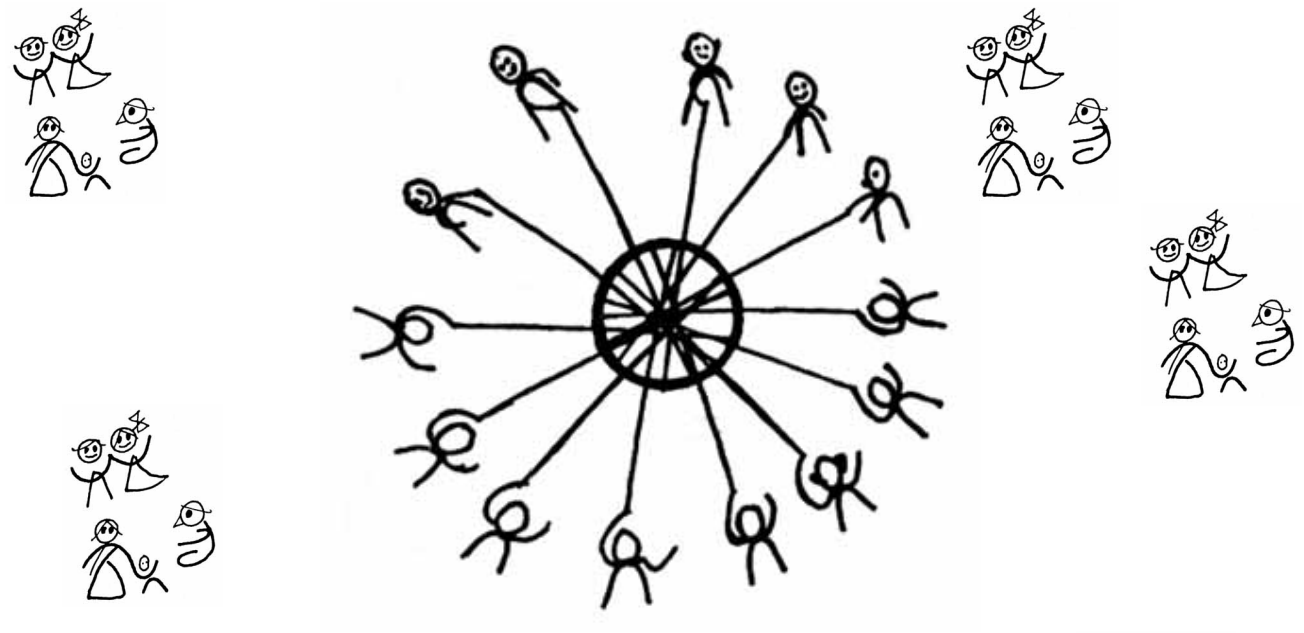
2014-2015

Community Health Learning Programme

A Report on the Community Health Learning Experience

Huntiful Lyngdoh Marshillong



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Humanity to Health: A New Phase of Learning

Huntiful Lyngdoh Marshillong
CHLP Bangalore
2014-15

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Acknowledgement

I give my thanks and glory to God for being with me in each and everything I do in life

I deeply paid my sincere thanks to **Dr.Thelma Narayan** the Director of SOCHARA, Bangalore and **Dr. Ravi Narayan.**

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Last but not the least I sincerely give my thanks to my parents, sister and brother and to all my friends who always have encouraged and helped me in whatever I have done during this whole year of my fellowship here in Bangalore.

About me and my journey before I join CHLP

My name is Huntiful Lyngdoh Marshillong from Nongstoin, West Khasi Hills District, Meghalaya. I was born and brought up there in a Christian family, where I am the eldest sibling among six of us with one younger sister and four younger brothers. My parents are doing their own business work.

My background before I join SOCHARA

I did my graduation in the Arts stream (BA). After I completed my graduation I wanted to do my post-graduation so I took admission in Martin Luther Christian University, Shillong choosing Master Social of Work (MSW). In my MSW I have been taught about community and other subjects that relate to the society, and how to work with it though at that time I had an understanding about the community in my heart I wanted something more where I can learn and get more insight about the community. When I completed my MSW I was in search for a job and in the mean time I did voluntary work for four months with the Social Services Centre, Shillong to gain more knowledge about working with the community. In Social Service Centre, Shillong I got to do social audit on the MGNREGS (Mahatma Gandhi National Rural Employment Guarantee Scheme) in Ribhoi district, Meghalaya. The audit was a nice experience for me because for the first time I got involved with the people of the different villages, and audited the work in their villages and went to the field to see the work done by them. After this I had to write a report which I found a little difficult in the beginning but later it went well. I was happy that I got a chance to be involved in this audit and where I could talk and listen to the people. I got more involved with the people in the community and at the system level I had to submit my reports to the block office for the public hearing about the audit. It was during this time that I went to our University to meet the Head of Department and she told me about this fellowship program on community health learning. This struck to my mind and at the same I am very happy as I want to learn more about community so without any delay or second thoughts in my mind I wrote to SOCHARA that I want to join this course. I thank God that I got the privilege to be in SOCHARA learning about community health.

My Passion

My passion since the time I was doing my MSW was to work with the community in doing social action and prevention and to put into practice what I have learnt from this course.

Why Humanity to Health a New Phase of Learning

The topic I chose, humanity to health, was because I did my graduation in BA with the elective subjects as economics, sociology and political science which are humanities subjects and later for my post-graduation I joined MSW. From here it has been a turning point for me where I got myself to do community health learning program for one year at SOCHRA, Bangalore. This community health learning was like a light to me because if I would not have joined this program I would not be able to understand about health in its wider perspective and now I realised that those subjects that I have learnt during my BA and MSW are correlated with health and health system.

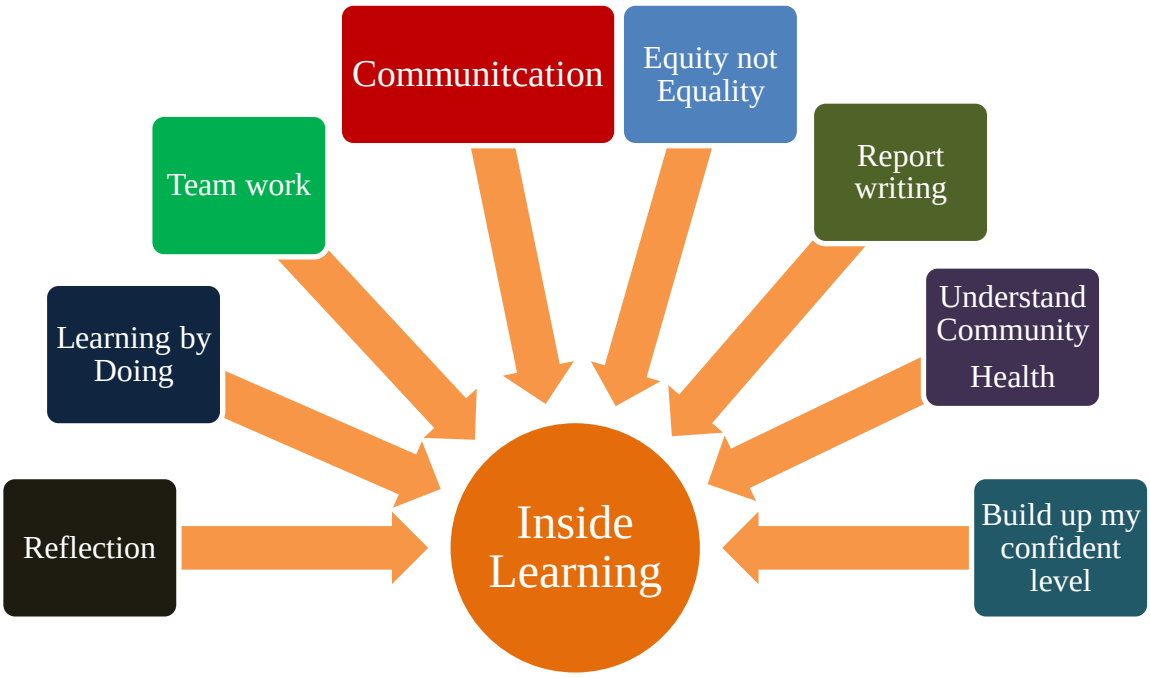
Why I joined Community Health Learning Program

Why I wanted to join the community health learning program is because I am interested and wanted to get more knowledge and experience from this course so that I can help, create awareness and make the people understand on how health is important for each one of us. I want to understand more about what community health is all about and by getting exposure in this field I would be able to work and give the best of my knowledge to the people in the community.

Learning objectives

- To understand about community health
- To explore different fields during my fellowship program
- To get an in depth knowledge on how to deal with the problems in the community
- To build my confident level of understanding

My Inside Learning



Learning from collective sessions

The community health learning program was an insightful learning for me. One of the most important part which I like the most is when they tell that we are all learners and we need to learn from each other throughout this fellowship and there is no teacher here but there are facilitators to facilitate fellows in the journey of community health learning. The sessions that facilitators give were creative, make the fellows get involved in many activities and to relate what that has been taught in the class we were able to practice in the community. It is like a platform for me to see myself where I am and what I can do for the community.

In the four collective sessions that we had during our community health learning program I have learnt and understood community health more clearly. Apart from the sessions that we had in class we got to go for visits to different organisations and community. My learning and reflection about the collective session are:

What is community health?

Health

About health I learnt that health is not only being healthy in the body or the absence of disease. From the WHO definition and explanation I learnt that health is the wellbeing where a person has to be physically, socially, mentally and spiritually healthy and not merely the absence of diseases.

Community

I learnt that community means to bring people together and to build a community with them where we can have a common understanding and common goal. In community we can have different structures and denominations but they still share togetherness. We have to build community in spite of the differences into a positive change.

Community health

I learnt that it is the process of enabling and empowering people to identify their own health problems and prioritise them, and what action they want to take to solve the problem. People have to demand health as their right.

Community development

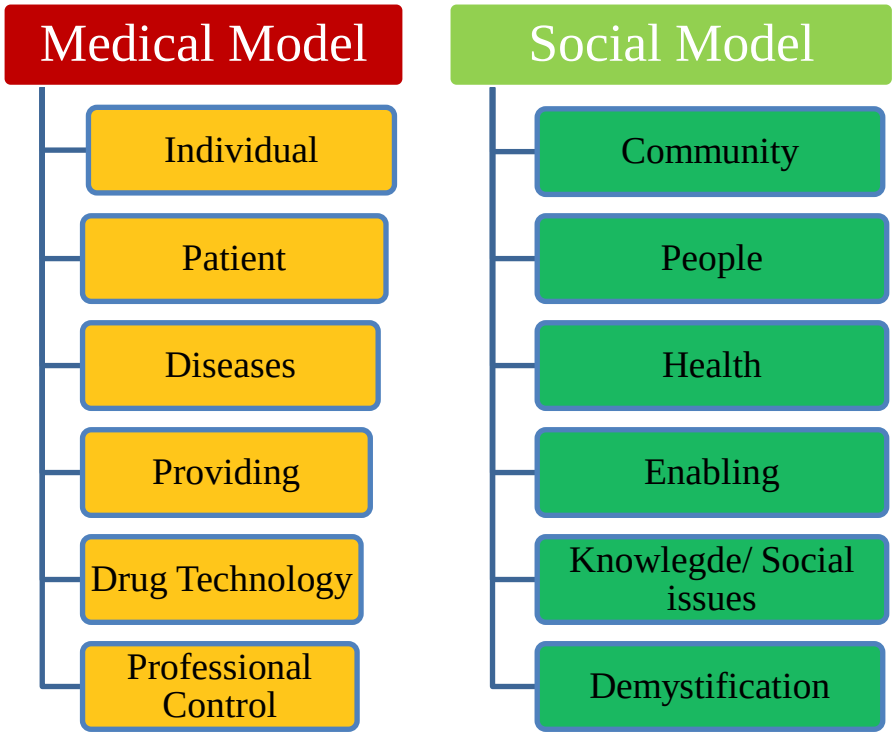
From the session and group discussion I understand that development is not only the development in terms of having big buildings, pucca roads and having many institutions but development can be called development when all the facilities and services that are available to people in the community can be used, everyone has access to it and reach to the people who are unreached. People need to have their right to food, right to education, right to health, right to employment and other resources in the community.

From here I understand clearly about health, community, community health and community development and how all these have a link with each other.

Ten Axioms of community health

About these ten axioms of community health I understood and learnt that they are the tools for community health that we need to follow to improve our work with the community. From the axioms I learnt that in community health rights and responsibilities are important so we have to give awareness to the people about their own rights and responsibilities, like right to food and shelter and they have their own responsibilities to take care of entitlements when they get them. Autonomy over health is where the people have the right and power to control and make decision regarding their health. I learnt that how health has to be connected with development in the community. People's participation, reaching the unreached, strengthening and empowering the community people are also a part of community health. To see the common interest of the community, help to promote and enhance the sense of oneness, build capacity for confronting any problems or cause of ill-health, bio medical problems and super structure of health services are also a part of axioms. In community health it is not that we have to go with a package of professionalism but with the attitude of being with the community and create new ideas and orientation for health action and from the last axiom I learnt that we need to reached the people who are unreached to achieve health for all. From this I learnt that we need to go to the people talk with them and understand them. These axioms are very helpful for me to see that if we work for the community is it from our point of view or from the community point of view.

Paradigm shift



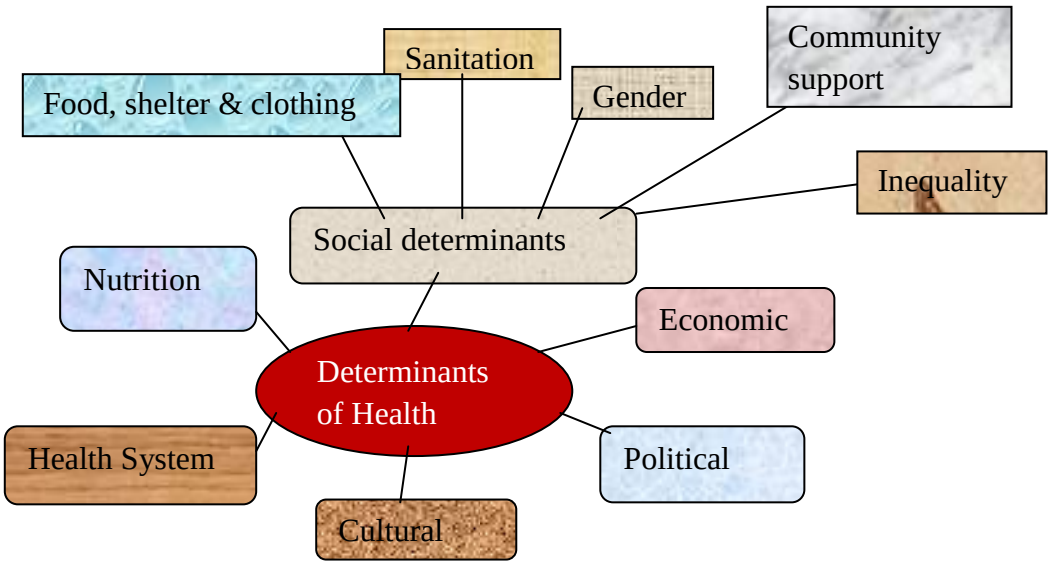
This paradigm shift session has been a great learning since in the beginning when I joined the fellowship I thought that health is only the medical part and I hadn't thought that it can be done in the social part. But after the session I understood that health doesn't need or mean only the medical model but can be shift to the social model. Like I mentioned in the above diagram where we can work and help the community understand the different social determinants of health at the grass root level.

From my observation during the time when I was doing my voluntary work they used to go to the community and give services and medicines to the people but I have noticed that they do not teach the people about the diseases how it caused, how it spreads. So the paradigm shift is like shifting my mind to think in a different way when we go to the community we have to know the root cause of the problem and give awareness to the people on how it is caused and how it can be prevented and how to promote health.

From the diagram I learnt and understand that in medical model treatment and services they are given to the people but in the social model we focus on people of the whole community to identify health problems of the people within the community and try to find out the solution for that problem with the people itself. It was a very nice and interesting session for me.

Determinants of health

When I first heard about social determinants of health I understood to an extent but sometimes got confused about them. When we were in the field I got to interact with the people in the community and when they shared about their problems I realised and got a clear understanding following discussions with my mentor. I learnt that social determinants of health are social, economic, political, cultural and ecological and all these can be a determinants in some way or the other. For one problem there are many determinants which influence that problem- education, unemployment, no proper, no safe drinking water, no proper health care facilities among others.



Malnutrition is one of the determinants of health from what I seen in my field work where women are anaemic and children are malnourished. Causes which leads to less nutrition are:

- Don't have enough food proper
- No safe drinking water
- No money to buy good and nutritious food
- Lack of access to proper health care
- Unclean environment
- No proper sanitation
- Poverty

This can relates from one cause and it is based on where I observe and talking with the people in the community.

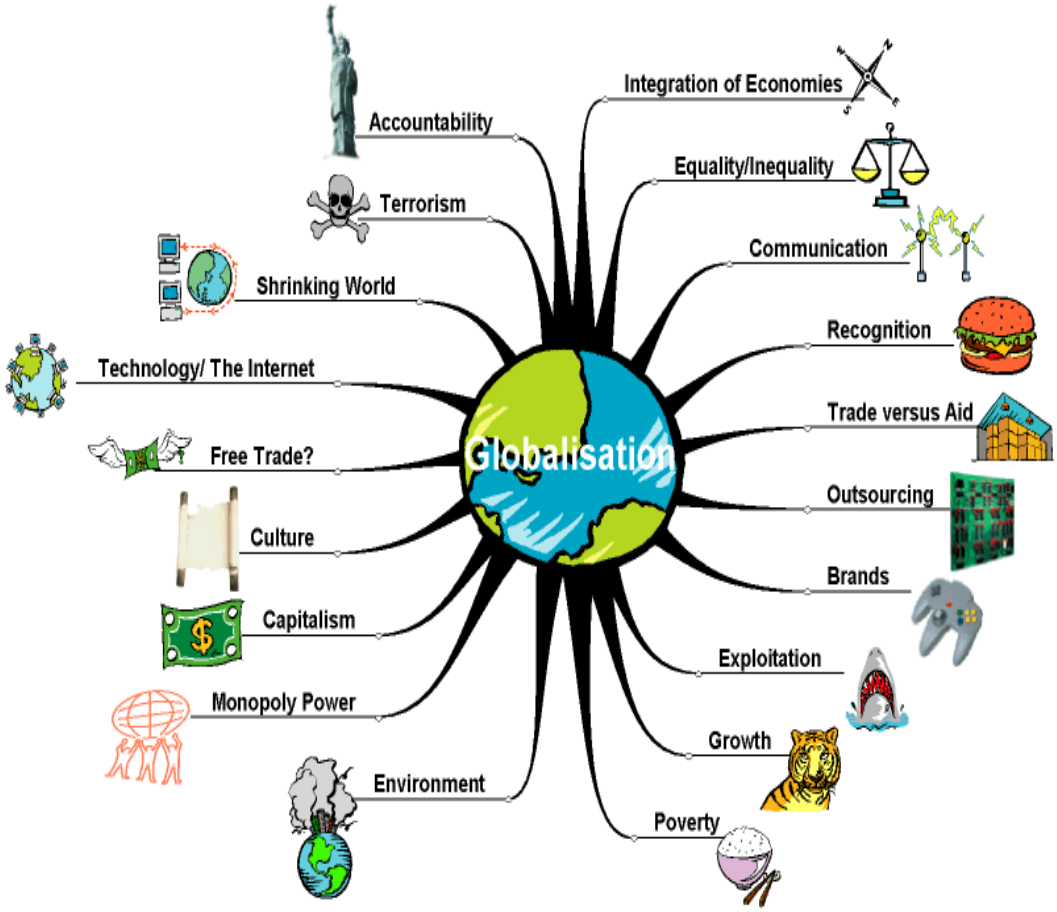
Social stratification

Social stratification in the society is a structure that divides or categories the people in terms of power and status like caste, class, gender and an unequal distribution of resources.

I learnt that social stratification which exists in our society is one of the social determinants of health as people cannot have an equal access to the services which are there in the community as they have been divided into different status where the lower caste cannot mix with the upper caste and also there is inequality distribution. Stratification affects the life of the people, the opportunities that they are supposed to get but do not get, and it continues from generation to generation.

Gender inequality and social exclusion is another social problem in the community and are also one social determinants of health as people are looked upon and treated according to the gender and also the exclusion of people from the society. From the movies that I saw during various sessions people with low caste and class have been excluded in the community

Globalisation



Source: www.bized.co.uk

The class on globalisation was a very interesting; I understood and learnt that globalisation is seamless or borderless. From the picture we can see there is capitalism and monopoly of power. Due to globalisation the people who are rich are becoming richer and the poor are becoming poorer. It also affects the environment (global warming), privatisation, equality, exploitation and urbanisation. In today's world though everything is becoming more and more technical and scientific by the use of technology people who are supposed to get the basic necessities are not able to access to them. Globalisation can affect the environment and the people's health like in my place, West Khasi Hills District of Meghalaya, where UCIL Company and government want to mine uranium in spite of opposition from the people but they want to do the mining and this can be one of the examples of exploitation as a result of

globalisation and instead of Aid they want only the trade. Globalisation has only one goal and that is profit.

Primary Health Care

The term primary health care was introduced in the Alma Ata declaration. There are four pillars of primary health care that is equity, appropriate technology, intersectoral approach and community participation. These four pillars were designed too reach health to all by using the resources which is available in the community, which are appropriate and to involve people through participation and intersectoral coordination with other systems of the government. Primary health care is for promoting health, for preventing ill health and for people take the responsibility over their own health.

Communitisation in National Rural Health Mission (NRHM)

NRHM is one of the national initiatives of the government that provides health care facilities to addresses the health needs and follows a bottom up approach in order to reached people in every community in the country. Introducing NRHM, I can say that, has been a great work done by the government to help in improving the health status of the country and to strengthen the systems where people can have access to health. In NRHM communitisation was one of the components, this includes the ASHA's worker, VHND and Village health sanitation and nutrition committee (VHSNC), where they were working with the people at the community level to promote health within the community.

Health as a Human Right

Health is a state subject. Health as a human right, from this I learnt that, health is a process and our part and responsibility is that we need to take care of it, it is not a commodity. It is our right to get health care that we need to be healthy and we should also have the access to health care that is available, accessible, acceptable and affordable, and to have a quality of service. I understand that we the people can exercise our right to health and better health system. It is our responsibility to take care as health itself is a part of life and we need to make the system work. Health is a fundamental right.

Occupational health

Occupational was one of the interesting sessions to know and learnt about. I learnt and understand that occupational is one of the major health problems as workers do not have any safety measures and they are exposed to an unhealthy workplace and environment where they

are working. I used to observe and see people in my community working in mines, crèche, constructions and other occupation and due to the job that they are doing they are facing a lot of health problems, for which they will go and take medicine from the private doctors and hospitals and as soon as they recover they will go and continue the same work. Hence it affects their health a lot on but they will not change their job because of the money that they get. From the movie which was shown I saw women and even children working in mines which was affecting their health but due to poverty they have to do whatever work they get to survive that too without any safety measures. Here I can say that right to health has not been to make people aware that they have the right to have safety measures in their work place and to have access to better health.

Quantitative and qualitative research

Research is to find out or to enquire about a problem. It is only a means not an end. Research was one of the main topics which we had in our collective session. Through this session I got more in depth knowledge of research and how to do it. It was a great learning for me as I got a clear understanding about qualitative research and did my study using mixed method to improve my knowledge about research.

Medical pluralism / Alternatives

From medical pluralism I understood that we do not have to depend only on the allopathic medicine but we also have the traditional medicine like home remedies where it is easily available at home and for which we don't have to go and spend a lot of money, and also different healers exists in the community. AYUSH (ayurveda, yoga, unani, siddha and homeopathy) are few of the alternatives.

Health management

From the session I understand that health management is where we identify the health problem and understand the social, economic, political, cultural and environmental factors in the community and also find out the local resources. In health management we need to have good planning between physical and human resources. It is a very important for us to know what resources are required and how we can implement programmes.

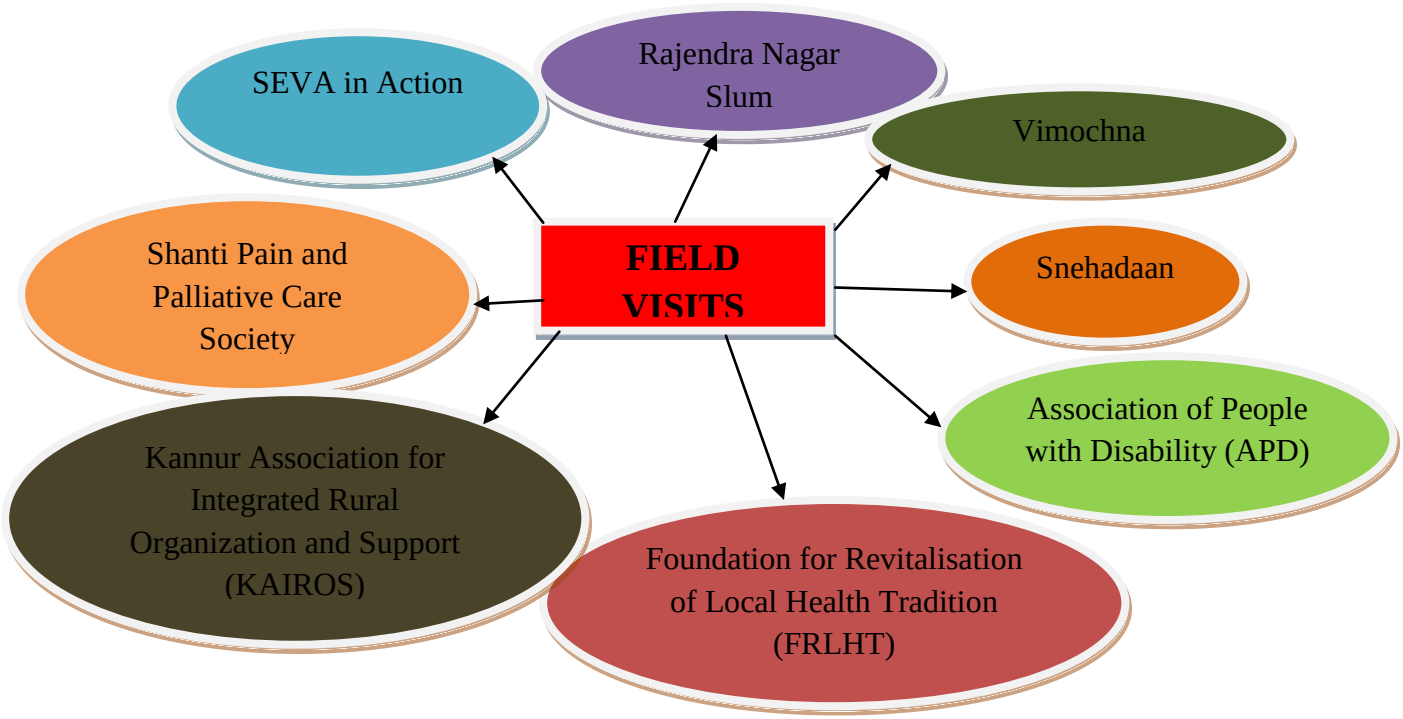
Guest lecture

We not only got sessions from the facilitators but also had guest speakers who gave sessions on various topics. From their sharing and classes I got inspired and also felt the need to

realise the realities. Communication class was one of the classes which I found very interesting as from this class I gained a lot to build up my confidence levels and how to communicate well with people. System thinking was one of the classes where I got to understand how I can go and build the community and how to identify the problems and prioritise them with the people in the community by using the different methods. It was very useful and informative classes I got from all guests who came and gave session during this fellowship.

Learning from Community

Field visits



Apart from the sessions in the class, along with other co-fellows and the facilitators, we got the chance to go for field visits to different NGOs which work in different areas and deal with different issues. From these visits I got to explore and learnt many things about the work done by the NGOs, community based organizations where in each of these organization worked in the community and how they help and tackle the problems. Each of them has played a very important role in the community to try and bring a change in the society by giving awareness, doing social action, promoting health and strengthening people. It was a nice experience going and visiting these organizations which gave me insights into how much they have done and worked for the people and with the people in the community.

Protest

Other activities that we got to take part in this one year course of community health learning program is to be a part of protests along with fellows and facilitators.

1 billion Women's Voice- this was a protest against women's violence and harassment and to demand their rights to stop violence against women and need to be treated equally.

Green Peace protest against Genetic Modified Organism and genetic modified foods. From this protest I learnt that there was a need to raise our voice for our own rights.

We all, the fellows, participated in the **blind walk rally** where many students had come and took part in the blind walk to show concern towards those people who are blind by joining with them in the rally. The blind walk was like practicing empathy and how much we could feel when our eyes has been blindfolded and walk with those who are blind. It was really a nice experience for me and I can understand how important it is for us when we do something we need to put ourselves into their shoes and help them in the way we can.

We also went for **solidarity of the Bhopal tragedy** to show our solidarity and remembrance for those people who have been affected by the gas tragedy.

Field Learning

1st and 2nd Field Learning

SATHIYA WELFARE SOCIETY, BHOPAL, MADHYA PRADESH

About the organization

Sathiya welfare society came into existence in 2003 and has got its legal status on 28th April 2006 under the Society Registration Act, 1973. It started with ten youngsters with a focus on empowering the people in the community, fight for their rights and take new challenges in their hands. The area of focus is mainly development and capacity building, providing training on livelihood skill enhancement, developing strategic and short term planning of organization. The approaches are mainly community mobilization, people sensitization and involving the community through participatory approaches and build their consciousness through developing a democratic set up. The organization is not only fighting for the rights of the people but also prepare the community to take their rights by involving them in process of ensuring rights for their brothers and sisters irrespective of belongingness of caste, culture and creed.

Sathiya welfare organization works in five district of Madhya Pradesh that is Rajgarh, Sehore, Betul, Shajapur, Agar and five slums in Bhopal that is Indranagar, Mira Nagar, Krishna Nagar, Ichwar Nagar and P.C Nagar.

Sathiya welfare organization has the non-hierarchal organogram, the head office is located in Bhopal and in the team they have a State and District co-coordinator, each staff has their own responsibility for the work and if any problem or difficulties arise they consult together as a team.

Sathiya welfare organization works with different disadvantaged groups like tribal, rural and urban poor by providing them skills based on training and linking them with the market directly. It also attaches them with various self-employment schemes which are run by the

government. It is also campaigning to the people on Panchayati Raj Institution. The focus areas at present are Malnutrition, Mother and Child health as these are the major issues which they have found while working with the community. In the slums now they are focusing on the Adolescent and Women health. The organization has networked with NABARD in which they coordinate with banks to ensure credits flows among its members and forge better bank borrower relationships through forming SHG's (Self Help Groups) and farmers clubs. It also as a bridge helping communities reach health facilities, it also working on strengthening the local health facilities/providers like Aganwadi worker and helpers, ASHA, ANM, VHSC and the community as well by strengthening their knowledge, capacity building through trainings and providing them information on various health schemes and facilities which are available from the government.

Their Vision is to access rights for all by ensuring active participation of women and men from the marginalized sections of society by involving them in a process of decision making on the basis of informed choices and strengthening local self-governance system in reality. Their aim is to strengthen and empower the community to demand their rights and community participation.

Reflection

I was happy that the organisation was very helpful in explaining how to do the logical frame work analysis so that we can do accordingly when we are in the field. When I reached the slum seeing adolescence girls and women who are in the centre with the organisation field staffs listening to them while they explain about malnutrition makes me happy as I can see their willingness to learn and know more about it. The adolescent's girls who shows a great interest to continue their studies if they have a chance and the approach done by Sathiya organisation to educate them in the centre was a very helpful to them.

Understanding and learning about the community

Socio-economic status of slum in context of urban health

Brief History of the Slum (Indra Nagar Slum, Bhopal - Ward No.-50)
Indra Nagar slum is a notified slum which situated in the southeast Bhopal near the 12 No

bus stop. This slum has been there for more than thirty years but does not have the exact date and year of when it came up.

The people who reside here are mostly those who come from Maharashtra known as Marathi people, the Nimadi people who come from Khandwa district of Madhya Pradesh and others parts of Madhya Pradesh. These people migrated from different parts of Madhya Pradesh and from the neighbouring states with the purpose of better earning for livelihood.

Demographic

The demographic population of this slum according to the data from "A glimpse of slums in Bhopal" the total number of house Hold was 800 and the total population was 8000. Here Scheduled Caste (SC) population was more than Scheduled Tribes (ST), Other Backward Castes (OBC) and General.

Community

SC	70%
ST	1%
OBC	20%
General	9%

Religion

Hindu	85%
Muslims	5%
Christians	10%
Sikhs	0%
Others	0%

This information was through our interaction with the people and observation

The major livelihood of the people here is domestic work, house painting, daily wage work and others kind of works. Both men and women are going for work to earn their livelihood.

Living Conditions

The living conditions of the people here in Indra Nagar slum are not good and the environment that they are in is not good as they don't have a proper sanitation, drainage system, proper place for dumping waste and housing. The type of houses where the people here lived was in semi-kutcha and kutcha houses. The place is very congested and there is no place for the children to play.

Sanitation status

The people in this slum mostly they do not have their own toilet and only few houses that have got their own toilet at home and use it. The sanitation status of the people living in this slum was not good as many of the people went for an open defecation and some went to the public toilet.

Water Sources/Supply

For water they get tanker supply and the source of water that the people get here was from Kolar. They have the water tank and from here it supplied by pipeline connection and people get water from the pipe only without a proper connection like water tap. There was no hand-pump, well or tap connection in this slum.

Electricity

The people have accessibility of electricity and street lights. There are houses which got electricity connection with a meter at home. There are some houses which they do not have a proper connection and they are connecting illegally from the main wire. Those people who have got the connection at home told that they find it difficult to go and pay the bill because they did not get it for each and every month and found it difficult to pay the bills one time all the bills that they got.

Type of Clusters

People in the slum are likely to settle with their own people who belong from their same place and same state. They like to settle in groups who are from their own clans and those who are belong to their same customs and traditions, beliefs and those who are from the same caste. This pattern of settlement which they followed where the Marathi people stay in one area, the Nimadi people in another area and the others who are from different community like Christian and Muslim they stay in different areas.

Status of Institutions/Infrastructures

Here the institutions which exist in the community are two primary schools one is private and one is government school. There were no health care facilities there is only one DOT centre and a nearby private hospital. There are small temples in the community where the people used to go and worship and celebrate and there is no community hall available. There are also two Anganwadi centres within the community.

The infrastructure was not good as the place where people lived was so congested and the houses that they build are kutcha and semi kutcha, they have access to roads, electricity and water but they do not have a proper place for dumping the waste and also no proper drainage system.

Anganwadi Centres in the Basti

There are two Anganwadi centres within the community.

- The first Anganwadi started in the year 1985
- The second Anganwadi started in the year 2007

These Anganwadi building centres was rented and they got a small room to use and there was no water facility and toilet available as it was a rented house where people stay in that Anganwadi. No proper place and the room are small. They use to distribute the cook food to the children's and for the adolescence girls they give iron folic acid tablet.

Table No 1: Weighing of children in one Anganwadi

Age	Total	Boys	Girls	SC	ST	General	OBC
0-3 years	49	22	27	22	0	4	14
3-6 years	23	8	15	12	2	3	6

According to the data given by the Anganwadi worker the total number of children who came to the first Anganwadi was seventy two and from the second Anganwadi we are not able to get the information.

Table No 2: Grades of malnutrition children as per their weight for age

Age	Normal	Moderate	Severe

	Boys	Girls	Boys	Girls	Boys	Girls
0-3 years	8	7	3	7	3	6
3-5 years	8	3	2	2	2	2

Through the weighing that we did on the 8th May, 2014 out of 62 children nine of the children are above five years so we did not include. This data we plotted on the growth chart and 13 children were severe malnourished, 14 are moderate and 26 of them are normal. This weighing was only from one that is the first Anganwadi.

Schools in the Basti (Slum)

There are two schools in this slum one is private and one is government and both the schools are primary schools.

Health institutions/Clinics in Basti (Slum)

No government health institutions exist in the community; there was only one nearby private hospital and one DOT centre which used as a clinic. The health care services which the people get are only from the private clinics that are available in the community and from the private hospital which was near to their place or went to the district hospital, and the distance to go to district hospital was about eight kilometres from the slum.

Public Distribution System

The people they use to get the ration every month where they used to get rice, sugar and kerosene and the distance is not far as they use to go and take from 12No stop which is near to the community. The amount that the people get was according to the size of the family members. They get the ration at a very reasonable price where most of them are able to afford it.

Problems identified

List of Problems on priority bases	Reasons
Housing	Poor people cannot afford to go and stay in the buildings provide by the as they to pay so much of money and the rooms are small in which the family having five or six members cannot be easily fit in along with their household

	things
Sanitation	Mostly people do not have their own toilet so they used to go for an open defecate which they sometime feeling shy sitting and facing with the other person but there was no space to construct toilet
Livelihood	Livelihood was one of the main important parts of the people in the community where they consider it as one of the top priority apart from education and health. If people did not get a proper job or wages they are very worried of how to feed themselves and the family.
Health	Health was one of the priority where the community people are not access to any government health care facilities.
Education	Education was one of the important parts but the people choose livelihood and health first and education last. There are who understand about the important of education and those who can afford to let their children to study they do that but there are some who cannot afford to make their children to study they have to make them involve with any job they get to survive.

Detailing of problems as on priority basis

Here the people like to settle with their own community and with their own people who belong from the same state or same places; they are not likely to stay or mixed with different groups from different communities and denominations. Their socio-economic are also different as mostly the Marathi people men are going for house painting and women are domestic worker and the other community also doing the same work for but there are others who are involve in other works. The response from the community people was good. Here the government stake holder function are not in proper as for electricity the connection they are delaying in giving the electric bill which the people have to pay three or four months bills where the people are find it difficult to go and pay and the BPL card which they did not issue in the right time and make the people to wait for months. There are government health care facilities

Intersectoral approach

In the field when I was placed for field learning the intersectoral approach is there as the NGOs people are working together with Anganwadi centre and with the community people to work in health. The ARSH is one which in the community they are collaborate with the ASHA, USHA, Anganwadi workers and schools where they use to provide the iron folic acid. Adolescents get iron folic acid, calcium and vitamins for free. They used to have discussion on different topics on adolescents health in schools, colleges, the teens groups. Per day four to five adolescents come for counselling. ARSH also networks with NGO's to work in the community and here in Bhopal they network with Agan Trust NGO and Bachpan NGO

Social determinants of health

In the community which I was placed social determinants was the main problem were people do not have proper housing, unsafe drinking water, poor sanitation, no proper drainage system, no health care facilities in the community, no proper electricity and unclean environment where all these can affect the health of the people because most of them they were struggle to earn their living by doing any kind of job they got. Therefore from the community I learnt the social determinant here includes the social, political, economical, cultural and ecological.

Health care providers and medical pluralism

I also learnt from the community about the health care providers where they have the Dais, general practitioners, and the private hospitals which they have nearby and the people of the community they will go to the general practitioners to take medicines rather going to the government because it is far. Medical pluralism was also there where the people are practicing home remedy when they are getting sick and they also go for allopathic medicines for quick recovery.

Health care systems

Health system was not seen in the community as there were no health care facilities and services but there are only Anganwadi worker and USHA who give health education to the people whereas from the government there was no health care institution. People can have access to health care facilities in the government hospitals but it was far from their place that is why it makes the people to choose the other option to go to the private doctors and general practitioners and no going to the government hospitals.

Through the visits to districts hospital, Hamedia hospital, PHC and the Gauravi centre I gain a lot of information and understand that what services and facilities it was good and they are functioning well but sometimes people in the community even though they know that all the services they can get from here but they are not going to use it properly as they said that it was crowded and have to spend a lot of time to be there in the hospital and it is far.

Problems faced by the adolescents

Outside the family

The adolescence girls who have to go for work sometimes if they have to go by themselves all alone they are not comfortable because on the way there are some boys who use to pass comments on them and teasing them on the way and if they ask someone from home to accompany them they did not get. They also have problem with the timing in their work place because if they want to shift the timing for their work the house owner did not allow them and they have to stick with it. The works that they did include in the house are washing clothes, cleaning utensils and cleaning the house but the payment which they get is less.

Inside the family

In the family these adolescence girls did not get the support from their parents, no trust and getting scolding from their parents if they did not for work and they feel like their parents are not given proper attention and love to them. Gender discrimination at home where their brothers will go and roam but for them they have to go for work and during eating time the parents will give more and for them later and the quality of food they did not get the same like their brothers get.

These problems makes them to think that they are not worth and they said that they even feel depressed and sometime even think about suicide and low self-esteem as no one is there to support them if they need. When they are in the community they are not allowed to talk and make friends with boys they have to be at home and talk only with girls. Mostly if they have any problems they use to share with their friends.

Discrimination and gender inequality

The parents treat the boys differently from the girls as mostly for them but for girls they have to study and doing household works after they came back from schools coming from school but for the boys they are not allow to even wash their own clothes which shows some

inequality. When they go to school for their brothers they will give more money but for them they will give only ten rupees and when they are at home they are not allowed to make friends or talking with any boys. For dresses also they have to dress with fully covered with dupatta. They do not have freedom like the boys has. For girls during their menstruation they are not allowed to go anywhere apart from school and not allowed to go to temple which is a part of their culture. These adolescence girls they did not get any information from the school about health education and when they reach the puberty stage their sister or mother has to help in explaining them about the menstrual period. Due to this inequality at home some of the girls think "why I was born as a girl not as a boy". One of the adolescent girls who face sexual harassment from her father is not able to speak to any one because her father would not allowed her to go out with anybody.

About ARSH clinic

From the visit to the district hospital I learn about the ARSH program and the helpline which is also one of the counselling centres for the adolescents which is running by the state government for the adolescent health. It is one of the centres where the adolescent can get medicine like IFA tablet and counselling. They also the help line which use to give counselling through phone as well as face to face counselling for both adolescent boys and girls

Reflection

Through the discussion and interaction with the people in the community was that mostly teenage boys and girls faced their different problems at home as well as outside. Peer pressure, family problems to earn the living and other problems like relationship problems which leads them to substances abuses when they don't anything to do. From the interaction with some girls was that the food that they take was very less as they don't have a good appetite to eat which can leads them to anemia. They never go to the Anganwadi to get the IFA tablets and this seems that most of them do not like to go to the Anganwadi and they don't know that IFA helps them in case they are anemic. Lack of awareness on the need of nutrition and health education can affect their growth as for them nutritious food is important due to lack of appetite to eat. Therefore awareness for both boys and girls is needed and life skills education is very important.

Other social issues in the community

Here mostly men are engage in gambling, taking alcohol which leads to domestic violence and even the younger children start to imitate the habits that they see in the family. The unhealthy lifestyle practices by the elders within their home as well as outside the family affects the children and adolescence where adolescence boys are eating khutka, pooch which it is not good and which affect their health.

Overall Reflection

From these two fieldwork my reflection was that the living condition of the people in the urban slum are not good and we can say that what the people in rural areas are getting like MNEREGA schemes the people here in urban poor did not get any scheme, no primary health care available for them. People have to struggle to go and search for job so that they will be able to meet the needs of the family. They have to face a problem to meet their needs like sanitation, unsafe drinking water, no proper electricity and place to throw the garbage are not available in the community and due to this the surrounding are unclean. Many children's who are supposed to go to school they did not go and some they have to drop their schooling as no one was there to look after their siblings as parents are going out for work. Malnutrition among children are high and from the interaction with some mothers the food or milk that they give to the children they mixed with water and give the child and there are mothers who are suppose to breast feed the child but want to give something like cerelac this it was due to lack of awareness and education among them. What I like from the people who stay in this slum was that even they are come from different places and settle here they still have that love and to be proud about their own culture and tradition where they use to celebrate it which shows the uniqueness in them. Adolescents in this community faced a lot of the problems either with the community, at home they also faced gender discrimination, not equally treated and harassment. It is their time to get a lot of support either socially, mentally, physically, spiritually but they didn't get they have to strive and search for their living and help the family. Through the visits to the different hospitals and PHC it was very helpful for me to see the different services that give and how the government services provide to the people but human resources are still less. Through these four months of my community learning in Bhopal has been a very useful, informative and has made me understand more about the community in urban.

3rd Field Learning

Bethany Society Shillong, Meghalaya

About the organisation Bethany Society it is a non-profit organisation and it was established in the year 1981 and it was a charitable society. Bethany Society dream 'Of an earth fully alive, where everyone can enjoys fullness of being'.

Bethany Society work towards this by "Forming partnerships with people, communities and resources so as to create opportunities which empower enhance dignity and lead to security of health, food, livelihoods, and shelter in a sustainable manner".

Bethany Society works with "People's in vulnerable situations such as persons with disabilities, children, youth and women living in extreme poverty, particularly in remote rural areas"

Bethany works with many different projects and some of those project are

- Hostel for people with disability in Shillong and Tura
- Jyoti Sroat School, school it is an inclusive education
- Community based rehabilitation program (CBR) in Mawkyrwat
- Promoting mental health across Meghalaya

Learning

In the third field learning I was placed in Bethany society, Shillong, Meghalaya where I have to do my research study in one of their working district that is in Mawkyrwat, South West Khasi Hills District. In this two months of my third field learning it was a great experience for me to do my study and also to participate in different programs which has been conducted by Bethany Society, Mawkyrwat.

ASHA profile in Meghalaya

In Meghalaya there are 6258 ASHAs where in each districts they have ASHAs. From the interaction with the ASHA in the field they tell that they have to do a lot of things to be done where sometimes she said it is difficult for her because the incentives was less but they have to do it. The activities of the ASHA was

- Mobilizing pregnant mothers for ANC and escorting them for Institutional delivery.
- Mobilizing Children & mothers for immunization
- Conducting home visits & surveys
- DOTS Provider

- Collecting blood slides
- Salt testing & water testing
- Conducting VHSC meetings
- Organizing VHND & other health activities in the village
- Motivator of family planning
- Depot holder of basic drugs
- Promoter of healthy lifestyle
- Assisting ANM in Home Deliveries

The ASHAs that I met and interact with them was working very hard to promote health along with the VHND and VHSC. They are doing her work with responsibility.

Health status in Meghalaya

Meghalaya as per census of 2011 it has a population of 26.59lakhs. Health status of Meghalaya was

Table 1. Demographic, Socio-economic and Health profile of Meghalaya State as compared to India figures

Indicator	Meghalaya	India
Total population (in crores) (Census 2011)	0.30	121.01
Decadal Growth (%) (Census 2011)	27.82	17.64
Crude Birth Rate (SRS 2013)	23.9	21.4
Crude Death Rate (SRS 2013)	7.6	7
Natural Growth Rate (SRS 2013)	16.4	14.4
Infant Mortality Rate (SRS 2013)	47	40
Maternal Mortality Rate (SRS 2010-12)	NA	178
Total Fertility Rate (SRS 2012)	NA	2.4
Sex Ratio (Census 2011)	986	940
Child Sex Ratio (Census 2011)	970	914
Schedule Caste population (in crore) (Census 2001)	0.001	16.67
Schedule Tribe population (in crore) (Census 2001)	0.2	8.43
Total Literacy Rate (%) (Census 2011)	75.48	74.04
Male Literacy Rate (%) (Census 2011)	77.17	82.14
Female Literacy Rate (%) (Census 2011)	73.78	65.46

Table 2. Health Infrastructure in Meghalaya

Particulars	Required	In position	Shortfall
Sub-centre	789	397	392
Primary Health Centre	118	109	9
Community Health Centre	29	29	0
Health worker (Female)/ANM at Sub Centres & PHCs	506	787	*
Health Worker (Male) at Sub Centres	397	133	264
Health Assistant (Female)/LHV at PHCs	109	79	30
Health Assistant (Male) at PHCs	109	69	40
Doctor at PHCs	109	104	5
Obstetricians & Gynecologists at CHCs	29	5	24

Particulars	Required	In position	Shortfall
Pediatricians at CHCs	29	1	28
Total specialists at CHCs	116	9	107
Radiographers at CHCs	29	22	7
Pharmacist at PHCs & CHCs	138	142	*
Laboratory Technicians at PHCs & CHCs	138	134	4
Nursing Staff at PHCs & CHCs	312	414	*

National Bio-ethics Conference Reports

The 5th national bio-ethics conference was held on 11th -13th December, 2014 in St.John's. The theme of this conference was Integrity in Health Care, and Research.

This was my first experience in attending the national conference which gives an insight to understand the integrity in health care and research. As has been said by Prof. Shiv Visvanathan in the first plenary session is that ethics is cognitive. Ethics is not only what we think that it is what we feel from our heart but it should also be cognitive by using our mind to think.

From the talk given on the dualism of bio-medicine by Prof. Farhat Mozoam I learnt that in a person we have the dualism that is the good and the bad. The two realms that is physical which it is biological machine which can be studied and the mental realm of mind studied through philosophical and religion. The physician's world is about the body based on facts, biology and about diseases but the patient's world is with the living body which they experience emotions and illness and it is subjective reality.

Parallel workshops session

Public Ethics -1

A critique of extractive capitalism: The role of public health ethics which presented by Agnus Dawson

In this workshop Agnus Dawson give his presentation on 'an extractive capitalist economy' where he explain about the development in Odisha in practice of mining of metal ores and aluminium. Explicit focussed on top-down economic development. The mining companies are foreign own and are perceived which involve corruption in the state. Extractive industries often fail to deliver on the promises of employment and other economic benefits to the people of the state. Here the critique is about how development can have a major impact on integrity of the community people, their health and the environment. Here Public health ethics has brought to discuss on the concept such as solidarity, equity and the common good of the people

Learning

Through the discussion I got to understand that how the people or the community has to face the difficulties just because of the development that the mining industries try to extract the resources from their land. The impact of development which leads to migration of the tribal population and getting false promised on land, money and employment.

Reflection

From the session my reflection was how can public health ethics can be practice and help the people as the aims of preventing, promote health and reduces inequities. Public health has the values of equity, solidarity, trust and community common goods but these are missing instead of giving the community the harmonious idea of development instead their environment, health status and livelihood has been affected, whose rights has been protected.

US funded measurements of cervical cancer death rates in India: Scientific and ethical concerns

Scientific studies had established cervical cancer screening for preventive health intervention. Starting 1998 three separate randomized trials in India funded by the US National Cancer Institute and the Bill & Melinda Gates foundation. To date, at least 254 women is unscreened control groups have died from cervical cancer. Eric J Suba was talking about scientific and ethical concerns about US funded death rates measurement which has been published in peer-reviewed journals.

Reflection

Through the presentation my reflection was how much the US funded has been given to in India for cervical cancer screening but the death rate measurements continued even after mortality benefit from screening has been confirmed. Scientific design required for ethical misconduct and an informed consent should be taken before screening.

Learning

Ethical concerns among women who do screening were that its subjects have not provided inform consents. Manipulate to benefits the academic industrial complex.

Occupational health in India

In the session three presentations has been presented on occupational health in India where the presenter presents their topics in which the first speaker was Dr.Naveen which talks about the key points from the code of occupational health ethics as prescribed by the International Commission of Occupational Health. The second speaker Mr Jagdish Patel shared his interesting work experience in which he himself went with the workers to visit the doctors for treatment. The third speaker, Amulya Nidhi, showed a short movie of silicosis patient discussing about their problems and situation they faced and where they took up the case study of workers from tribal population in Madhya Pradesh who migrated for work.

Learning

Through this workshop about occupational health that I attend was very helpful for me to understand more and a clear understand on what is silicosis how it affects people and what are the result of it

I learnt about the code of occupational health ethics in which the code raised issues on prevention for the welfare of the worker in their work place and follow up of remedial action.

Workers are not informed and being misled by the doctor if they are diagnoses as silicosis where they have been told that it was a TB and keep the reports confidentiality. 93% of occupational health was in unorganized sectors.

There is Ethical dilemmas in which inform consent is not given to the workers and also the safety. Doctors are not sitting and discuss with the patient and how the patient who have been affected by silicosis and they have been informed that ‘coal dust is not harmful’.

Through the discussion after the presentation what I learnt was that awareness for the people, safety in the work place and trained doctors is needed to address the problem.

Reflection

Through this workshop it makes me understand that occupational health was one of the main health problems where people do not understand. People being mislead by the doctors in diagnose the diseases that they got and the untrained doctors or medical students who give treatment. In this ethics has not been practice as the workers are not given any consent about the hazards and unhealthy of the work that they are going to face and keeping confidential about their health status report. If the government did not approved that the patient who got silicosis has been told and treated as a TB patient this makes people think that it was TB only because they do not have any awareness about silicosis and not a proper support from the system people are helpless.

2nd Day parallel workshop

Public Health Ethics -2

In this workshop on public ethics-2 in which the first presenter present on the Ethics of Dental Health Screening in communities in India where screening was done among the school going children which it is easier to implement and this was done to promote regular screening of the dental diseases. The second presenter presents on the topic of polio eradication in India: a national mission? Exploring some ethical issues through a case study in Odisha which has been talk on how polio eradication has been one of the main goals to achieve. The third presenter present on financial inclusion is an ethical imperative to reduce health inequities and strengthen integrity in health schemes in which Sridevi Seetharam explain about their study which has been conducted in the tribal hamlets of a rural district in Southern India.

Learning

From the whole session my learning was that the increase in numbers of dental teachings hospitals has an impact where the schools as an institution where children's in school has been one of the target point which they find it easier to do dental screening and even the community people with their intention to promote awareness on dental diseases but this is one way to create the demand for the dental care and capitalised for enhancing their clinical activity. No involvements of parents, no informed consent which is their rights and no follow up after screening.

About polio eradication what I learnt is that people think it as a government medicine where some people who followed their traditional medicine didn't want their children to take the polio drops. It is a top-down structure and politics where the ground level problems are not able to understand and to negotiate for roads, water and electricity taken place.

From the presentation on financial inclusion I learnt that among the 56 tribal hamlets out 177 pregnant women only 59% received JSY schemes and that too after many weeks of delivery. Most of the tribal women didn't understand the guidelines and they also find it difficult to maintain their documentary requirements as most they will migrate from one place to another.

Reflection

From this whole workshop on public ethics I feel like mostly there are system errors and not been able to understand the problems at the ground level. Ethics and integrity was not seen in some cases where inform consent are not given properly. In giving any schemes to the beneficiaries financial literacy has to be given to get a proper implementation about the schemes. Health has sometimes been negotiate with the other developments in the states and as medical institutions increased people will be like women and children has become vulnerable to screenings and trial of drugs.

3rd parallel workshop

Clinical Ethics Consultation

From this workshop on clinical ethics consultation which has been presented by Dr. Robyna Ershad Khan I learnt that in good clinical practice they have informed consent and truth telling that is the between the physician and patient or family member of the patient. Cases arise when it comes to financial aspect as it differ from one patient to another, facility of care, end of life care and when it comes to decision making who will the decision on behalf of the patient whether the family member, the patient himself or the doctors. Ethical consultation can have 2 or 3 people.

Reflection

Through this reflects me was that ethics in clinical practice can be practice but there are cases when it come decision making and financial aspect for the patient. The need of building trust and respect the person and quality of life care is also needed for the patient.

Over all reflection

The first time of getting like this opportunity to get and attend like this type of conference it was interesting and helpful for me to get to know about bio-ethics what is it all about wand what does it mean. The sessions and workshops was mostly in line to the medical term which is quite difficult for me to understand but as I attend the workshops I get an understanding that all the sessions can relate to our community and health system.

Conclusion

This fellowship program was a great time and learning to me I got to understand more and in depth about community health from all the sessions that I got in the class, field visits to different organisations that I have learnt from the visits and other activities that we as fellows we went and take part in the protest which the organisation conducted and the guest lecture that we got from the people who are really committed with their work in the community. This whole learning program which I got from the class and the field it was really precious and insightful where now I got a lot of knowledge and understanding about community health. The learning process which I got from here was very good, innovative and creative which I can say that I am lucky to be here and learnt about community health in one year of my community health learning program.

My Reading

1. Public Health Resource Book
2. Main Streaming Women's Health
3. Reproductive & Child Health module for health worker female (ANM)
4. Where There Is No Doctor
5. Taking Sides by Doctor C Sathya Mala Et.al
6. Articles on adolescent health

RESEARCH STUDY

A study on the functioning of the Anganwadi centres and the people's perception regarding the services in Mawkyrwat, South West Khasi Hills District

Background

ICDS was one of the national programmes under the Women and Child Development Ministry. This programme has been initiated for over 38 years by the government of India in every State to uplift the health and nutrition status of the child, pregnant women, adolescents and the lactating mothers in the country. The main objective of the programme is to improve the nutritional and health status of the children 0-6years. In India according to the NFHS 3 44.9% children under 3years are stunted, 22.9% are wasted and 40.4% are underweight and children 12-23 months who get fully immunized were only 43.5%. According to the NFHS 3 in Meghalaya children who are underweight are 43%, 32% are wasted and 48% are stunted and only 35% of children below six years of age are in the areas covered by an Anganwadi and only 33% children of 12-23 months get fully immunized. In West Khasi Hills District according to DHLS-4 data children 12-23months who get full vaccination were only 47.3% from all the North East State Meghalaya was highest in having malnutrition children.

Anganwadi has been implement and function for over 38 years but through the studies that has been conducted in different States in India the function was still need to be improve. From the other studies that has been studied the health check-up and growth monitoring are still poor because the weighing machine in some Anganwadi is not available and have to borrow from the other Anganwadi centre and the non-availability of the new growth chart booklets, no toilets facilities and small centre. The referral services was record in the registers which is a part of documentation and the pre-school education that is supposed to be given to the children of 0-5years but the Anganwadi worker do not have time to give proper education to them. The supplementary nutrition and immunization are mostly done and there is lack in providing nutrition and health education.

According to the Research on ICDS an Overview Vol.3 a study on the function of the Anganwadi in Meghalaya which has been conducted in East Khasi Hills has been found that the Anganwadi centre in the district on an average every centre had 96 beneficiaries and enrolment of children of 0-3years was 37.53%. About 52.5% they give services to the

pregnant women, 87.5% for lactating mothers but records has not update and kept to justify that the services has been provide. No proper maintaining of record by the Anganwadi worker for the malnourished children of Grade I and Grade II where nearly 90% AWCs had between 1-9 children who are in grade I malnutrition.

Rationale

The study has taken up to assess the function of the Anganwadi centres and to get the people's perception on Anganwadi as this is one of the national program which has been running for 38 years to improve the nutrition level among children but malnutrition was still high and according to the NHFS3 data children under 3years were 44.9% are stunted, 22.9% are wasted and 40.4% are underweight. From the DHLS-4 data children who get full vaccination in West Khasi Hills District was only 47.3%. From the other study it shows that the there is less community participation, they have scarcity of water, unavailability of toilets, poor attendance of children, less motivation from the supervisor, no proper weighing of children, not maintaining of registers properly and nutrition and health services lacking in most of the Anganwadi centres this is from the Delhi report visit on 8th July 2011 and ICDS study article in Munger District.

Despite of the good services provided by the government through the ICDS programme which runs through the Anganwadi centres in every State but still malnutrition among the children is high. In Meghalaya malnutrition among the children is high as we can see from the figures given by NFHS3. Therefore the study has taken up as less study has been conducted in the state and to assess the functioning of the Anganwadi centres and the people's perception about the services provided by ICDS through the Anganwadi centres.

Research question

How was the functioning of Anganwadi centres in line with ICDS programme and what are the people's perceptions regarding the services provided to children 0-6years

Specific Objective

1. To assess the functioning of the Anganwadi centres in Mawkyrwat, South West Khasi Hills with reference to nutritional services provided to 0-6
2. To assess on the nutritional status of children 0-6years
3. To understand the people's perception about the services being provided by the Anganwadi centres

Methodology

Study design

Descriptive study using a mixed method for data collection

Study Duration

September – November 2015

Study Area

In three villages which fall under Mawkyrwat Block, South West Khasi Hills District, Meghalaya

Sampling design

Purposive sampling

Sampling unit

Village with Anganwadi centres

Study unit

Anganwadi workers, mothers of registered children 0-6years in the Anganwadi

Data Collection

- Tools
    - Questionnaires
    - Interview guide
    - Using recorder for in depth interview
- Methods
    - In depth interviews with the mothers of the children who are registered in the Anganwadi centres
    - Observation, review of registers and interview of data

Data Analysis

In the study the researcher used an audio recorder and also hand written notes which were used for transcription. The transcripts were translated from Khasi into English. Data entry and analysis was done on Microsoft Excel for the quantitative section and on Atlas-ti for qualitative section.

Ethical Considerations

In the study participants were provided with a written consent sheet which explained about the title, objectives of the study and the rights of the participants including voluntarily participation and information of using an audio recording or written record, taking pictures and also mentioned that in case of any inconvenience the participants can withdraw

themselves from taking part in the study. The risk for the participants was minimal as confidentiality is of the most priority and the researcher maintained the rights of the participants throughout the study.

Analysis

Table No 1: Details of the Anganwadi worker in four Anganwadi centre

Details about the Anganwadi worker	**Anganwadi 1**	**Anganwadi2**	**Anganwadi3**	**Anganwadi4**
Age	39	27	27	44
Qualification	8^{th}	12^{th}	10^{th}	8^{th}
Years of working	7	2years	2years	5 ½
Complete any training	Yes	Yes	No	Yes
Are you from this village	Yes	Yes	Yes	Yes

The above table shows about the details of the Anganwadi workers working in different Anganwadi centre where the Anganwadi worker age ranges from 27 to 44 years of age, their qualification was from 8^{th} standard to 12^{th} standard, the years of experience as an Anganwadi worker ranges from 2-7 years. All the Anganwadi workers have been selected from the village itself and of the four Anganwadi workers, three of them have completed their training.

Table No 2: Anganwadi infrastructure

Details about Anganwadi centre	**Anganwadi 1**	**Anganwadi2**	**Anganwadi3**	**Anganwadi4**
Anganwadi building	Pucca	Pucca	Pucca	Pucca
Anganwadi centre	Primary school	Own house	Own house	Community hall
Do you have a kitchen for preparing food	No	Yes but not regularly used it	Not proper	No
Do you have a toilet	Yes	Yes	Yes	Yes
Functioning or not	Functioning	Functioning	Functioning	Functioning
Sources of cooking	Firewood	Firewood	Firewood	Firewood
Your main source of water	Water tap	Pond	Pond	Pond

Table no 2 shows that all four Anganwadi centre were having a pucca building and two of the centres were in their own building where as the other two are located in the community hall and in primary school respectively. From the four Anganwadi centre only one has their own kitchen but is not used regularly whereas the other three they do not have their own kitchen. For cooking they use firewood and the main source of water use for cooking are ponds and water tap. All Anganwadi centres had a toilet and it was functioning.

Table No 3: Equipment received by the Anganwadi centre from the ICDS office

Equipments provide by ICDS	**Anganwadi 1**	**Anganwadi2**	**Anganwadi3**	**Anganwadi4**
Registers	Yes	Yes	Yes	Yes
Weighing machine	No	Yes	Yes	No
Growth chart	No	Yes	Yes	No
Utensils	Yes	No	Yes	Yes
Charts	Yes	Yes	Only one	Yes
Carpets	Yes	No	Yes	Yes
Are they being used	Yes	Yes	Yes	Yes

Table no3 shows that all Anganwadi centres got the registers whereas only two Anganwadi centre received weighing machines and the other two did not have as it as they were mini Anganwadis. Growth chart were available in two Anganwadi centres. Three Anganwadi centre had cooking utensils. One Anganwadi had one only chart whereas others had more and one did not get the carpet. These resources are being utilised by all the Anganwadis.

Table no4 gives details of food availability both cooked food as well as raw food and food supply that they get from the ICDS. All the Anganwadi centres get food supplies once in three months. Delays in food supply from the ICDS happened in two Anganwadi centres and sometimes due to weather condition during rainy season they got spoiled food.

Table No 4: Food availability in the Anganwadi centres

Availability of food supplies	**Anganwadi1**	**Anganwadi2**	**Anganwadi3**	**Anganwadi4**
Type of food supplement	Both ready to eat and raw and kutcha	Ready to eat and raw and kuthcha	Both ready to eat and raw and kutcha	Ready to eat
Do you get supplementary facilities every month	No, once in three months	No, once in three months	No, once in three months	No, once in three months
Is there any interruption of supplementary nutrition	No	No	Yes, delaying sometimes due to Weather conditions Spoiled food during rainy season	Yes, only once during rainy season we got spoiled food

Table No 5: Services provided by the Anganwadi centre

Services provided in the Anganwadi centre	**Anganwadi1**	**Anganwadi2**	**Anganwadi3**	**Anganwadi4**
Supplementary nutrition	Yes	Yes	Yes	Yes
Immunization	Yes given by the ANM	Yes given by the ANM	Yes given by the ANM	Yes given by the ANM
Health check up	Yes by the ANM	Yes by the ANM	Yes they came from the CHC	No
Referral services	Yes	Yes	No	No
Pre-school education	Yes	Yes	No	No
Nutrition and health education	Yes but once in a month	Yes	Yes	Yes once a month for women

Of six services provided by the ICDS only supplementary nutrition, immunization by the ANM and nutrition and health education (once in a month) were being provide at all the Anganwadi centres. Health check-ups were done in three Anganwadi centre by ANM. As for referral services two Anganwadi centre said yes. Preschool education was given by two Anganwadi centres. (Table 5)

Table No 6: Other services provided deworming and IFA tablet

Other services provided in the Anganwadi centre	Anganwadi1	Anganwadi2	Anganwadi3	Anganwadi4
Is deworming done for children	Yes	Yes	Yes	Yes
Do you provide Iron Folic Acid in the centre?	Yes, but not regular only sometime	Yes	Yes	No
To whom do you provide?	Pregnant women, adolescent girls	Pregnant women, three uneducated adolescent girls	Adolescent girls	No

Deworming tablet was provided at all Anganwadi centre to children; IFA tables at two Anganwadi centre were providing, at one Anganwadi centre they are not given regularly whereas the other anganwadi did not give IFA tablets. The three Anganwadi centre which give IFA tablet do so to adolescent girls and pregnant women where in Anganwadi2 they IFA to those adolescent girls which are uneducated in the village.

Table No 7: Services on education and health education

Education on nutrition	Anganwadi1	Anganwadi2	Anganwadi3	Anganwadi4
Provision of nutritional health education	Yes	Yes	Yes	Yes
Methods used	Demonstrations Dance and songs sometimes	Discussion Demonstration	Discussion Dance and songs	Discussion Demonstration

In table no7 shows that all Anganwadi centres give nutritional and health education and the methods they used includes discussion, demonstration and dance and songs.

Table No 8: Home visits by the Anganwadi worker

Home visits	Anganwadi1	Anganwadi2	Anganwadi3	Anganwadi4
Do you do home visits	Yes	Yes	Yes	Yes
How many you visits in a week	3-4	3-4	3	2-3

For what purpose	• Educating parents of malnourished children • Advising pregnant and lactating mothers • Advice of sick children • Motivating parents to send children to Anganwadi regularly	• Educating parents of malnourished children • Advising pregnant and lactating mothers • Advice of sick children • Motivating parents to send children to Anganwadi regularly	• Advising pregnant and lactating mothers • Advice of sick children • Motivating parents to send children to Anganwadi regularly	• Advising pregnant and lactating mothers • Advice of sick children • Motivating parents to send children to Anganwadi regularly

In the above table talks about home visits done by the Anganwadi worker where all the four Anganwadi workers used to go for home visits and the house visits per week ranged from 2-4 houses. The purpose of doing house visits was to give advice to the pregnant and lactating mothers and motivating parents to send their children to the Anganwadi centre, where only two Anganwadi worker went and give education for the parents of malnourished children and two Anganwadi worker wgo and give advice for sick children.

Below table shows about availability and updating of registers. Not all registers were available at the Anganwadi centres and not all of them were up to date.

Table No 10: Availability and updating the registers

Availability and updating registers	**Anganwadi1**		**Anganwadi2**		**Anganwadi3**		**Anganwadi4**	
	A	**U**	**A**	**U**	**A**	**U**	**A**	**U**
Survey register	Yes	Not yet update	Yes	Not yet update	Yes	Not seen	Not available during the interview	
SNP register	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mother	Yes	Yes	Not available during the interview		No		Not available during the interview	
Child	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Attendance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Delivery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Growth chart	No	No	Yes	No	Yes	No	No	No
Food stock	Not seen	Not seen	Not seen	Not seen	Not seen	Not seen	Not seen	Not seen

Mothers meeting	Yes	Yes	Yes	Yes	Yes	Yes	Not seen	Not seen
Child weight	No	No	Yes	No	No	No	No	No

Table No 11: Supervision visits in the Anganwadi centre

Supervision	Anganwadi1	Anganwadi2	Anganwadi3	Anganwadi4
ANM visits in the last 30days, 90days,6 months	Yes, once a month	Yes, once a month	Yes, once in 2 or 3 months	Yes, once in 2 or 3 months
ICDS supervisor visits in the last 30days, 90days, 6 months?	No, once in three months	No, once in three months	No, but in a year nearly 8 times	No, in 6 months 1 or 2 times
CDPO/ ACDPO visits in the last 30days, 90days, 6 months?	No, once a year	No, once a year	No	No
Medical Officer visits in the last 30 days, 90days, 6 months?	No, last 8 months back	No	No	No

In table 11 about supervision the ANM visits used to visits every 30 days in anganwadi1 and anganwadi2 whereas in the other two Anganwadi only once in two or three months. No visits in the last 30 days from the ICDS supervisor (they visit once in three months in two Anganwadi centres, eight times a year in the anganwadi3 and in the anganwadi4 one or two times in 6months). There was no visits from the CDPO/ACDPO for the anganwadi3 anganwadi4 and in the Anganwadi1 and anganwadi2 it was once a year whereas there was no visits from the medical doctor in the last 30 days in all Anganwadi centres and the last visit was 8months back in anganwadi1.

Table No 12: Beneficiaries 6months- 3years

Beneficiaries	Anganwadi1			Anganwadi2			Anganwadi3			Anganwadi4		
Children (6months -3 years)	**B**	**G**	**T**	**B**	**G**	**T**	**B**	**G**	**T**	**B**	**G**	**T**
No. of children identified during survey	26	21	47	44	28	72	11	23	34	14	15	29
No. of children registered	26	21	47	44	28	72	11	23	34	14	15	29
No. of children received IFA	0	0	0	0	0	0	0	0	0	0	0	0
No. of children for whom deworming was done	2	1	3	10	10	20	0	0	0	0	0	0
No. of children for whom growth monitoring was done	0	0	0	10	10	20	0	0	0	0	0	0
No. of children weighed in previous months	0	0	0	12	1	13	0	0	0	0	0	0

B-Boys, G-Girls, T-Total

Table 12 shows that the total number of children's from the four Anganwadi centre was 182 which has been identified during the survey and registered in the Anganwadi centre. Deworming has been done for children only 23 in Anganwadi1 and anganwadi2. Growth monitoring was being for 20 children only in Anganwadi2 and the number of children that has been weight in the previous months was only 13 children.

Table no 13 shows that the total number of beneficiaries in 3-6 years with all those identified during the survey being registered in the Anganwadi centre. The number of children who got deworming tablets from the centre was 47 from the three Anganwadi centre and only Anganwadi4 has not given. Growth monitoring was done only in the Anganwadi2.

Table No 13: Beneficiaries 3-6years

Beneficiaries	**Anganwadi1**			**Anganwadi2**			**Anganwadi3**			**Anganwadi4**		
Children (3years - 6 years)	**B**	**G**	**T**	**B**	**G**	**T**	**B**	**G**	**T**	**B**	**G**	**T**
Number of children identified during the survey	20	16	36	39	25	64	25	24	49	9	12	21
Number of children registered	20	16	36	39	25	64	25	24	49	9	12	21
Number of children received IFA	0	0	0	0	3	3	0	0	0	0	0	0
Number of children for whom deworming was done	3	2	5	15	15	30	7	5	12	0	0	0
Number of children for whom growth monitoring was done	0	0	0	12	10	22	0	0	0	0	0	0
Number of children weighed in previous months	0	0	0	12	10	22	7	5	12	0	0	0

B-Boys, G-Girls, T-Total

Table No 14: Pregnant mother's beneficiaries

Pregnant women	**Anganwadi1**	**Anganwadi2**	**Anganwadi3**	**Anganwadi4**
Number of PW during survey	8	11	7	8
Number of PW registered	8	11	7	8
Number of PW delivery registered	2	6	0	0
Number of PW attending NHE last month	0	0	0	0

PW- Pregnant Women

Table no14 shows that pregnant women who are the beneficiaries are 34 from the four Anganwadi centres which registered in the Anganwadi centre but only 8 received supplies.

Table No 15: Lactating mothers beneficiaries

Lactating Mothers	Anganwadi1	Anganwadi2	Anganwadi3	Anganwadi4
Number identified during the survey	1	0	0	0
Number of LM registered	1	0	0	0
Number of LM delivery registered	0	0	0	0
Number of LM attending NHE last month	0	0	0	0

In the table above only Anganwadi1 has identified and registered one lactating mother where all the Anganwadi centre have not identified any lactating mothers.

Table No 16: Adolescents girl's beneficiaries

Adolescent girls	Anganwadi1	Anganwadi2	Anganwadi3	Anganwadi4
Number of AG identified during survey	29	63	37	15
Number of AG registered	29	3	3	15
Number of AG delivery	2	2	0	0
Number of AG getting weighed regularly	0	0	0	0

The number of adolescent girls who were identified during the survey ranged from 15 to 63 however only in three Anganwadi centres adolescent girls were registered and only in two Anganwadi centres were receiving supplies.

Table No 17: Number of malnourished children as per the weighing of the Anganwadi

Number of children malnourished	Anganwadi1			Anganwadi2			Anganwadi3			Anganwadi4		
Measure	B	G	T	B	G	T	B	G	T	B	G	T
As per wage for age	0	0	0	1	0	1	0	0	0	0	0	0
As per height for age	0	0	0	0	0	0	0	0	0	0	0	0
As per weight for height	0	0	0	0	0	0	0	0	0	0	0	0
Referred to PHC	0	0	0	0	0	0	0	0	0	0	0	0

From table no 17 from the four Anganwadi centres only one Anganwadi centre has identified one malnourished child.

Assessment of the nutritional status of children 0-6years

Weighing of children's in the Anganwadi centre from 0- 6years was done to find out how many malnourished children are there. This weighing of children has been conducted by the researcher to find out the level of malnutrition and to see how many malnourished children

are there to compare with the data given by the Anganwadi worker where only one child is malnourished from among the four Anganwadi centres.

Table No 18: Weighing of children in two Anganwadi Centres

Age	Total	Boys	Girls
0-3years	16	6	10
3-5years	14	6	8

In table 18 the number of children that have been weighed by the researcher is 30, the number of children of 0-3years age is 16 (10 girls and 6 boys), and 3-5years is 14 (6 boys and 8 girls).

Table No 19: Grades of malnutrition of children as per their weight by age

Age	Total	Normal		Moderate		Severe	
		Boys	Girls	Boys	Girls	Boys	Girls
0-3 years	16	5	9	1	0	0	1
3-5 years	14	4	6	2	1	0	1

The grades of malnutrition of children according to their age is that in 0-3 years age out of 16 children 1 boy is moderately malnourished and 1 girl is severely malnourished. For the children of age 3-5years 2 boys are moderately malnourished and among girls 1 is moderately and 1 is severely malnourished.

The researcher has taken a sample of 30 children from the two Anganwadi centre to weight the children's to be able to find out the nutritional status of the children and found it is different from the records that the Anganwadi centres have. From this weighing the researcher found out that out of the 30 children, 2 children are severely malnourished and 4 are moderately malnourished..

People's perception about Anganwadi Centres

From the table below all the respondents are female; their age ranges from 22-35 years; among the ten respondents four of them are housewife, three of them are working as a teacher in the Lower Primary and other are daily wages workers, agriculture workers and domestic workers.

The number of children that they have ranges from 1-6, school going children ranges from 2-5 children, children who has been registered in the Anganwadi centre ranges from 1-4, children who has been sent to the Anganwadi centre everyday ranges from 1-3. Some children are not sent regularly to the Anganwadi centre because they have no one to take them to the centre and the distance of their house to the Anganwadi centre.

Table 20. Description of the respondents

S.No	Age	Sex	Occupation	No of children	School going children	Children registered in Anganwadi	Children sent to the Anganwadi centre	Children not send to Anganwadi centre regularly
1	31	F	Teacher in LP School	4	2	4	2	0
2	32	F	Housewife	4	3	4	3	0
3	28	F	Housewife	3	2	3	2	0
4	22	F	Housewife	1	0	1	0	1
5	35	F	Domestic work	6	5	3	3	0
6	34	F	Teacher in LP school	5	4	3	3	0
7	26	F	Agricultural	3	2	2	0	2
8	32	F	Daily wages	5	4	2	0	2
9	29	F	Teacher	1	0	1	1	0
10	33	F	Housewife	4	3	3	3	0

Perception about timing of the Anganwadi centre

From the ten interviews that have been conducted there is a mixture of responses towards the timing of the Anganwadi centre. Out of the ten respondents five told that the Anganwadis open in the morning between 6 or 7 o'clock and 8 or 9o'clock in the morning and four said that the Anganwadi centre in their village was open in the evening at around 4.30 pm.

> *"I don't know the exact timing when they open and when they close because they use to open in the evening". (22 year old mother of one child)*

About the timing the respondent's say that it is not a problem, they are satisfied with it and they are happy about the time that are given by the village committee. There are respondents which said that evening timing is good as their children after they come back from school they will just go to the Anganwadi centre.

Opening Days

The respondents told that the Anganwadi centres used to open every day but there are days when they do not open and they inform the children not to come. They also mention that Anganwadi worker are not on time in coming to the centre and as has been said by one of the respondent that in rainy and windy days they close the centres and also during the shortage of food.

P2 "Yes it open every day but only when there is shortage of foods she will open in alternative days" (32 years old mother of four children)

P6 "Here it use to open every day except Sunday but the Anganwadi worker mostly she is late to come and give the food" (35 years old mother of six)

P2 "Every day it use to open only rainy season then there are days which it close due to rain and windy as no one like to go out early in the morning otherwise if she is not open she use to inform the children not to come"(34 years old mother of five children)

Awareness about the services

All the respondents said that they are not getting any awareness but what they know is that their children are getting supplementary food and preschool education when they are going to the Anganwadi centre.

P4"No awareness that we get from the Anganwadi worker about the services" (33 years old mother of three children)

P5"No..as for now I didn't get any kind of awareness about the services since they change the Anganwadi worker but before when it was looking by the another Anganwadi worker I use to know if there is any meeting or programs but now I don't know. As from what I remember only once they have meeting where the supervisor come and give awareness about health education". (35 Mother of six children)

Food

The perception of the respondents about the food that the Anganwadi worker provides in the centre to the children was good. They get cooked food usually and there are days on which they are given raw food. One of the respondents mentioned that the packet food that her children got was spoilt. The respondent also said that their children have to take their own box or bowl to take food.

P2: "Supplementary food that was provided from the centre was good as it was the nutritious food and she use to give cook food only sometimes they give the raw food like shira, yummy and milk" (26years old mother of three children)

P4: "They give cook food, for shira and milk they give raw but the milk sometime it was a spoiled packet that children get and children got loose motion because she didn't keep it properly"(33 years old mother of four children)

Activities

The activities that the children use to get and do in the centre was only singing and praying before they give the food as mention by the respondents.

Preschool

Preschool education which is one of the services that the children are supposed to get from the centre but this is not happening in all the Anganwadi centres. Some respondents said that their children get preschool education in the centre which helps their children learn their basics like ABC, how to sing and pray before eating whereas other respondents said that the children didn't get preschool education and they only get supplementary food.

P3 ".. preschool it was helpful for the our small children to try to learn the basic things like singing, writing and being taught on some morals before it's the right time for them the go to school and start their schooling"(28 years old mother of three children)

P6 "Now this new Anganwadi worker didn't give any preschool education she give only supplementary food and every time she will reached late in the centre"(35 years old mother of six children)

Weighing

Regarding weighing of the children in the Anganwadi centre only three respondents said that their children are weighed by the Anganwadi worker when the ANM come to the centre during the immunization and there are also respondents which said that in their Anganwadi centre they don't have the weighing machine so they didn't get to weigh their children. Some of the other respondents said that in their Anganwadi centre the weighing machine is there but the Anganwadi worker haven't weighed the children till now. Even though the Anganwadi worker weighed the children the growth chart are not shared with the parents and kept with them.

P3 "Weighing machine are there but they haven't weight the child till now" (29 years old mother of one)

P5 "..before the old Anganwadi worker use to weight the children nearly every month and she use plot in the chart but now this new Anganwadi worker I haven't seen her weighing the children"(22 years old mother of one)

P3"Yes she use to weight the children every month but the growth chart has not been given to us to see how much my child improve in the nutrition"(28 years old mother of three children)

Service delivered

The six services that are provided by the ICDS through the Anganwadi centre are supplementary nutrition, immunization, health check-up, referral services, preschool education and nutrition and health education. Of these six services according to the respondents the services which they get regularly are supplementary nutrition, immunization and weighing of children done once a month when the ANM come to the centre but no proper records are maintained by the Anganwadi worker after weighing the child. Health education and home visits was there but not in all the Anganwadi centres it differs as there are respondents who said they received and there who have not received. Delivering of services in the Anganwadi centre are not the same for all the respondents and there are respondents which tells that the Anganwadi worker use to come and deliver the services by herself and among the respondents there are which says that she was not coming on time to the centre she will be late and send some relative to come and delivered the services

P4"Only the supplementary food for children, no preschool or tablets like IFA and deworming which before we use to get and the Anganwadi worker during polio drop she didn't inform and we know when they announce in the church and the same for immunization whereas before the old Anganwadi worker she will inform through children or she will come home and tell"(33 years old mother of four children)

P2 "They got only the supplementary nutrition" (32 years old mother of five children)

P3 "The services that the Anganwadi worker mostly first that she gives to the children are the nutritious foods and preschool education where others like immunization and weighing the children also is there where the ANM from the CHC comes once in a month"(28 years old mother of three children)

P6 "Yes she use to come but late so the children have to wait and sometimes when she is not coming she will send someone to come and give the food to the children"(35 years old mother of six children)

Perception about the functioning of the Anganwadi centre

The respondents' perception towards the functioning of the Anganwadi centre was a good if the Anganwadi worker is delivering all the services and has the responsibility to them. There are respondents who said that it is good having the Anganwadi centre as it help their children to get nutritious food and learn the basics in the centre but not in the other services.

P1 "Yes it function well only when it comes to food supplementary as they use to give it every day but not the other services" (26years old mother of three children)

Perception on Anganwadi worker attitude

Though the perception of the respondents on the attitude of the Anganwadi worker was good, friendly, responsible and doing her work well there are respondents who are not happy with her attitude as they were comparing the new Anganwadi worker with the old Anganwadi worker and say that they like more the old Anganwadi worker rather than the new one as she is not that much friendly and for any program that they have in the centre she is not giving any information to them.

P2 "The Anganwadi worker was nice and kind towards the children and also she is very friendly with all of us and whenever there is any kind of awareness or program in the centre she will inform to all to come and attend and she has the responsibility towards her work to try to improve in what she did" (32 years old mother of four children)

P3"Attitude of the old Anganwadi worker is different from this Anganwadi worker now before that Anganwadi worker she is very polite and friendly with children's and now this new Anganwadi worker she will come and give food not that friendly and kind towards children"(29 years old mother of one son)

Perception on the community participation

The respondents said that the participation of the community people is there by sending their children to the centre everyday but there are also who can't send their children to the centre because they stay far. The participation from the community when the Anganwadi worker tell them that she need firewood for cooking the community they will bring and give to the Anganwadi worker.

Benefits of having Anganwadi

The perceptions of the respondents about the benefits of having Anganwadi centres in their village was that their children get the supplementary food as it is a nutritious food for them and instead of spending money to buy food from outside as they are getting from the Anganwadi centre, they got preschool education and also some activities like singing and praying but there are respondent which says that it is not benefitting them as she never gives any information on program like immunization.

P3 "To me personally I feel that by having this Anganwadi centre it was a great benefits for my children even though they got only the food and preschool but it has help a lot in trying to build my children health and education where we do not need to pay money but get it for free and that also every day."(28 years old mother of three children)

P3 "To me now I didn't get any benefits because when the old Anganwadi worker is there then I get benefits as for pregnant women she will come and tell that we have to come and weight in the Anganwadi and for children also she will do like that she use and give health education to the adolescent girls, the mothers she will give awareness on health. All this I use to get because she use to inform but now nothing and no information if they have program or meeting."(29 years old Mother of one son)

Discussion

The ICDS programme has been running for 38 years now in every state in the country and it has been in a great expansion to improve the nutrition health status for the mother and child care. For better understanding of the progress and performance we need to look on the functioning and also to get the perception of the people about the services being provided by the Anganwadi centre. In the study conducted by Sarva Siksha Abhiyan 39% of the Anganwadi centres are part of the primary school and 44% are built by the panchayat which similar to my study where two Anganwadi centres got their own building where the other two Anganwadi centres are part of primary school and using the community hall which is given by the panchayat. In their study Anganwadi centres have the own kitchen and in my study the Anganwadi do not have their own kitchen so they cook at home and bring the food to the centre for distribution. From the study by Meenal M Thakare study on the functioning of Anganwadi centres in Aurangabad registers and maintaining records are up to date but in my study though the registers are available but they are not keeping the records properly and also not all registers are available in the centre which is similar to the study of ICDS Assam and Meghalaya where the Anganwadi workers said they have the registers but they are not updated or maintained well.

The supervision from the ICDS centre was less- from the discussion with the Anganwadi worker the researcher gets to know that the Anganwadi workers have difficulties in updating the registers and when they have to submit the reports that time they will fill the register.

For the beneficiaries the Anganwadi centres provides the services 6 days a week in all Anganwadi centres and the number of beneficiaries identified and registered in age group 0-6 years is different from one centre to another. For adolescent girls they give the services only to those who are uneducated and only three girls can come and register in the centre. The

services to the beneficiaries in the study by Meenal M Thakare shows adequacy of nearly all the services is average when compared to my study because from what I observe and discuss with the people in the community even though the Anganwadi worker said that they give nearly all the services but the main services which they give was supplementary nutrition in all the Anganwadi centre and preschool was given only in one Anganwadi among the four and other services like immunization and health education they give only in the time when the ANM come for immunization day.

My observation was that the Anganwadi workers were providing regular services of only the supplementary food and the maintaining of registers was lacking. One of the Anganwadi worker expressed that she is having difficulties in maintaining the registers and she needs more training for that.

From the Anganwadi centres they said they give all the services however to the participants it is not like that even though they get the services not all have been given the information by the Anganwadi worker. From the study it was discovered that there was lack of awareness on the six services among the respondents given by the Anganwadi worker and the respondents send their children to the centre to get supplementary food and no preschool are available in the centre which shows that there is less of services delivered by the Anganwadi worker to the people.

It has been identified that growth monitoring was poor as there are Anganwadi worker who have the growth chart and the machine for weighing but they are not doing it and no records are maintained, not all beneficiaries can avail the services, no machines in the mini Anganwadi. The respondents were not that much happy with the Anganwadi worker attitude, and there are respondents which feels that the Anganwadi not has benefitted them. As from the observation during the visits in the Anganwadi centre maintaining of register was not being done properly. It has been express by the respondents that there is less responsibility of the Anganwadi worker and not punctual in coming to the centre.

Conclusion

The study shows that from the ICDS give six services to the Anganwadi centres services that have been provided are not running smoothly as from what it has to be as nearly all the services to all the beneficiaries but through the interviewed with the people the researcher found that services was mainly for the children 0-6years not all the beneficiaries. Even though from the study the malnourished that has been identified by the Anganwadi worker

was only but when the researcher took samples of 30 children and weighed them to check and from the weighing there were 2 who are severely malnourished and 4 who are moderate which shows that if the Anganwadi workers keep the proper record and weighing there can be more than one. The lack of knowledge in documenting was one of the barriers to the Anganwadi worker who are not able to do by themselves and there is less supervision from the office. The responsibility of the Anganwadi worker to delivered and give awareness to the people it would very helpful as from this study there are Anganwadi worker who give the services just because they have been appointed as an Anganwadi worker. There is negative and positive perception about the system of the Anganwadi functioning where there are respondents are happy with this and there are which are not happy with it.

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Photo Gallery

Housing in Indra Nagar slum, Bhopal

A place where people throw garbage in Indra Nagar slum

Interaction with women of Indra Nagar Slum

No proper sanitation, used open defecation

Interaction with the adolescent girls in Meera Nagar Slum,Bhopal

Awareness on breast feeding for pregnant women in Indra Nagar slum

Awareness on rights and responsibility to get the old age pension scheme

Interaction with the Dai in Indra Nagar Slum

Discussion with field mentor from Sathiya organisation

Showing documentary movie to adolescent girls on nutrition in Indra Nagar Slum

Home base visit with Bethany staff Mawkyrwat

Awareness on HIV/AIDS in Bethany Mawkyrwat

Celebrate mental health day in Bethany Mawkyrwat

Mental health camp in Mawkyrwat organised by Bethany Society

Visit Bachpan organisation Bhopal

Anganwadi centre in Mawkyrwat

Interview the Anganwadi worker

Class room activities

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