worker is there, according to NRHM Program between community and health ASHAs identification, giving trainings so they will give the importance for community, in this state nowadays approximately 33,000 ASHA volunteers will do the peoples services.

Objectives:

- ➢ Giving importance for community
- ➢ Who have knowledge about community with them will give the health services
- ➢ Health organizations and community with them will do the work, take care of community health
- ➢ Giving importance services for mother and child and reduce the infant and maternal mortality rate.

Assignable for ASHA worker

- ➢ 7^{th} class pass, knowing reading and writing likewise leadership quality.
- ➢ She has 2 children's as 2^{nd} child minimum have above 5 years.
- ➢ ST/SC and BPL family for give the importance.

ASHA Workers Responsibilities:

- ASHA will give the health awareness for the community
- Doing work in the organization as community member
- Nutrition, health, sanitation and hygiene about that will give the awareness for community
- What are the facilities are available in the health center for that giving awareness for community, for those facilities will take like helping for community
- Registration for pregnancy women and for poor women helping for BPL card
- Delivery preparation, safe delivery, feeding milk, safe sex, disease, sexual disease, child care about these topics discuss as giving counseling for the women's
- Pregnant women's and health services necessity children near health centers will do the registration/taking facility for them.
- Immunization facility
- Minor diseases for that giving first aid
- Keeping first aid kit facility
- Village health and hygiene members, anganawadi workers, ANM, and with SHG village health and hygiene program about that giving information and doing implementation.
- Anganawadi workers and ANM with them monthly once or twice celebrating health day
- Anganawadi workers appropriate the mainly services like iron tablets, ORS, sanitary pads for that giving support for them.
- ASHA workers will not get the salary with government.

- **My Key Learning's from Field Work**I learnt participatory skill and communication with Community people
- I understood non adjust mental attitudes
- In group discussion I got a clear idea about community problems and facilities
- I understood Tribal (Haadi) people's attitudes and their culture
- I understood the difference between tribal and non tribal's
- I understand primary, secondary and tertiary prevention of health care services
- I We learnt PPT report writing skill

SAKHI TRUST (Hospet)

ABOUT SAKHI

Sakhi is a youth Resource Center working for enabling the human resource within youth in Hyderabad Karnataka region with a specific focus on the girl students of vulnerable communities. Dr. Bhagyalakshmi, who had finished her doctoral studies initiated this centre as a part of the SAMVADA youth program and took up the challenge of working since 2002 for enabling girls to become important human resource for their own empowerment and the development of the region.

The important objectives of this process were:

- Empowerment of women , children and youth affected by economic and social exploitation
- Promotion of education of youth particularly young women
- Supporting the higher education of girls from vulnerable communities for their empowerment

Sakhi has been working among…

- Girls dropped out of schools and young women initiated into labor
- Girls from Devadasi (a practice still rampant among the Madiga caste) families who are forced into becoming Devadasis themselves.
- Girls who were sexually abused and from families at risk
- Girls from SC/ST and other vulnerable groups whose livelihood was at threat due to various reasons in the context of socio-political and economic situation of Hyderabad Karnataka regions.

Sakhi's Strategy:

SAKHI has adopted two-pronged approach of prevention (of drop-out) and promotion (of education). The strategy of preventing the drop out of girls from the educational and higher educational institutions due to socio-economic and cultural factors included addressing the issue of discrimination and corruption in hostels, addressing the issue of quality of education in colleges by giving them additional inputs in some subjects like English.

Intervention with the families of girls who wanted to pre-maturely marry them forcefully, exposure of girls to different conferences, motivating sessions, giving them opportunity to participate in perspective building sessions etc. The strategy to promote education in these communities involved in creating a space in SAKHI for girls for sharing, counseling, providing information of various educational courses and possibilities available and helping them choose relevant courses suiting their aptitudes, finding out economic support and scholarships for the educational expenditures etc.

As against the earlier context where the number of girls who dropped out due to various unfavorable conditions in colleges and hostels, lack of adequate facilities in hostels etc. Was very high, due to the intervention of SAKHI and constant follow up, the retention became very high and SAKHI also intervened in situations where the girls had problems in hostels, colleges in their own families or personal life.

Sakhi Programmes:

Sakhi works with youth from rural areas, urban slum, college going youth and school/college dropout. Currently Sakhi has two programmes; first is child care centers aimed at supporting working women from the slums (supported by TDH Germany), second is higher education support for youths from families at risk (supported by SDTT). Sakhi's main office is in Hospet and a field centre is in Kampli.

Working with youth envisages having Meetings with youths, providing support for higher education, English tuitions, library support, special lectures for Youth groups, computer Training, counseling and counseling classes, gender training, tuition support for school dropout slum youth, theatre workshops, field studies and Sakhi student's magazine.

While Working with Urban slum Women and children, Sakhi has started day care centers for children from slums, supporting college fees for girls from the slums, vocational trainings for school dropout young girls, dissemination workshops for young girls and women, formation of young girls and women SHG's, medical camps for families at risk in the urban slums along with networking and campaigning for issues related to women and girls of the slums.

Total sakhi students comes from

1. 07 Taluka
2. 25 Villages
3. 02 Hostels
4. 05Colleges
5. 15 slums

Sakhi has empowered human resources through different programs:

- Fashion technologist and tailors
- Lab technicians
- Drama, Music, Art Teachers
- Social Workers, Counselors, Teachers for special children, Bala Sevika (pre-primary teachers),
- College Lectures
- Nurses
- Computer operators
- Beauticians
- Community Health Fellows

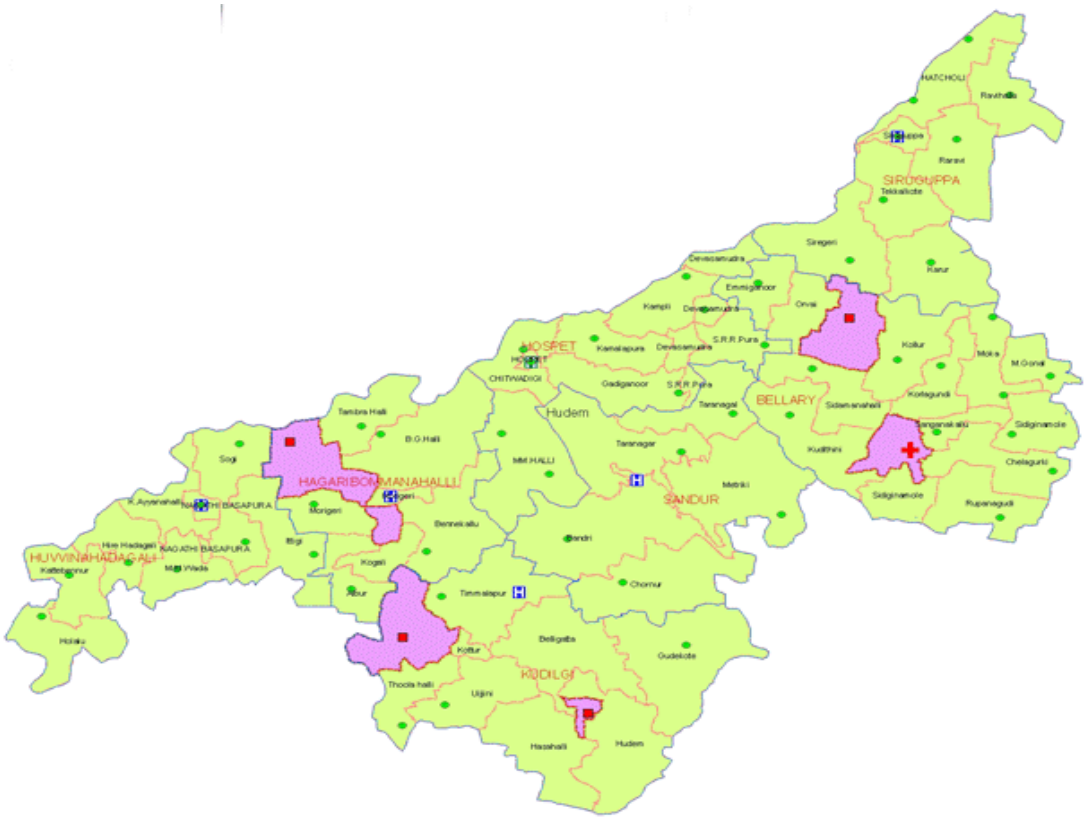
Potnal:

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

District profile – Bellary

Information:

As per **2011** census the population of the district stood at 24,52,595 (Male : 12,36,954, Female : 12,15,641). Rural Population is 15,32,356 and Urban population is 9,20,239. Scheduled Castes population is 5,17,409 and Scheduled Tribes population is 4,51,406.The geographical area is 8447 sq. km. It has 2 revenue sub divisions, Ballari subdivision and Hospet subdivision, which in all have seven taluks. The Ballari subdivision has 3 taluks, while there are four taluks in Hospet subdivision. There are 27 hoblies, two CMC's, one town municipality, seven town panchayats, 542 revenue villages, and 436 thandas/habitations. The rural populations constitute 62% of the total population. The density of population is 290 per sq. km.The scheduled caste/scheduled tribe populations constitute 39.50% of the total population. The sex-ratio was 983. The normal rainfall is 639 mm. The major occupation of this district is agriculture and 75% total labor force is dependent on agriculture for its livelihood.



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Dept	Roads Details gÀ¸ÉÛUÀ¼À «ªÀgÀ 31/03/2013 gÀ CAvÀåzÀªÀgÉUÉ		Architecture Details PÀlÖqÀUÀ¼À «ªÀgÀ 31/03/2013 gÀ CAvÀåzÀªÀgÉUÉ	
	State Highway gÁdå ºÉzÁÝj (KM)	Major District RoadÛ (KM)	¸ÀASÉå Number	Area «¹ÛÃtð (ZÀ.«ÄÃ)
Bellary	588.57	982.20	322	242595.86

Hadagali	**427.49**	**822.34**	**117**	**41386.51**
Raichur	**1073.27**	**1520.07**	**639**	**217971.14**
Koppal	**709.02**	**1503.65**	**251**	**71377.70**
Total	**2827.51**	**4841.86**	**1329**	**573331.21**

My personal journey

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

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

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

<u>Looking Outward</u> –

What did I Learnt about the community?

Go to the people

Live among them

Love them

Learn from them

Start from where they are

Build upon what they know

But of the best leaders,

When the task is accomplished,

The work completed,

The people all remarks:

"We have done it ourselves"

Lao Tsu

LEARNING and REFLECTIONS:

- The orientation programme began by providing the basic definition of Health, but with the progress of the session's the multi dimensional aspects of health, which is beyond just "physical health" for the very first time, was introduced to me in such explicit manner.
- While understanding the concept of society and social determinants of health. I understood that the society is thoroughly stratified in to various strata's and it is the power structure dominated by a few, who decides. It is because of the resources available to this few, which make them the dominant class. The SEPC analysis gave a better picture on the social determinants of health.
- The monsoon game made me realize, though we say or belief that fight with situation, come out social barriers ,and bindings, a simple game taught me how difficult it is to fight out the social norms, the structure, the power plays, the rules. Poverty, marginalization does not allow you to question. But game thought me if one does not question the norms, the norms would always oppress only a section of society. The role play as one of the farmer family and the situation, which was the put forward for the game, was extremely unjust and is very much faced by farmers in real situation also made me realize the daunting difficulties which the farmers has to overcome.

Community Health Learning Programme - Orientation report

The orientation programme gave an extensive understanding on various aspects of health, the programme dealt with various concepts as listed below:

- Understanding the concept of health. (Definition community health, core components and health as human right)
- The monsoon game, understanding society, social determinants of health.
- The alternative paradigm in community health, skills and values needed for community health
- Historical overview of health care system.
- Introduction to public health system, its structure and functions. Public health approach to control of diseases – role of health system.
- What is primary health care? How do PHC components get translated to practice?
- The story of Alma Ata to present time

- National Rural Health Mission (India's effort to strengthen health system and improve people's health)
- What is globalization? Various aspects of Globalization and its impact on health
- Understanding Gender distribution system.
- Overview of national programe on vector borne diseases
- Alternative system of health
- Commercialization of drugs

7. Research Study Report

Title: "A Study on Occupational Health Problems associated with the Women mining laborers and the health system response to it in Danapura community, Hospet Taluk"

Aim:

This study aims to explore the occupational health problems and the safety measures adopted by the women miners and the health systems response to it in Danaapura community.

Specific Objectives:

- To identify the occupational health problems associated in the mining activities
- To understand Knowledge, availability and usage of safety measures
- To understand Perceived occupational health services and facilities among women workers

Methodology

Study design

Mixed method study (Mixed method using qualitative and quantitative)

Type of study

- Descriptive study

Sampling unit:

Women mining workers, ASHA workers, PHC staff, Danapura village, Hospet Taluk, Bellary District.

Techniques and tools

- In-depth interview
- Discussion with PHC staff and ASHA workers

Tools

- In-depth interview guideline
- Observation
- Consent form
- Recording
- Photos

Planning of Data collection:

People plan to be interviewed	**Methods used**	
10 Women mine workers	In-depth interview	
02 – Discussion	ASHA Workers	PHC Staff

Results:

Background of community and work

In my research I had 10 respondents in that 6 people were Devadaasi and another 4 people were married. Devadaasi was their traditional system so they are continuing that. These people are working in mining Company from many years because Devadaasis have to take care of their father mother and children so they are working here. And they have to take care of children's studies. Many respondents said if they won't go to work they can't survive without money because they are taking care of their family.

Type of work in the mines:

- **Segregation of iron pieces:**

They do iron work, they refine iron pieces from mud and waste iron materials also, and they keep it in fire after that it will be melted by machine and they will get big iron pieces and also it becomes iron angler pieces. So here they won't waste any small piece of iron, this is their daily work. This iron pieces are taken by magnet and keep in another machine there it will change to big iron raads.

1. Occupational health problems associated with mining:

a. Commute/transport associated problem:

They work on contract basis so they don't have bus facility. It's 3 KM from their home so daily they have to go by walking and so it's very difficult for them so they feel bad for that. They get leg pain and body pain. They don't have any problem in working hard but the problem is distance between work place and home.

b. Accidents and injuries

From this research I understood that before accidents and injuries occurred to people commonly but now it's seen very rarely.

Ex:

R: For 6 years I had to carry 280 kg bags on my back and the company gave free treatment for the people suffering from back pain, from many hospitals I took treatment and some of the hospitals I took treatment are Hospet hospital, Tirupati hospital. I was admitted for 3 months in city hospital and 2 months in Hostur hospital all total 6 months I was in hospital. Then I went to a specialist for a year and I didn't even pay a single penny for that treatment, company paid it all, when I was admitted in hospital they paid 300 rupees per week for food and encouraged me to recover and also they pay us 350 rupees per week as salaries.

R: it's 7 months back while I work in constructions site one stick fall down on my head that time I got severe headache, that time they took me to company doctor, and they did scan on my head by god grace I was saved so I am very happy for that and I didn't even pay a single penny for that treatment. Company paid it all, now I don't have headache but sometimes I get body pain and legs pain that's it. Many years ago accidents and injuries were common but nowadays it's reduced.

C. Musculo-skeletal pain and tiredness

- Field work - When they work in field work, where they refine mud from dust particles, small iron pieces, stone pieces and they take out the waste materials and keep it another side and they clean that places, they face cough, cold, headache, fever, breathing problem, throat pain, and back pain and also they feel tired frequently and sometimes they go to the company doctor, here they will give free treatment and free medicines, if they get severe pain they have to go to private hospital in Mariyammanahalli village.

- Office work – when they do office work they have to walk more and employees what they will tell they have to do it. If they have heavy work in office they get leg pain and they feel tired.

- Canteen workers – when they do in canteen they wash the plates, wipe, mop and serve food for 700 employees, 4 to 5 people have to work in canteen. When they do canteen work if anyone takes leave then sometimes two peoples have two do all work, then they get heavy work then I feel difficult and they feel tired and sickness.
- Construction work – sometimes they work in road department there they do construction of roads and buildings, helping in the construction work. While working if any health problem like stone falls down to their leg or any injuries caused means they take them to company doctor here they give free treatment to them.

2. Knowledge, availability and usage of safety measures:

a. Awareness/knowledge/training:

Here they won't give any trainings and awareness programs but all they say is this is for your safety because you people are doing mining work so dust will go inside your mouth and eyes so you have to wear these things and they say that if you use the safety measures you can get healthy, and they didn't tell about the side effects of working in mining sites so we don't have any awareness about the health hazards caused from working in mining sites and sometimes they shows us the screening movies about safety.

b. Availability:

Safety Measures like shoes, mask, glasses, helmet, and hand gloves and these items are provided by the company once in a year. Daily they provide hand glove. Glasses sometimes if they lost, if stock is there they provide otherwise if lost means they scold them. Sometimes if they lost any safety things they give old equipments of people who already resigned. Otherwise they take 1 or 2 months to give new things or else they have to take their own money. Sometime when they show bill they pay back their money, from company these types of facilities is there for them.

c. usage of safety measures:

while they work in field they use shoes, mask, glasses, helmet, and hand gloves and these items are provided by the company once in a year and they use it while working with stone and mud

work so they will have to use it compulsory, if they are doing the canteen work and office work then they don't have to use these things.

d. Monitoring of workplace safety:

Daily safety workers come to them and they check their safety equipments and if they didn't wear safety they will scold them and they throw out them from their work. So they have to wear safety in work time otherwise they get injuries and when it's heavy sun light that time they get sweat so sometimes they remove their safety. So they tell them if you remove your safety in work time sometimes you get injuries and so we tell for your safety like that they tell them.

3. Perceived occupational health services and facilities among women workers

- **Company**

From 10 respondents I got this information like there they have monthly checkups like blood checkup, BP, eye checkup, weight checkup and if they get sickness that time also doctor will do these checkups. Two doctors will go daily and one doctor works for the company another one is from karingnoor village. 3 visits that are alternative days they will go and treat them, here they will give free treatment and free medicines. When labors fall sick if doctor is not there they will take them to the hospital in office vehicle or ambulance otherwise they refer to private hospitals.

- **Local hospital:**

If they are not recovered in one day by the doctor next day also they will go there and they will take new medicines. If again it's not recovered next they will go to private hospital in Mariyammanahalli village, then they take 50rs for consult fee. If they need more injection or medicine they have pay more money from their pocket. Within 2 or 3 month they have to go private clinic. Otherwise they won't get cure. Sub center is there in that village but they don't have any facilities. Sometimes if they get fever they take fever medicine from ASHA workers.

- **ESI & Insurance:**

They don't have ESI & insurance services because they are contract workers.

Discussion:

What are the reasons for the findings? Why?

- The Company is not providing bus facility and hence the employees are getting tired before reaching Company.
- They don't have weekly leaves and hence the employees are irritated with this.
- In that village sub center don't have any facilities for labors so the labors has to go to nearby village which is somewhat far from their village.
- The employees are very much satisfied with the work and salary what they are getting.
- They are not providing food facilities, rest room facilities and toilet facilities during field work. Management is not providing proper awareness about dust related problems.

Strengths and weaknesses of the study

Strengths:

- The main strength of the study was the whole hearted corporation of the responders even in their limited time.
- I conducted the whole interviews alone for all respondents and I collected the maximum details I can in limited period.

Weakness:

- As leaves are not available and due to busy work shift of the employees I was not able to conduct FDG even though I previously I planned that. Even Sundays are not holidays for them.
- Since I conducted the interviews alone I feel like data that I collected incomplete and would have been better if I had a companion.
- Since I conducted the interviews in the evenings it was difficult for me come back because of transport problem.

Note: No respiratory problems as they are using mask

References:

1.Bhanumathi, K. (2002). The status of women affected by mining in India. *Tunnel Vision: Women, Mining and Communities*, 20–25.

2. Donoghue, A. M. (2004). Occupational health hazards in mining: an overview. *Occupational Medicine*, *54*(5), 283–289.

9. Reading List during my fellowship

- Where there is no doctor
- Jana Arogya aandolana

- Samate mattu asamaanate
- Health rights
- NRHM programmes

10. Participated the following workshops, assembly, training programs

- Water and Sanitation workshop
- Devadaasi sampurna nirmulane mattu agatya kramagalu (Hampi University)

Field Photographs

Group Discussion

PRA

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