COMMUNITY HEALTH LEARNING PROGRAMME

REPORT

SOCHARA SOPHEA, 2014–2015

Reported by

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2. Acknowledgment

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

SOCHARA is wonderful place with beautiful people with beautiful hearts. Friendly smiling faces always welcome people here, I would like to thank first of all Dr. Thelma Narayan, a successful woman in public health, her in-depth analytical and intellectual lectures were extremely helpful to think through myself during the fellowship.

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I would like to tanks my SOCHARA sportive team Mr. Josef, Mr.hari, Mr.yhulusi Mrs.kamalamma and Mrs.vijju.

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

I would like to thanks MY Field mentors Mr.shankar ujulambe from MYRADA Yadagiri, Dr.Maya, MYRADA Bangalore & team of that I visited for giving me the opportunity to learn. Another learning experience by observation is the staff of SOCHARA truly I saw an invisible structure without any hierarchy. I would sincerely thank all the staff at CHC who helped me feel friendly and comfortable during the course of the learning program.

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

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

3. Why I wanted to do the Community Health Fellowship

My academic background is a BSW (Bachelor of social work) in 2012 and MSW (Master of Social Work) which I completed in 2014. After completion of my post-graduation I was participate in NFMS survey and trained well.

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

4. My Learning Objectives

- Need support and guidance in identifying my own strength
- Improve my communication skill in reading writing and speaking

- To develop my overall personality, specifically in public speaking
- Understand my role as a community health sector
- Learn how to mobilize resources for community health
- To develop Programme management skill's
- To develop documentation and Computer skills
- To develop skills for facing challenges in the field
- Fund raising skill
- To improve my knowledge on MCH ,counseling method ,teaching skills and also

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

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

5. Learning from collective teaching sessions and field visits

6 months of collective based learning as well as 6 months Field based learnings.It's an affective methodology. Field visits, role play, aching videos, meetings, events Collective teaching sessions. all the above things are very needful to our professional life in future upcoming days. field work placements learning's very helpful to my personal and professional developments.

- ❖ Well experience of working with community
- ❖ Knowing the structure of NGOs
- ❖ Learning of non-government organizations and theirs Role and Responsibility to the Society as well as Community
- ❖ Learning the Role and Responsibilities, Functions, Activities of health deportment in terms of rural life style and this health issues
- ❖ It help to making of action plan and organizing of Meetings,programmes,events,Workshops,Trainings,FGDs and PRA
- ❖ Learning of women and Child health and their life style
- ❖ It help to how to reach services and facilities to community
- ❖ It help to face problems and conflicts at field level
- ❖ It help to interaction with community

- ❖ It helps to collection and Presiding of information of community.

Orientation

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

Health

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

Physical Health

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

Mental Health

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

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

Social health:

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

Spiritual:

- ➢ Generally Is something everyone can experience
- ➢ Helps us to final meaning and purpose in the things we value
- ➢ Can brings hope in times of suffering and loss
- ➢ Encourages us to seek the best relationship with ourselves, others and what lies beyond

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

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

Ex – PHC, Hospitals, teaching & research institutions.

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

1978 – ALMA ATA DECLARATION

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

After ALMA ATA

G – Growth monitoring

B – Brest feeding

I – Immunization

F – Female Education

F – Family Planning

O – Oral Rehabilitation

Components of Primary Health Care

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

- **Communicable and non-communicable disease**

Communicable disease:

A non- communicable disease spread form one person to another or from an animal to a person the spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid, the terms infections and contagious are also used to describe communicable disease.

Communicable diseases many new vaccines against infectious agents have been and are being developed and many have become more affordable. The WHO's regional offices working with individual countries have conducted intensive immunization programmes against the major preventable infectious diseases of childhood, but there are significant barriers to complete coverage, including poverty, geographic obstacles, low levels of education affecting willingness to accept vaccination, logistical problems, civil unrest and wars, corruption, and mistrust of governments. Poverty, weak governments, and misuse of funds have also prevented the control of disease vectors, provision of clean water, and safe disposal of sanitation, all essential for the control of communicable diseases.

- Ebola
- Enter virus D68
- Flu
- Hantavirus
- HIV/AIDS
- MRSA
- Peruses
- Rabies
- Measles
- Syphilis
- Tropical Diseases

Non communicable disease: "A non – communicable disease or NCD is a medical condition or disease that can-transmissible among people, NCDs can refer to chronic diseases which last for long periods of time and progress slowly

With increasing control of communicable diseases and increasing lifespan, non-communicable diseases have emerged as the major global health problem in both developed and developing countries. Even in developing countries, non-communicable diseases have assumed greater importance. The prevalence of type 2 diabetes in rural India is 13.2% (12). Cardiovascular diseases have become a major cause of death in China. During 2000-2008, the incidence of stroke in low- and middle-income countries exceeded that in high-income countries by 20% (13).

The causes of non-communicable diseases are many and complex. Although the immediate causes are factors such as increasing blood pressure, increasing blood glucose, abnormal lipids and fat deposition, and diabetes, the underlying causes are behavioral and social. These behavioral factors include unhealthy diets that substitute pre-packaged and fast foods high in fats for a balanced diet, physical inactivity, and tobacco use; these in turn are the products of social change, including globalization, urbanization, and aging. WHO estimated that insufficient physical activity contributed 3.2 million deaths and 32.1 million DALYs in 2008, and that obesity contributed to 2.1 million deaths and 35.8 DALYs globally (5). Some non-communicable diseases have been associated with infectious disease agents. For example, Chlamydia pneumonia has been implicated in the development of atherosclerosis (14), hepatitis C as a leading cause of hepatocellular (liver) cancer, and human papilloma virus (HPV), as a cause of cervical cancer. Recently, an effective vaccine has been developed, which protects against cervical cancer, but it is expensive and must be administered before sexual activity begins (i.e., early adolescence).

- Cancer : cancer is a NCD disease that affects all ages, as stated by the CDC in 2005 the three most common cancers among woman are breast, Lang and colorectal the three most common cancers among men are pros fate, lung and colorectal Lang cancers is at the top of list for cancer deaths in men and women
- Diabetes
- Hypertension
- Osteoporosis
- Alzheimer's
- Heart Disease
- Fibromyalgia

Classification of disease:

- Communicable disease
- Non-communicable disease
- Injuries
- Maternal
- perinatal
- nutritional

VECTOR BORNE DISEASES:

- MALARIA
- FILARIA
- DENGUE
- CHIKUN GUNYA
- YELLOW FEVER
- KAARA

Social determination of health – women:

- Mental health
- Gender inequity
- Access to health care
- Nutrition
- Reproductive and child health
- Work and occupation
- Violence
- Water and sanitation

❖ **Nutrition:**

During the collective session learned about nutrition management, nutrition to mother and child, adult, Importance of Nutrition and Nutrition related more information.

Nutrition and health problem at the community level:

- Food borne infections
- Communicable disease
- Non -Communicable disease
- Dietary diversity
- Personal hygiene
- Physical activist

- Micronutrient supplementation

Nutrition and health promotion at the community level:

- Food safety
- Washing hand
- Prenatal care
- Breast feeding
- Community kitchen gardens
- Emergencies'
- Nutrition

❖ **Water and sanitation:**

Water, Sanitation and Hygiene (WASH) are some of the most basic needs for human health and survival. WASH can also be crucial components in freeing people from poverty. Still, 1 out of 10 people do not have access to an improved source of drinking water and more than a third of the world's population does not have access to a hygienic means of basic sanitation

The attainment by all peoples of the lowest possible burden of water and sanitation-related disease through primary prevention, Safe and sufficient drinking-water, along with adequate sanitation and hygiene have implications across all Millennium Development Goals from eradicating poverty and hunger, reducing child mortality, improving maternal health, combating infectious diseases, to ensuring environmental sustainability.

The Need for Latrines and Toilets

Proper Sanitation facilities (for example, toilets and latrines) promote health because they allow people to dispose of their waste appropriately. Throughout the developing world, many people do not have access to suitable sanitation facilities, resulting in improper waste disposal.

Absence of basic sanitation facilities can:

- Result in an unhealthy environment contaminated by human waste. Without proper sanitation facilities, waste from infected individuals can contaminate a community's land and water,

increasing the risk of infection for other individuals. Proper waste disposal can slow the infection cycle of many disease-causing agents

- Contribute to the spread of many Diseases and conditions that can cause widespread illness and death. Without proper sanitation facilities, people often have no choice but to live in and drink water from an environment contaminated with waste from infected individuals, thereby putting themselves at risk for future infection. Inadequate waste disposal drives the infection cycle of many agents that can be spread through contaminated soil, food, water, and insects such as flies.

Human health and well-being are strongly affected by the environment in which we live — the air we breathe, the water we drink, and the food and nutrients we eat. Community water systems and water safety plans are important ways to ensure the health of the community.

In many places, communities lack the capacity to effectively adapt their water, sanitation and hygiene to the community's changing needs (population growth, changes in water quality).

According to the World Health Organization, the objectives of a water safety plan are to ensure safe drinking water through good water supply practices, which include:

- Preventing contamination of source waters;
- Treating the water to reduce or remove contamination that could be present to the extent necessary to meet the water quality targets; and
- Preventing re-contamination during storage, distribution, and handling of drinking water.

❖ **A4. accessibility, availability, affordability, acceptability:**

The key barriers to care are unaffordable costs to households, weak availability of inputs and services, and poor acceptability (the appropriateness of the social interaction that accompanies care), collectively referred to as the access framework In low and middle income countries, patients often either do not seek care, or do so only when they have access to funds, thus affecting continuity of care. Shortage of health service inputs (staff, drugs, and equipment) often mean that appropriate care is not available .Complex treatment seeking patterns ('healer shopping'), where a patient consults a variety of providers, can also prevent the provision of regular chronic care. Effective chronic care requires productive interactions between informed and prepared patients and organized and well-equipped health care teams in the context of an informed and supportive community. If health systems are to be organized to reduce access barriers the patients' perspective on the difficulties of accessing care and 'healer shopping' needs to be better understood..

❖ **Approaches in community health:**

1. Integrating health with development
2. Preventive primitive , and rehabilitative orientation
3. Appropriate technology
4. Utilization of local health resources
5. Community participation
6. Community organization
7. Financial self sufficiency
8. Education for health
9. Conscientization and political action

Axioms of community health : Rights and responsibilities

1. Autonomy over health
2. Integration of health development activities
3. Building decentralized democracy at community team level
4. Building equity and empowering community beyond social conflicts
5. Promoting and enhancing the sense of community
6. Confronting the biomedical with new attitudes skills and approaches
7. Confronting the existing super structure of medical/health care to be more people and community oriented
8. A new vision of health and health care and not a professional package of action
9. An effort to build a system in which health for all can become a reality

Mental health :

A state of wellbeing in which the individual realizes his or her own abilities can cape with the normal stresses of life can work, {the brain and behaviour – 1250 gms}

Mental illness and disability:

- MI MH problems do not constitute a person's identity
- Socio medical
- Obsessive compulsive disorder

Types of mental health problems :

- SMD-severe mental disorders
- CMD-common mental disorders

❖ **Globalization:**

Globalization is transforming not only trade, finance, science, the environment, crime, and terrorism; it is also influencing health and medical care.

Globalization is the tendency of investment of funds and businesses to move beyond domestic and national markets to other markets around the globe, thereby increasing the interconnectedness of different markets. Globalization has had the effect of markedly increasing not only international trade, but also cultural exchange. The global spread of infectious diseases is related to major changes in our environment and lifestyles. Indeed, to make matters more complex, it is not only people and plagues that travel from one country to another; unhealthy lifestyles are also being exported. Smoking and obesity are the exemplars of emerging health risks linked to globalization.

❖ **Health polices :**

2015 framework national health policy and health polices, health movement, history of health polices, import ant's of polices, its related to health right, WHO, ALMA ATA this are all sport the policy making, policy change .its depend the develop country .

What is the policy :

- ✓ Label for field activity
- ✓ Specific proposals
- ✓ Decisions of government branches
- ✓ formal legislation
- ✓ program/project

- ✓ output outcome
- ✓ underling model or theory

MCH – national health mission

A National health mission started April12,2005 , domain Expend consultant and advisor public health manage mint, evidence based, child survival and sofe motherhood (CSSM) programmed (April 1992 to march 1996)

Function of child health:

- New born care
- Primary immunization by 12 months
- Administration of VIT "A"
- Respiratory infection control
- Diarrheal disease control

Function of mothers:

- Antenatal care
- Anaemia control during pregnant
- Checkups and early detection of pick pregnancies and complications and retired
- Medical terminated

Ethics:

Ethics and research is very related, I learned about ethics guide line and SISEC projection, Qualitative and quantitative research method, in-depth interview, group diction, findings I am very interested and more learned ethics meter

- ❖ **HEALTH – SYSTUM:**

Sub center level :it is the peripheral of the existing health care delivery system in rural areas, they are being established on the basis of one sub center for every 5000 population in general and one for every 3000 population in general and back ward areas

- Currently a sub center is staffed by one female
- Auxiliary nurse worker
- One health assistant known as lady health visitor

PHC : The central council of health at its first meeting held in January 1953 had recommended the establishment of primary health centers in community development blocks so as to provide population

The national health plan (1983) proposed reorganization of primary health centers on the basis of one PHC for every 20,000 population in hilly, tribal and backward areas India public health services standards (PHS) recommended set of standards provide optimal level of quality health care.

A medical officer supported by 14 paramedical and others staff means a PHC it acts a refer at unit for 6 sub centers.

CHC :

The community health center (CHC) the third tied of the network of rural health care institution, was required to act primarily as a referral entre for the primary health care institutions was two-fold to make modern health care services, accordingly designed to be equipped with four specialists in the areas of medicine, surgery pediatrics and gynecology 30 beds for indoor patients operation theatre, labor room x-

ray machine, pathological laboratory standby generation etc along with the complementary medical and par medical staff

Functions: A facility that normally provides primary health care services 24 hour maternity accident and emergency services and beds where health care users can be observed for a minimum of 48 hours and which normalliy has a procedure room but an operating thertre.

District hospital :

A district hospital typically is the major health care facility in its region, with large numbers of beds for intensive care and long term care.

Functions :A hospital which receives referrals form and provides generalist support to clinics and community health centers with health treatment administered by general health care practitioners or primary health care nurses.

NRHM Program:

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

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

GOALS

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

Objectives:

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

NRHM Programs:

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

Janani Suraksha Yojana (JSY)

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

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

Prasuthi bhatya:

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

Madilu kit:

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

Beneficiaries:

- BPL/SC & ST
- Deliveries in government hospital
- Only for 2 children's
- Who have mother card
-

Taayi bhagya yojana:

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

Taayi bhagya plus:

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

- **Accredited Social Health Activists**

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

- **ASHA Program:**

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

Objectives:

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

Assignable for ASHA worker

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

ASHA Workers Responsibilities:

- ASHA will give the health awareness for the community
- Doing work in the organization as community member
- Nutrition, health, sanitation and hygiene about that will give the awareness for community
- What are the facilities are available in the health center for that giving awareness for community, for those facilities will take like helping for community
- Registration for pregnancy women and for poor women helping for BPL card
- Delivery preparation, safe delivery, feeding milk, safe sex, disease, sexual disease, child care about these topics discuss as giving counseling for the women's
- Pregnant women's and health services necessity children near health centers will do the registration/taking facility for them.
- Immunization facility
- Minor diseases for that giving first aid

- Keeping first aid kit facility
- Village health and hygiene members, anganawadi workers, ANM, and with SHG village health and hygiene program about that giving information and doing implementation.
- Anganawadi workers and ANM with them monthly once or twice celebrating health day
- Anganawadi workers appropriate the mainly services like iron tablets, ORS, sanitary pads for that giving support for them.
- ASHA workers will not get the salary with government.

❖ **What is the community and community type:**

A group of people lives in the same place or having a particular characteristic, living together we feeling, cooking one eating and sleeping and define the one particular culture.

Tribal community

Urban community

What is the good community?

A good community is one where neighbors take pride in their living environment, respecting and supporting one another regardless of age, gender, race or creed. A good community is a cohesive, safe, confident, prosperous and happy place. It is free of poverty and crime, providing a high quality of life for everyone that lives there.

- Building
- Petrifaction
- Dynamics
- Mobilizations

- **What is the community health:**

Community health, a field of public health a discipline which concerns itself with the study and improvement of the health characteristics of biological communities.

Community health, often referred to as public health, is the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. Community health professionals analyze the effect on health of genetics, personal choice and the environment in order to develop programs that protect the health of family and community.

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

- **Primary health care** which refers to interventions that focus on the individual or family such as hand-washing, immunization, circumcision, personal dietary choices, and lifestyle improvement.

- **Secondary health care** refers to those activities which focus on the environment such as draining puddles of water near the house, clearing bushes, and spraying insecticides to control vectors like mosquitoes
- **Tertiary health care** on the other hand refers to those interventions that take place in a hospital setting, such as intravenous rehydration or Mosquitoes.

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

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

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

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

2) Awareness, Availability, Access, Affordability and Capability

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

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

The importance of the public sector:

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

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

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

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

The scope and concerns of public health

Public health is the art and science of preventing disease, prolonging life, and promoting health through the organized efforts of society. The goal of public health is the biologic, physical, and mental well-being of all members of society. Thus, unlike medicine, which focuses on the health of the individual patient, public health focuses on the health of the public in the aggregate. To achieve this broad, challenging goal, public health professionals engage in a wide range of functions involving biological sciences, technology, social sciences, and politics. Public health professionals utilize these functions to anticipate and prevent future problems, identify current problems, identify appropriate strategies to resolve these problems, implement these strategies, and finally, to evaluate their effectiveness. Public health is a global issue, and will become even more so in the 21st century, as the interconnectedness of nations increases through modern communication, resulting in the need to deal with epidemics of communicable and non-communicable diseases and environmental issues that require transnational solutions. Thus, public health must address the challenge of confronting health problems and political, social, and economic factors affecting health, not only at the community, state, and national levels, but at the global level as well.

Functions of public health

Public health is concerned with the process of mobilizing local, state/provincial, national and international resources to assure the conditions in which all people can be healthy (2). To successfully implement this process and to make health for all achievable public health must perform the functions

1.Prevent disease and its progression, and injuries.

2. Promote healthy lifestyles and good health habits.

3. Identify, measure, monitor, and anticipate community health needs.

4. Formulate, promote, and enforce essential health policies.

5. Organize and ensure high-quality, cost-effective public health and health-care services.

6. Reduce health disparities and ensure access to health care for all.

7. Promote and protect a healthy environment.

8. Disseminate health information and mobilize communities to take appropriate action.

9. Plan and prepare for natural and man-made disasters.

10. Reduce interpersonal violence and aggressive war.

11. Conduct research and evaluate health-promoting/disease-preventing strategies.

12. Develop new methodologies for research and evaluation. 13. Train and ensure a competent public health workforce. Source

Public health interventions

One important task of public health professionals is to raise the level of anxiety of the public about public health problems to the level at which they will be willing to take an appropriate action. Raising the level of anxiety too little will result in inadequate or no action. On the other hand, raising the level too high will promote a fatalistic attitude and, as in the case of the recent HIV/AIDS epidemic, may promote stigmatization and isolation of affected individuals, seriously complicating the task of intervention. The difficulty for the public health professional is creating the level of anxiety that results in the required action while minimising unintended consequences.

Public health interventions can be divided into four categories: social/biologic/environmental, behavioural, political, and structural. The public health professional must use strategies in all four categories to achieve the maximum health of the public.

The future of public health

Public health does not lack challenges requiring solutions. Poverty is the major cause of poor health globally, yet income disparities in most countries of the world are growing. Developing countries must continue to cope with infectious diseases while confronting the epidemic of non-communicable diseases, further compounded by the threat of emerging diseases such as new variants of influenza. The rapid development of communication and transportation assures that local problems will quickly become global problems in the future requiring international cooperation. An increasing proportion of the world's population will live to be old. We have been successful at adding 'years to life', but chronic diseases such as Alzheimer's have reduced the quality of life of the years of life added. We must now concentrate on adding 'life to years', helping older people to continue to be productive.

We cannot afford to continue to ignore the quality of the environment. Continuing contamination of the air and water will not only cause and/or exacerbate chronic and infectious diseases, but will rob us of important sources of food. Addressing these problems will require eliciting the political will and commitment of the public and changes in lifestyle. Unchecked population growth and increasing urbanization will further exacerbate the problem of protecting the environment.

Despite the economic and health advances of the past century, disparities between the rich and the poor in many countries are widening. This gap must be narrowed if not eliminated, not at the expense of those who are better-off, but by improving the economic situation and health of the poor and disadvantaged. The rising cost of health care will make closing the gap in access to health care even more challenging.

Injuries and violence are robbing an increasing number of people of their ability to function and to enjoy a reasonable quality of life. Injuries can be easily prevented through a variety of preventive strategies, including better design of the workplace and tools such as ladders, but also include implementing behavioural and structural strategies.

Violence and war present a particularly great challenge, and will require new strategies not hitherto widely used in public health. Public health must contribute to strategies to resolve differences between countries by promoting cross-national and international cooperation in confronting global health problems and by contributing to strategies to implement successful conflict resolution.

Public health must convince people and provide the environment that allows them to adopt healthy lifestyles. The major strategies to combat the current epidemic of non-communicable diseases are regular exercise, a healthy diet, and development of good health habits.

We in public health know what needs to be done to significantly reduce non-communicable diseases such as cardiovascular diseases, stroke, and cancer, but we need to develop more effective ways to change behaviour and promote healthy lifestyles.

Balance between theory and practice:

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

- **My Inner Leanings from CHLP**

The main learning's of SOCHARA CHLP PROGRAMME are….

SOCHARA CHLP PROGRAMME is a semi structured training Programme participation with semi structured Programme of interactive Discussions and field visits includes 6 month of collective based learning's, and 6 months of field project based learning's. These all things helpful to my learning's. I experienced well in class learning's as well as practical in field level.

Learning's are…

A. Knowledge about various subjects

B. Improving of Communication and Teaching skills.

C. Learning to interaction, interview and collection of information communication with community.

D. Learned about methods of research is a step of learning.

E. Learning of community health related issues

F. I was learned heedless, conflicts and also working with community.

G. I learned about methods of FGD, Role play, PPTs Presentation and lecturing.

H. Updating of skills in management of community and community welfare related programmes

I. Communication and participatory skill with Community

J. Stage fear decreased

K. In the beginning I was so scared while talking English with everyone, now I improved English speaking

L. I learnt about cultural differences between states and also

Learned about Nutrition, Women and child health Rural and Urban health, Disability , Socio economic problems , Concept of community Health , Health system in Karnataka ,Health Problems and Diseases and Learned all community Welfare and Development related things…

Group Learning

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

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

Field learning in collective session:

PHC, Dhomma Sandra : I have visited **Health centre located in Dhommasandra** for the first time and there i have observed and learned about the

1. Concept of health center
2. Building structure
3. Roles and responsibilities of a health worker
4. Implementation of various govt schemes and
5. Administration system.

During the interaction with Doctors and community members we have discussed about PHC services HIV/TB/STI and NCD.

Secondly i have visited a **Anganavaadi at Mailasandra village** there are **3 schools** located in this village 2300 **is the total population here** during the visit i have observed and learned about

1. Anganavaadi structure
2. Staff structure
3. Services

4. Nutrition supply to the children and
5. Anganavaadi records.
6. Children Growth chart
7.Anganavaadi study curriculum
8. Importance of Anganavaadi
9.Functions of Anganavaadi ect...

Snehadhaan

Snehadaan Care Center for People Living with HIV

"Snehadaan is the first Community Care Centre (CCC) for PLHIVs in Karnataka, under the Sneha Charitable Trust run by the Camillians of the 'Order of the ministers of Sick' founded by St. Camillus around 450 years ago. Our task is to provide care, treatment & support for the sick, especially the marginalized sick. The centre is situated on Sarjapura Road, at the outskirts of Bangalore city 11 Km from the St. John's Hospital, Bangalore". It's a 50 bedded facility for the treatment & care of PLHIV with at least 10 beds dedicated for palliative care.

In 2003, the Camillians established the Sneha Charitable Trust® to coordinate the HIV/AIDS care initiatives in India. At present the trust runs 5 centers (Snehadaan, Bangalore, Snehasadan, Mangalore, Snehatheeram, Kochi, Sneha Kiran, Secunderabad and Sneha Agnes, Nagpur) and coordinates Care and Support activities in Karnataka. Snehadaan is the pioneering centre for providing Care and Support to the PLHIV and training of health care personnel in the HIV/AIDS care field.

Snehadaan is a 50 bed community care center for PLHIV. Through a holistic and comprehensive approach Snehadaan provides an array of services for the HIV infected and their families ensuring their dignity and overall quality of life.

Vision

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

The Mission

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

Objectives

- To provide holistic care to PLHIV that enhances their quality of life
- To help PLHIV maintain their personal dignity and worth in spite of their infection
- To extend psychosocial and spiritual services to PLHIV.
- To provide effective treatment to HIV related illnesses
- To provide compassionate care to those who are in the end stage of their disease
- To prevent the occurrence and spread of HIV by providing counseling and value education.
- To train health care professionals in the management of HIV.
- To network with other organizations working in the field of HIV.

Core Values of Snehadaan

- Compassion
- Care
- Commitment, and
- Competence

Comprehensive Approach to Care, Support and Treatment of PLHIV
Understanding & Defining Care, Support & Treatment

For understanding Care, Support and Treatment of the PLHIV, it is imperative to understand their needs. The needs of the PLHIV are not just medical; they range into the socio–economic and psychological fronts as well. Hence treatment demands a more comprehensive approach that addresses all the needs of the patients in a holistic manner.

Needs for PLHIV

Medical needs

- Access to treatment of opportunistic infections;
- Access to antiretroviral treatment
- Palliative care for terminally ill patients
- Complementary home based or community based care.
- Nutrition and hygiene

Psychological needs

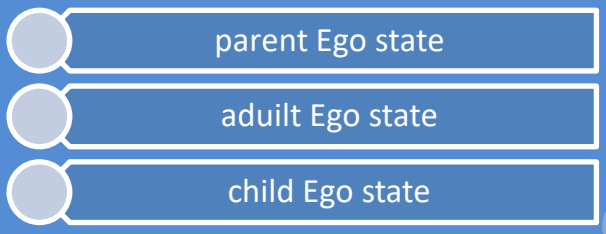
- Stress reduction
- Full information
- Retain self esteem, dignity and respect of others
- Positive emotional stability and
- Enabling future planning

Social welfare needs

- To continue to work
- Income support through social security etc.
- Shelter/housing, equal access to existing provision
- Care for dependent children
- Legal assistance and prevention against discrimination.

Seva jhothi sadan :

I have attended the seva jhothi sadan workshop for 2 days. in this workshop I learned about TA-transactional analysis, 3 Ego states, and Ego state scale. This work shop learning's very helpful for me.



APD (The Association Of People With Disability)

The Association for People with Disability (APD) is a non-profit organization based out of Bangalore. Founded in 1959, we have worked extensively over the last 55 years to reach out and rehabilitate People with Disability from the under privileged segment.

Aim

create an inclusive society, where people with disabilities are accepted into the mainstream economy and social life. A culture and eco system where they can earn, live and sustain with dignity and respect.

Mission

To enable and empower all stakeholders:

- Ensure opportunities
- Promote inclusion
- Access to rights and entitlements

Vision : Equality and Justice for People with Disability

APD key works

- Education
- Livelihood
- Health care
- Eco system

FRLHT (Foundation for Revitalization of Local Health Traditions) Bangalore since 1991.

ABOUT THIS INSTITUTE:

FRLHT is a registered Public Trust and Charitable Society, which started its activities in March 1993. The institutional agenda of the Foundation for Revitalization of Local Health Traditions (FRLHT) is derived from its vision: "enhancing the quality of medical relief and healthcare in rural and urban India and globally by creative application of our rich medical practices, action oriented research, education, training and Community services based on India's Traditional Health Sciences" and thus revitalize Indian medical heritage.

Vision: To revitalise Indian Medical Heritage.

Mission:

To demonstrate the contemporary relevance of Indian Medical Heritage in providing Medical relief, in extending Education, training and imparting creative Community services by designing and implementing innovative programmes related to

A. High quality medical practices and research in Indian systems of medicine,

B. Conservation of the natural resources used by Indian systems of medicine

C. Revitalisation of social processes for transmission of our medical heritage, on a size and scale that will have societal impact.

GOAL OF THIS INSTITUTE:

(i) Demonstrating contemporary relevance of theory and practice of Indian Systems of Medicine [D]. (ii) Conserving natural resources used by Indian Systems of Medicine [C]. (iii) Revitalization of social processes (institutional, oral and commercial) for transmission of traditional knowledge of health care for its wider use and application [R]. All the current programs and projects of FRLHT can be covered under these three thrust areas.

The following paragraphs cover briefly the scope of activities being carried out as well as those envisaged, under the three thrust areas mentioned above.
In operational terms FRLHT has articulated specific programs and sub-programs under each of the thrust areas. For instance, under the first thrust area viz., Demonstrating contemporary relevance of theory and practice of Indian systems of medicine, FRLHT engages in major programs such as assessment and documentation of local health practices prevalent in different rural and urban communities. It also has a major program related to interpretation of traditional medical theories and practices with the use of scientific laboratory tools. Other programs under this thrust area include creation of traditional knowledge databases and development of methodologies for trans-disciplinary medical research.

In the second thrust area viz. Conserving natural resources used by Indian Systems of Medicine, FRLHT concentrates on research programs involving studies related to: medicinal plants in different forest types; threat assessment; saving species on the verge of extinction and sustainable harvest. Under this thrust area, FRLHT also undertakes other important programs related to efforts towards development of databases and establishment of a bio-cultural herbarium and raw-drug repository of the plants of India.,

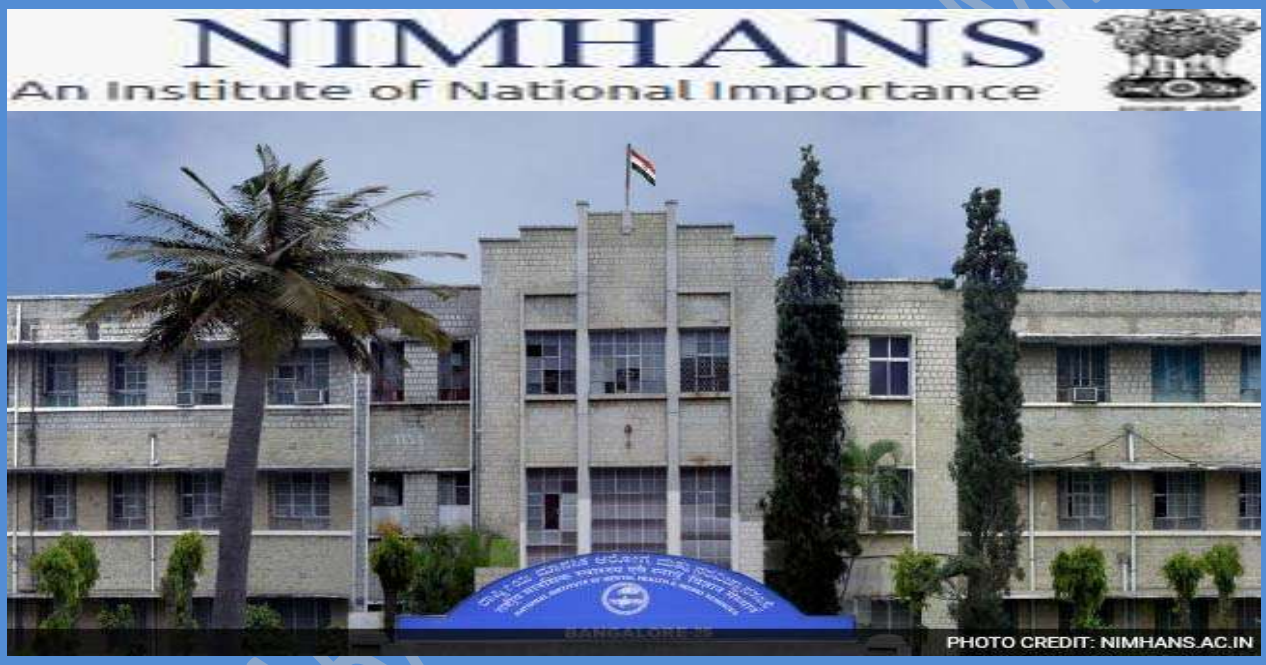
The third thrust area deals with the Revitalization of social processes (institutional, oral and commercial) for transmission of traditional knowledge of health care and the main programs under this thrust area are; building decentralized associations of folk healers and self-help women groups, home herbal gardens and promoting community-owned enterprises. A major initiative under this thrust area for influencing institutional processes is the development of a research hospital, pharmacy and a post-graduate training institute and University affiliated PhD degree programs.

The overarching objectives of FRLHT are:

1. To engage in high priority, trans-disciplinary research that bridges Ayurveda with biomedicine, life sciences, engineering, pharmaceutics and the social sciences, art & culture and build new paradigms, standards, products, processes, technologies and communication strategies.
2. To engage in research to uncover the algorithms of theoretical foundations and therapeutic strategies of Ayurveda and to use digital technology platforms for documentation and interpretations.
3. To engage in clinical research to establish the clinical theories and practice of Ayurveda and promote Good Clinical Management (GCM).

4. To design and demonstrate conservation strategies including the creation of geospatial database focused on threatened species.
5. To design and demonstrate augmentation strategies for sustainable use of natural resources (flora, fauna, metals and minerals) used by the Indian medical heritage.
6. To design and implement innovative online and offline educational programs for rural and urban households, school and university students and folk healers.
7. To design and implement strategic outreach programs for widespread dissemination of validated health interventions derived from traditional health sciences and practices which can impact rural and urban communities in India and globally.

NIMHANS : National Institute of Mental Health and Neuro Sciences Hospital (NIMHANS)



Vision

To be a world leader in the area of Mental Health and Neurosciences and evolve state-of-the-art approaches to patient care through translational research.

Mission

- Test Establish the highest standards of evidence-based care for psychiatric and neurological disorders and rehabilitation
- Develop expertise and set standards of care for diseases of public health relevance in the developing world
- Work with the government and provide consultancy services for policy planning and monitoring strategies in the field of Mental Health and Neurosciences and facilitate execution of national health programme.

- Human resource capacity building by training in diverse fields related to Mental Health and Neurosciences.
- Develop and strengthen inter-disciplinary, inter-institutional and international collaboration with universities and research institutes across the globe to foster scientific research, training in advanced technology and exchange of ideas in the areas of Mental Health and Neurosciences.
- Strive to enhance equitable accessibility of primary care in Mental Health and Neurological Disorders to all sections of society and ages including the vulnerable population.
- Evolve and monitor the strategies for disaster management and psycho-social rehabilitation in different cultural and ethnic groups.
- Promote Mental Health literacy and eliminate the stigma attached to the Mental and Neurological Illnesses by taking the measures and the delivery system to the centers of primary health care honoring the human rights and dignity.
- Integrate allopathic and oriental medicine into health care delivery and promote evidence-based research.
- Integrate physical and metaphysical aspects of Neuroscience research to promote yoga and its application to positive mental health.
- Participate in broad field of Neuroscience and Behavioral Research applicable to human ethics, organ transplantation, stem cell research, space science, and nuclear science.

❖ **Deportment of Child and Adolescent Psychiatry**

I have visited Health Deportment of Child and Adolescent Psychiatry **for the first time and there i have observed and learned about the**

The Department of Child and Adolescent Psychiatry at NIMHANS came into existence on the 31st December 2010. Currently this is the only department of Child and Adolescent Psychiatry in the public health sector in India .We currently have 4 Consultants (3 Professors and 1 Associate Professor) who work in effective liaison with Consultants from departments of Clinical Psychology, Psychiatric Social Work, Speech Pathology& Audiology,

Vision

- To set standards for the nation in mental health care of children and adolescents
- To spread the knowledge, skills, and build capacities in child and adolescent mental health care all over the nation in all sectors.
- To increase the knowledge base in understating and amelioration of metal health problems in children and adolescents
- To make a strong contribution advocacy and activism in the area of child and adolescent mental health

Mission

- To develop models of preventive, promote and curative care relevant to child and mental health
- To carry out high quality cutting edge research in child and adolescent psychiatry
- To develop NIMHANS as a model training institution in the area of child and adolescent mental health

- To participate and contribute in all the governmental efforts that concern policy and advocacy

Objectives

- Objective 1: To provide high quality tertiary care for inpatients and outpatients services
- Objective 2: To build models of intervention
- Objective 3: To carry our basic and clinical research in mental health disorders including neurodevelopmental disorders.
- Objective 4: To device courses, training modules, training packages for mental health professionals, doctors, psychiatrists
- Objective 5: To develop training /teaching ,materials, IEC materials in CAMH 4
- Objective 6 : To play an active role in government policies, programs, legislation.

6. Learning from field work

- **Mysore Resettlement and Development Agency (MYRADA)**

myrada
BUILDING POOR PEOPLE'S INSTITUTIONS

Mission & Goals

Myrada was started in 1968. Myrada at present is directly managing 18 projects in 20 backward and drought prone Districts of Karnataka, Tamil Nadu and Andhra Pradesh. There are other States where it has collaborated with Government, Bilateral and Multilateral Programs, by contributing to program design and supporting implementation through regular training, exposure and deputation of staff. Examples of such long-term support are in the States of Haryana, Assam, Meghalaya, Manipur, Jharkhand, Orissa and Chattisgarh. It also provides similar long-term support to programs in other countries like Myanmar, Indonesia, and Timor Leste and in a small way, in Iran. This approach arises from Myrada's decision not to fly its flag all over, but to promote, in collaboration with other institutions, a proven development strategy in which the rights of the poor, women and marginalized to build and manage their own institutions, to develop their own livelihood strategies, to associate in order to lobby effectively to change oppressive relations, to access resources and build linkages are recognized

"Building institutions of the poor and marginalised which are appropriate to the resource to be managed and objective to be achieved"

Status	A secular organization established in 1968 to work with the government in resettling 15,000 Tibetan refugees in the state of Karnataka; one of the larger NGOs in India. Works with government bodies (departments of the state and central governments) to achieve a wider reach and to influence policy decisions. Supports a network of eight NGOs involved in forestry in Andhra Pradesh (AP); is

	a member of various operational district-level networks in Karnataka. Also represented on the FWWB Ahmadabad, Corporation Bank. National Wastelands Development Board, AME, GVT and on several other government committees at state and national levels. Registration: Society.
Focus	To re-create a self-sustaining habitat that balances the legitimate needs of people with the availability of natural resources; promote strategies that help realize the full potential of women and children and influence public policies in favor of the poor.
Geographical reach	Karnataka, Tamil Nadu, AP; supports initiatives in Haryana, Uttar Pradesh and Northeast states of Assam, Meghalaya and Manipur with capacity building, supports international programmes in Cambodia, Myanmar, Bangladesh, Sri Lanka and Indonesia.

Mysore Resettlement and Development Agency (MYRADA) is an NGO that has had extensive experience in incubating, developing and managing savings and credit programmes in Southern India. Realizing the shortcomings and inadequacy of the existing system of delivery of formal credit the poor, Myrada experimented with many local institutional arrangements in providing credit delivery systems to the very poor. These included local cooperatives, rural bank branches, Voluntary Development Agencies etc. One common feature that ran through most of these earlier approaches/models was that the target community formed a group, from 15-20 each to the entire community.

OBJECTIVE

The overall objective is to assess whether the assumption made by Myrada in the 80s - that the Self help affinity groups are the appropriate peoples institutions of the poor which provide the space for the members to develop a livelihood strategy and to acquire the skills and confidence to initiate change in themselves, in their relations at home and in society and linkages with other institutions - is a valid one.
The study does not intend to compare the SAGs formed by Myrada with those formed by others. Myrada had some assumptions. Others have their own assumptions. What Myrada wants to understand is whether its assumptions have proved to be valid.

By a "livelihood strategy", Myrada means that: a) the poor do not have a single or even two large income generating activities; they take several loans for several income generating activities including those based on assets (cows, land, agriculture) as well as non-assets like trading and repaying high cost loans; b) the whole family is involved and hence the nature and size of loans taken depend on the willingness and ability of family members; as a result the strategy of each household differs; c) loans for food, clothing, education and to get a job in Government are all part of a livelihood strategy. Data collected by Myrada shows that in the initial years, they take many small loans for food and health, but gradually
the loans are for income generating activities of several types; they also become larger. There is also a trend that as loans get larger, the number of activities gets reduced. After 8
years or so the trend of the purposes of loans is off farm including getting a Government job. It is also clear that each family has a different set of livelihood activities. If this trend does not emerge, Myrada considers that its investment in the area in promoting a livelihood base has not been successful.

This Mission is pursued by:

- Fostering a process of ongoing change in favor of the rural poor in a way in which this process can be sustained by them through building and managing appropriate and innovative local level institutions based on their rights and rooted in values of justice, equity and mutual support .
- Re-creating a self-sustaining livelihood base and an environmentally clean habitat and the institutions to sustain them, based on a balanced perspective of the relationship between the health of the environment and the legitimate needs of the poor.
- Building institutions, strategies and skills through which poor families are able to secure the rights of women, children and marginalized sectors to develop their livelihood strategies leading to food security and sustained incomes.
- Promoting convergence in the PRIs that fosters effective, appropriate and timely primary health care and education and which addresses the issues related to gender, HIV/AIDS/STIs, maternal and infant mortality rates and water borne diseases in a holistic and sustainable manner.
- Strengthening producer and market institutions and communication networks between and among formal and informal institutions that can foster and sustain the livelihood strategies of the poor
- Influencing public policies in favour of the poor.

MYRADA through its various programs reaches out to people in various districts of Karnataka, Tamil Nadu and Andhra Pradesh. While the objective is to help the poor help themselves, MYRADA achieves this by forming Self Help Affinity Groups (SAGs) and through partnerships with NGOs and other organizations.

- **MYRADA Programmes**

- **Community led process for a successful vocation education programme**

For the past 4 years beginning January 2010, over 800 villages in 3 districts of South India have witnessed a quite extraordinary unfolding of a series of interconnected activities all relating to providing vocational education to school drop-outs of BPL families in these villages.

What is extraordinary about the situation in these 847 villages is not the mechanics of imparting vocational education. After all, at least 16 different departments and ministries of the State Government and the Government of India have spent considerable resources in developing and offering a number of educational programs for rural youth to acquire professional skills and to earn a livelihood. Such schemes already offer several attractive sounding rewards and benefits and promise a way out for rural youth to move from traditional agri-based livelihoods to better paying off-farm sector jobs.

What is extraordinary about these villages is that almost all the necessary activities have been carried out by 23 Community Managed Resource Centres(CMRCs): who have, in the process of doing so, attained a level of operational effectiveness which they could have hardly imagined in January 2010. Seen from the merely 'numbers' perspective, 23 CMRCs have arranged vocational trainings in over 30 different skills for

over 7000 school drop-outs and arranged for over 4000 of the trained candidates to find either a salaried job or self- employment. Though the events were kick-started with Rs. 65 m EU sanctioned Vocational Education Project (VEP), these did not remain confined to that one source of funding. Other sources from the public sector and corporate sector under CSR schemes were tapped to achieve numerical results well beyond the originally agreed targets under the EU project. As a measure of the buy-in by the families of the students, the CMRCs were able to persuade the families to contribute over Rs. 9 m as their share towards the training costs of their wards - a significant amount considering that almost all were BPL families with not much fixed earning and not much savings to draw from. With a payback period of 6 months or less, the investment of the VEP, in purely money terms, seems to have been well made. Currently, the 4000 families can enjoy the additional Rs.12m income which their children are bringing home every month.

What is extraordinary about the program as implemented is that the CMRCs have learnt to manage a highly complex and demanding protocol of surveying, counseling, selecting and matching candidates and the training providers in the first instance; and the trained candidates and job providers subsequently. While they received a lot of help initially from Myrada, now the CMRCs are in a position to build on their acquired experience and provide a much needed structured training and placement service to unemployed youth in their areas. Considering that the number of BPL families yet to be helped out in the areas of operation of these 23 CMRCs is at least 1 lakh, a scope for sustainable servicing on the proven lines seems to be available to such CMRCs who are willing to continue this activity. Several Government Departments regularly earmark a significant amount for providing trainings to rural youth. By virtue of their experience gained during the project, most CMRCs will be able to offer a transparent and effective platform within their community for operating such training programmes.

MYRADA HEALTH PROGRAMMES

OVERVIEW

Myrada ventured into the health sector in a big way only in the last decade. Prior to that, it did implement programs that had some health based interventions. These interventions focused on health education, conducting health camps and promoting reproductive and child health services in its working area.

However, in 2003, Myrada was invited by the Avahan program and KHPT to partner them in implementing focused prevention programs with high risk groups in 4 districts of Karnataka. Titled the Myrada Soukhya project, the institution got a chance to implement a targeted program for HIV prevention and care within the high risk group comprising female sex workers (FSW) and men who have sex with men (MSM) across 44 towns in 6 districts of Karnataka. With the opportunity to work over 7 years with around 13000 FSWs and 3500 MSMs, Myrada learned a lot about the community and developed a few key strategies that, in the long run, have had a sustainable impact. There were several experiences and learning's, but the key take home messages we would like to share are;

1. HIV prevention in high risk FSW communities is achieved through an equal emphasis on both risk reduction and vulnerability reduction.
2. Building local institutions of female sex workers was an effective strategy for both reduction of vulnerability and risk.
3. Intervention programs in respect of FSWs and MSMs need to be differentiated in terms of content and delivery in view of their distinctive features which do not permit a common approach.

4. A sustainability plan and exit strategy must be in place, and shared with the community (FSWs/ MSMs) from day one – for an effective and sustainable program.
5. Organizations with experience in community based development programs are better suited than those with experience only in health delivery; a factor which should not be ignored during selection of NGOs.

At the end of March 2012, Myrada handed over all HIV Soukhya programs to the community based institutions it had built and strengthened over the years in all 6 districts. Today, these institutions are being supported by NACO to carry out HIV prevention programs on their own. Myrada continues to foster them as part of its Myrada group of institutions (MGI).

MYRADA has tried out several strategies in its health programs which have proved to be successful and sustainable. The key ones are:

1. Soukhya program – formation of Soukhya groups, federated to a district level registered Soukhya Samudhaya Samasthe in 5 districts – a community based institution that has taken over all TI programs
2. A comprehensive and integrated model for rural HIV prevention and care.
3. A 7 step treat and tracking tool to manage anemia
4. An all-inclusive plan to manage malnutrition encompassing steps to address food availability, accessibility and utilization.

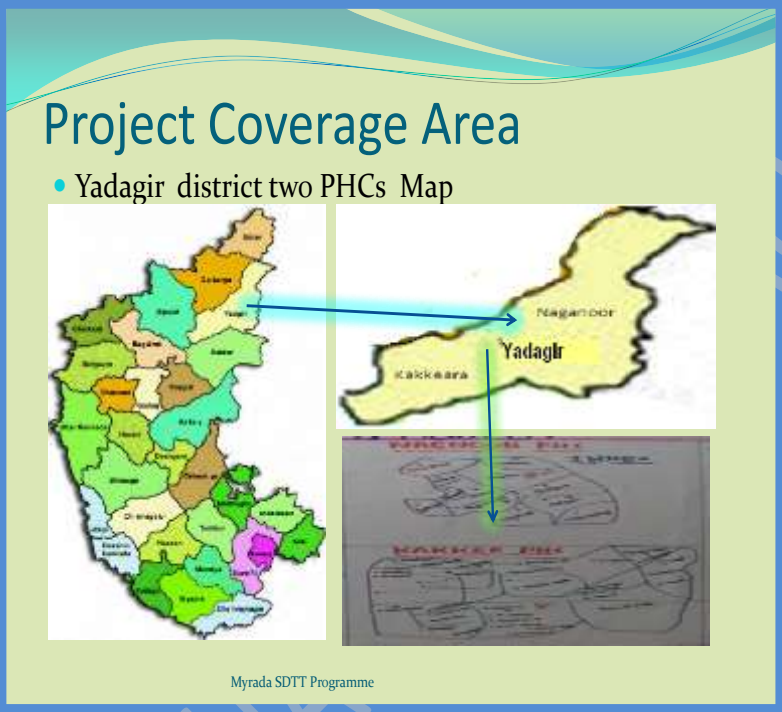
Myrada Watershed Programs

MYRADA has been involved in Watershed Management in Karnataka, Andhra Pradesh and Tamilnadu in some of the driest and drought prone areas of the Deccan Plateau. Myrada took up watershed management programs in the early 1980s when it realized that: a) productivity was declining in dry lands; b) the poor who had lands were largely engaged in dry land farming on the middle and upper reaches. Therefore investment in this dry land
Areas were required. However Myrada also realized that given the diversity of soils and land ownership and the presence of large farmers as well as landless in the watersheds, a sustainable strategy had to be inclusive - it had to involve all sections of the community. Therefore Myrada endeavored to organize various types of peoples' institutions to Promote: a) equity (these became the self help affinity groups), and b) sustainability of investments in micro watersheds11 Integrated Farm Development is an innovative concept to improve farm productivity in a sustainable manner through integrating various farm resources and recycling various farm / home waste. The main objective of IFD is to integrate the animal and human waste into useful and productive components such as for the manufacture of vermicompost, biogas and crop pest repellant, thereby reducing input cost for farmers. Any technology must be farmer friendly and this IFD technology is feasible and helps the farmers to easily perceive and adopt. Nearly 5-10 interventions are demonstrated in this IFD program which is location
specific, technically feasible, economically viable and eco friendly. Integrated Farm Development helps the small and marginal farmers in reducing the input cost and increasing the yield. This manual educates the farmers on the value of
resources (wastes) in both their fields and homes and the technology to convert these resources (wastes) into wealth. By adopting this technology, the farm economy will definitely improve if they realize and adopt the same.

The following components have been demonstrated under IFD:

- Cattle shed with urine collection pit
- Biogas
- Vermicompost
- Panchakavya
- Pest repellant
- Green fodder
- Kitchen garden with drip irrigation
- Grain storage management
- Ecological sanitation
- Biomass

MYRADA YADAGIRI



MYRADA SDTT-MPHC Covering Arias

- Naganoor PHC
- Kakker a PHC
- Jeratagi PHC
- Aralagundagi PHC

Current projects in Yadagiri District

- MPHC project
- Child found

- TDF
- SDTT-MPHC

MYRADA SDTT-MPHC Project

"MYRADA **SDTT-MPHC** project making primary health care a reality. A model for sustainable strategies through good governance and community based monitoring in rural North Karnataka .3- year project with support from Sir Dorabji Tata Trust (2012- 2015)

Goal of project

To improve quality and reach of primary health care through effective community based responses with the support of local institutions such as the VHSC, GP and Arogya Raksha Samithi program me

8 Elements of primary health care

1. Health Education concerning prevailing health problems
2. Promotion of proper nutrition
3. Adequate safe water supply &basic sanitation
4. Maternal and Child Health including Family Planning
5. Ensuring Immunization
6. Prevention & control of locally endemic diseases – dengue, malaria etc.
7. Appropriate treatment of common illnesses – fever, cough, pain, diarrhea etc.
8. Provision of essential drugs and first aid

This field work placements learning's very helpful to my personal and professional developments. I e…..

- Well experience of working with community
- Knowing the structure of NGOs
- Learning of non government organizations and theirs Role and Responsibility to the Society as well as Community
- Learning the Role and Responsibilities, Functions, Activities of health deportment in terms of rural life style and this health issues
- It help to making of action plan and organizing of Meetings,programmes,events,Workshops,Trainings,FGDs and PRA
- Learning of women and Child health and their life style
- It help to how to reach services and facilities to community
- It help to face problems and conflicts at field level
- It help to interaction with community
- It help to collection and Presiding of information of community.

- I learned about SHG concept, Book of accounts,Leadership,Member role and responsibilities, Group activities and Functions
- I learned about Proposal writing
- I learnt about SAM- MAM system and Anganavaadi concept and Services
- I learned about Documentation skills
- I learned about Gram Panchayath Role in village development and Functions and also Grama Sabha Concept
- I learned about Tippy tap, kitchen garden concept

- I learned about Health system in rural aria and health care Providers/services

- I learned about Project implementation, Field Monitoring,Statagis,Progamme progress review, counting system, Target w/s Achivements,Gap Analysis and Documentation.

- ❖ I Learned about MYRADA Developed Federation,CMRC concept and MPI.

SITUATIONAL ANALYSIS YADGIRI DISRTIC

- Population : 1247666
- 0 – 6 year child population : 190279
- Rural : 158127
- Urban : 32152
- Government hospitals : 50
- Private hospitals : 206
- Total : 256
- HIV : 2806
- LEPROSY : 54
- T B : 1104
- SHG : 2771
- Anganavadi center : 1300
- Anganavadi teachers : 1270

My personal journey

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

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

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

LEARNING and REFLECTIONS:

- ➢ The orientation programme began by providing the basic definition of Health, but with the progress of the session's the multi dimensional aspects of health, which is beyond just "physical health" for the very first time, was introduced to me in such explicit manner.
- ➢ While understanding the concept of society and social determinants of health. I understood that the society is thoroughly stratified in to various strata's and it is the power structure dominated

by a few, who decides. It is because of the resources available to this few, which make them the dominant class. The SEPC analysis gave a better picture on the social determinants of health.

Community Health Learning Programme - Orientation report

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

- Understanding the concept of health. (Definition community health, core components and health as human right)
- The monsoon game, understanding society, social determinants of health.
- The alternative paradigm in community health, skills and values needed for community health
- Historical overview of health care system.
- Introduction to public health system, its structure and functions. Public health approach to control of diseases – role of health system.
- What is primary health care? How do PHC components get translated to practice?
- The story of Alma Ata to present time
- National Rural Health Mission (India's effort to strengthen health system and improve people's health)
- What is globalization? Various aspects of Globalization and its impact on health
- Understanding Gender distribution system.
- Overview of national programe on vector borne diseases
- Alternative system of health
- Commercialization of drug

RESEARCH REPORT:

Title: An exploratory study on " cultural practice" linked with maternal health

1. **Background**.

Community : The people might include the total population of more identifiable smaller groups of people, sometimes a community might include smaller outside the geographic place, the people who are interested in, affected by, affecting the issue of concern or community based project are often called 'stake holders'

Culture : Culture refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meaning, hierarchies, religions, notions of time roles, spatial relation concept of the universe, and malarial objects and people in the course of generations thorough in Devi dual and group striving.

Culture is communication, communication is culture.

Culture is the systems of knowledge shared is the systems of knowledge shared by a relatively large group of people.

Culture in its broadest sense is cultivated behavior, that is the totality transmitted, or more briefly behavior through social learning.

Antenatal care:

Antenatal care is the care you receive from health care professionals during your pregnancy, the purpose of antenatal care is to monitor your health, your baby's which are right for you.

Antenatal care: is the name of the particular form of medical supervision given to a pregnant woman and her baby starting from the time of conception up to the delivery of the baby. It includes regular monitoring of the woman and her baby throughout pregnancy by various means including and a number of simple tests of various kinds.

1. **Postnatal care:** Postnatal care is given during the first 6-8 weeks after birth, and pre-eminently about the provision of a supportive environment in which a woman, her baby and the wider family can begin their new life together. It is not the management o a condition or an acute situation.

2. Title aim and objectives of the study

Title: An exploratory study on "cultural practice" linked with maternal health

Aim: To study the cultural aspects influencing the health status of pregnant women and lactating mothers

Objective:

1. To understand cultural practice and its influences on maternal health
2. To understand the positive and negative impacts of culturally determined factors on pregnant mother's and lactating mother's health.

Planning of Data collection:

People plan to be interviewed	Methods used	
pregnant women and lactating mother's	In-depth interview	
02 – FGD	5 pregnant women	5lactating mother's

3. Study Design and methodology

- **Study design :** Qualitative research method
- **Study period :** 5th October 2015 to 30th November 2015
- **Study area :** Nagnoor village of nagnoor gram panchayath, yadgiri district, Karnataka.
- **Sampling :** Five pregnant women and lactating mother
- **Sampling method:** Purposive method, five pregnant women and lactating mothers will be selected from the village indicated in the study area by using this method.
- **Study population :** yadagiri district shorapur thaluk, nagnoor village, in this village 6500 population, 5 anganavadi, 3 school, 4 AHSA, 55 SHG, 1PHC and 1 Grama panchayath.

- **Inclusive criteria.** 18 to 45 year pregnant women and lactating mother from the village

4. **Data Collection technique and tools :**

The study proposes to use the In-depth interview and Focus Group Discussion used in qualitative research methods for collecting information from the pregnant women and lactating mothers.

Discussion guideline used for conducting In-depth interview FGD is developed and used as tools for data collection. The same is attached to this application.

Data analysis:

The collected through In-depth interview and FGD will be analyzed manually using the principles of the qualitative data analysis software.

- **Challenges**

For the in-depth interview only 10 people will be included, others might think why they are not included. In the same way for FGD only 8-12 people will be included and others might also want to be included. They will be explained about the sampling principle and be convinced.

5. **Ethical Consideration**

Risks and Benefits:

Study is going to be conducted to determine the gap between the actual practices and required, practices to maintain health, no financial,social, mental, risk involved, if any risk identified during the study it will be address in order to protect the right of the respondent.

No immediate benefits is involved for the respondent as it is a descriptive study to determine the gap ,long term benefits are there for the respondent as awareness will be spread about health during the study and ir will help to improve their health status .

Consent:

This study doesn't have any immediate benefits for therespondent, the motive of this informed to assess the health problems only same will be informed to each and every respondent and a written consent will be taken on consent form, will be objective of the study will be explain to responded and oral consent will be taken oral or written consent will be obtained from subjects.

Confidentiality:

Confidentiality is a right of every respondent and will be protect during study and even after the study .The data will be kept confidential and anonymity will be maintained during sharing of the data with internal and external agencies.

Dissemination:

Finding of the study will be shared with MYRADA for initiating appropriate action.

6. Documents attached

1. Tools for data collection
2. Informed consent
3. Participants' information sheet.

Results / Finding:

Research finding of pregnant woman:

1. Participation pregnant woman list Table

S.NO	Participation Age of pregnant woman	Number of pregnant woman	percentage
1	**18-25**	**07**	**70%**
2	**26-30**	**03**	**30%**
Total		**10**	**100%**

Analyses: in research total number of participation 10, deferent cast group and 18-25 old age 7 pregnant 70% number of participation, 26-30 old age 3 pregnant 30% number of participation.

2. Pregnant woman during the srimantha program list Table

S.NO	Numbert of the pregnant	Srimantha program during	**percentage**
1	5	Yes	50%
2	5	No	50%
Total	10		100%

Analyses: 5 pregnant woman are doing srimantha proram 50% percentage, other 5 pregnant woman are not doing srimantha proram 50% percentage, because in this is rural all cast culture during the srimantha program for only first pregnancy.

3. Pregnant woman home toilet fealties Table:

S.NO	Number of the pregnant	Pregnant toilet available	percentage
1	4	Yes	40%
2	6	No	60%

Total	10		100%

Analyses: 4 pregnant woman are have toilet and using 60% and 6 pregnant woman are not have toilet facility, because in 60% of pregnant woman in home not interested have toilet and its culturally avoid the toilets, not en of place for constriction toilets.

4. Pregnant woman health problem Table:

S.NO	Number of the pregnant	Health problem	percentage
1	5	Vomit, stomach pain,	50%
2	2	Haddock. Vomit	20%
3	3	No problem	30%
Total	10		100%

Analyses: in research 5 pregnant woman are having vomit, stomach pain, 50% and 2 pregnant woman are having haddock and vomiting 20%,3 2 pregnant woman are no health problem, because food practice, heredity, and first pregnancy time having this kind of problem,

5. Pregnant woman living place Table:

S.NO	Number of the pregnant	Living place	percentage
1	5	7 month living in husband	50%
2	5	After 9 month mother home	50%
Total	10		100%

Analyses: 5 pregnant woman is during pregnancy to 7 month living in husband home 50%,after 7 month go for delivery mother home, 5 pregnant woman is living in husband home up to 9 month, after 9 month go to for delivery mother home, because first delivery doing srimantha program, after delivery not doing, and its rural culture first delivery doing in mother home, and first delivery after 7 month going mother home, after all delivery compulsory after 9 month going mother home are doing the delivery in husband home also.

6. Pregnant woman food practice Tabal

S.NO	Pregnant woman eating food	Numbers	parentage
1	Roti, pulse rice dal cured milk vegetable	4	40%
2	Roti pulse rice dal egg meat chicken	3	30%

3	Fish milk egg rice dal curds roti veg ,non-veg	3	30%
ttt Total		10	100%

Analyses: 4 pregnant woman eating roti,pulse rice dal cured milk vegetable 40%, 3 pregnant woman eating Roti, pulse rice dal cured milk vegetable 30%,3 pregnant woman eating Fish milk egg rice dal curds roti veg ,non-veg 30%, it's a culture depend same cast not allow, nonveg same cast not eating same things at pregnancy time its belief for old and elder people talking.

7. pregnant woman avoided food Tebal

S.NO	Pregnant Avoided Food	Number	Percentage
1	Non veg,	3	30%
2	Papaya, black brinjal	2	20%
3	Spicy ,sourness	5	50%
Total		10	100%

Analyses: 3 pregnant woman avoided food of non veg 30%, 2 pregnant woman avoided food of papaya, black brinjal 20%,5 pregnant woman avoided food of spicy, and sourness 50%,because nonveg its help to more growth baby its problem at delivery time, same cast people not eating culturally, papaya its to hot for mother, blackbrinjal not using at pregnancy time grand mother told, spicy and sourness not using commonly all pregnant its time stomach very sinusitis.

8. Pregnant woman rest taken tebal

S.NO	Pregnant woman number	Rest taken	Percentage
1	4	yes	40%
2	6	no	60%
Total	10		100%

Analyses: 4 pregnant woman taken rest day time 40%, and 6 pregnant woman not taken rest day time 60%, because she is doing work agriculture in fume , day all busy, home work and agriculture also.

9. Pregnant woman meat ASHA worker tebal

S.NO	ASHA visit	Number	Percentage
1	Yes	10	100%
2	No	00	00
Total		10	100%

Analyses : 10 pregnant woman home meat the ASHA, its doing good job in rural, regular follow up ANC PNC home visit, and doing 100% delivery at hospital

10. Pregnant woman taken Anganavadi food tebal

S.No	Anganavadi Food	Number	percentage
1	Taken and eating	8	80%
2	Taken but not eating	2	20%
Total		10	100%

Analyses: 8 pregnant woman taken anganavadi food and eating 80%, 2 pregnant woman taken anganavadi food and not eating 20%, because same pregnant woman not like anganavadi food, family also not use its food using for buffalo eating.

Research finding of Lactating mother :

1. Lactating mother during delivery tebal

S.NO	Delivery	numbers	Percentage
1	Government hospital	7	70%
2	Private hospital	3	30%
Total		10	100%

Analyses: 7 Lactating mother during in government hospital 70% and 3 Lactating mother during in private hospital 30% because government hospital in village and very convent and no more expenses, same rich people going private hospital.

2. Lactating mother number of delivery

S.NO	Participant number	Number of delivery	Percentage
1	**1**	**3**	**30%**
2	**2**	**3**	**30%**
3	**3**	**4**	**40%**
Total		**10**	**100%**

Analyses : 3 Lactating mother doing first delivery 30% and 3 Lactating mother was doing second delivery 30% and 4 Lactating mother was doing third delivery 40% in my research responding.

3. Lactating mother education tebal

S.NO	Education	Numbers	percentage
1	Yes	4	40%
2	No	6	60%
Total		10	100%

Analyses : 4 lactating mother was educated 40% and 6 lactating mother was uneducated 60% in my research

4. lactating mother first Brest feed tebal

S.NO	Brest milk	Numbers	percentage
1	Yes	7	70%
2	No	3	30%
Total		10	100%

Analyses : 7 lactating mother was given to child first Brest feed 70% and 3 lactating mother was not given to child first Brest feed because child was sick jaundice, and fever child was ad mint other hospital.

5. lactating mother taken three days food tebal

S.NO	Food 3 days	Numbers	percentage
1	Tea bisect sajka upit gee	4	40%
2	Tea bisect edli sajka	6	60%

Total		10	100%

Analyses: 4 lactating mother was three days taken only tea, bisect, sajka (local sweet name) 40%,

6 lactating mother was three days taken only tea bisect, edli and sajka(local sweet name) 60%,

Because, three days given very normal food its easy digestion and sweet well energy for mother.

6. lactating mother taken forty days food tebal

S.NO	Food 40 days	Numbers	percentage
1	Sajka coconut jugry savage rice dal roti pulls veg milk egg gee	6	60%
2	Sajka coconut jugry savage rice dal roti pulls non veg gee	4	40%
Total		10	100%

Analyses: 6 lactating mother taken food is sajaka, coconut jugry savage (local sweet name) rice dal roti pulls veg milk egg gee 60%, and 4 lactating mother taken food is sajka coconut jugry rice dal roti pulls non veg gee 40%, this are all eating for agriculture food and forty days also given sweet food because mother milk are very sweet come and its food for energy mother and child .

7. lactating mother avoided food forty days tebal

S.NO	Food avoided	Numbers	percentage
1	Non veg, spicy	5	50%
2	Spicy , cool drinks, black bringal, sour.	5	50%
Total		10	100%

Analyses: 5 lactating mother was avoided food is non veg spicy 50%, and 5 lactating mother was avoided spicy, cool drinks, black bringal, sour because child and mother very sensitive and not digest and same culture reason

8. lactating mother using water tebal

S.NO	Hot water	numbers	percentage
1	Yes	10	100%
2	No	00	00%
Total		10	100%

Analyses: 10 lactating mother using drinking and bathing using the hot water 100% because its good for mother and child control the any diseases.

9.lactating mother doing tradition tebal

S.NO	Traditional practice	Numbers	percentage
1	Only oil. Neem garlic	3	30%
2	Neem turmeric garlic oil.	7	70%
Total		10	100%

Analyses: 3 lactating mother using Traditional practice like only oil, Neem, garlic 30% and 7 lactating mother using Traditional practice like Neem turmeric oil because neem turmeric was control the infection and its telling a grand mother, its tradition rural area.

10. lactating mother bathing number tebal

S.NO	Bathing mother	numbers	percentage
1	Two times	8	80%
2	One times	2	*20%*
Total		10	*100%*

Analyses: 8 lactating mother doing bathing two time 80% and 2 lactating mother doing bathing one time 20%, 2 timing bathing it is culture and mother sleeping well, it is very hygienic.

11. baby bathing number tebal

S.no	Bathing time baby	number	percentage
1	Two time	7	70%
2	One time	3	30%

Total		10	100%

Analyses: 7 number of baby bathing two time 70% and 3 number of baby bathing one time 30% because baby very hygienic and nice sleep and baby body massage two time. It is also cultur.

12. Baby for doing tradition practice tebal

S.No	Traditional baby	Number	percentage
1	Only oil	2	20%
2	Garlic oil	8	80%
Total		10	100%

Analyses: 2 baby for apply bathing time only oil 20% and 8 baby for apply bathing time garlic and oli 80% because grand mother told in old days also using for baby body massage garlic and oil both mix and hot it then after could apply for message and bathing. It will be child was growth nice.

13. lactating mother using cloths number tebal

S.No	Cotton	Number	percentage
1	Yes	10	100%
2	No	00	00
Total		10	100%

Analyses: 10 lactating mother using only cotton dress 100% it was good for baby and mother and all weather is good, and baby skin was very sensitive and.

14 .baby Wight at birth time tebal

S.NO	Number of baby	Wight of baby	percentage
1	**7**	2.5 kg	70%
2	2	3 kg	20%
3	1	3.5 kg	10%
Total	10		100%

Analyses: in my research responding baby Wight 7 baby wight 2.5 kg and 70%, 2 baby Wight is 3 kg 20% and 1 baby Wight is 3.5 kg 10%

Study limitation

1. Lack of time
2. Community support is good, but lactating mother and pregnant woman busy with agriculture work and that ti me two local festival, deepavali and dasera same women going mother home, same pregnant are busy, that's why my in-depth interview and FGD conducted to late in my research.
3. Weather

Suggestion

1. My research timing is very short. because I was conducted the study for lactating mother and pregnant women, 10 in-depth interview for pregnant, 10 in-depth interview for lactating and FGD also tow one for pregnant one for lactating, its better this kind of research doing log time like 6 six month or one year.
2. Another is in rural same Mansoon time very busy for agriculture that time we are conducting research, indirectly disturbance for people.

Discussion:

" **A study on cultural practice linked with maternal health"** this study is qualitative study using in-depth interview, FDS's and serve, discussion before I billed repo with community, and local instructionl, like Anganavadi centers, primary health care, Gram panchayath, VHSE, VHND, NRHM, local leader, they are coo prêt my research and help to me directly and indirectly, all research method using before pregnant women and lactating mother taken the consent, and I tell to all my responding, particular date and time when I meet. I conduct the in-depth interview 5 different cast like saiyad, reddys, lingayths, madiga, nayak.

In-depth interview for pregnant woman : I am conducted in-depth interview for 10 pregnant woman, in this discussion I was telling ethics, I introduce myself, after I ask the question, what you eat and how many time you eat, are you going for health checkup, you taken tablet or not, how many long time you living in husband home, how many long time you living in mother home, you doing "ghod bravo" are "sreemantha program" what you avoid in food, which type of cultch you using and day time you take rest are not and how you well feel about your first pregnancy, your family caring you at pregnant time? This are all discussion and they are talking culture practice related because I conducted different cast pregnant, culture practice good but all practice available only first pregnancy time.

In-depth interview for lactating mother : i am conducted in-depth interview for 10 lactating mother, in this discussion before I was telling consent, I introduce myself, after I ask the questions, where you doing delivery, in delivery time how many kg your baby, after delivery 3 days what you eat ? What kind of food you avoid, 40 days what you eat? What kind of food you avoid, at bathing time what you apply to baby and mother, after delivery how many long time give to baby Brest feeding, what kind of cultch you using , at delivery time who with you ? like family and dr. nurse and dhaya, your cast how types of culture you belief, soaps you have heath problem where you go dr. are any temple? You doing immunization your baby? And different cast mother I conduct the invite, same cast are very close the cutler practice, but all are belief different why, example: all cast are doing baby thottilu(naamkaran) program different days same people doing after delivery 13 days, 15 days , and 40 days 3 month. But practice one why is change. All meter come to this interview.

Focuses group discussion for pregnant woman : focuses group discussion conducted 10 pregnant woman, its very interested, five woman are first pregnant woman and other 5 woman's are 2th 3th pregnancy, I told first myself and consent also, after introduce all pregnant woman, I conduct the study in PHC because woman are very busy in agriculture work , and in PHC ANC day only come and checkup the health, first delivery we are all happy, family care very nice and doing the srimantha program, after going my mother home, my mother father and all family come with foots, sweets,and new sari, flowers, doing the srimanth program, that time we are very happy because all are with me caring my baby and me, its for first pregnant only, not doing any hard work, we are taken rest afternoon and long time living in mother home first pregnant, culture is good we are belief but second pregnancy and other pregnancy time we are doing hard work, living long time in husband home and after 9 month going to delivery mother home, in madiga cast not given to pregnant coconut and papaya, nonveg lot of tablets also because baby Wight increase its difficult to delivery and reddy and lingayaths not eat nonveg its not in culture. But doing all heath checkup month immunization all.

Focuses group discussion for lactating mother: I am conducting focuses group discussion for 10 lactating mother, different cast group like kuruba, shek, nayak, helavar, reddy, bramince. They are all told different practice, all doing delivery in hospital, after 3 days food culture is different, same people using gee and same people not using, but all eating only sweets, 40 days different types of food same people only eating vegtabal and sweets roty and same people eating nonveg , same kuruba cast eating nonveg but not give the mother 40 days its culture why they not eat told not digestion this food, all cast wear cotton dress are sari she told its its saf the mother and baby, first delivery care to lot 3 time given the hot food but second and third same time in husband home not this kind of fidelity, all bathing time using neem turmeric and garlic oil to mother and baby aply garlic and oil for masaj, thottilu program doing in food avoid the more spicy could item sour.

Reading list during my fellowship :

Books name :

1. Nutrition and child care a practical guide
2. CHLP report
3. Social justice in health
4. Ruckus story

5. International conference on urban health
6. WHO our city, our health, our future.
7. TB control in India developing role of ngos
8. Implication of the proposed revised nation TB control programme for India.
9. MYRADA health book
10. Anusha series
11. Health for all now
12. Alma ata
13. Community culture and sanitation
14. National health programs
15. ICDS book
16. Jagatikaranadindajanarogyanandiyaethu [kannada]
17. Samudayaarogyamattuparisaratarabethikaipidi [kannada]
18. Hombelaku [kannada]
19. Jana Arogya aandolana
20. Samate mattu asamaanate
21. Health rights
22. NRHM programmes

Conclusion: "An exploratory study on culture practice linked with maternal health" I am more interested this topics, basically in SOCHRA.org, I told first my interest area is woman and child department and SOCHARA.org, help to me MYRADA.org I am learning in MYRADA.org, making primary health care TATA project, that project related child nutrition, and maternal heath, I learn observation, and more interested culture als0, after I selected this topic help with my SOCHARA.org, and MYRADA.org, both mentors, in this study more help to me like I was doing research first time ethical guide line, I learn new concept in-depth interview and focuses group discussion in SOCHARA, and in field I conducted 20 in-depth interview 10 for pregnant, 10 for lactating mother, its good opportunity for me, and FGD also doing two groups one for pregnant woman and another is lactating mother, antenatal care, post natal care, and its learning in MYRADA, and more help to my research, but new learning is culture practice, means how related a maternal health, same positive like srimantha program for pregnant and family will more love and affection, hospital service culture is very good pregnant well be happy but one thing is first delivery is doing all programs and more caring for pregnant, but second and other pregnancy not mach of caring and doing agriculture work also it's not good for health like pregnant well very tiered, not take more rest, same nutrition food avoided culture also its come to negative, and lactating mother also I meat different cast group mother and all are doing culture practice like Neem ,turmeric, garlic, using bathing time its really good infection, garlic also using with oil massage to baby, and two time bathing also hygienic, hot

water drinking and bathing using its also positive, cotton cloth using, sweet food given to mother they believe Brest feed is come to sweet but in science also sweet are sugar is men ten in body glucose, but negative is food avoided and same more believe cast tradition. But more positive is there like " thottilu" ghodbarao- program, DAYA, will help to delivery ,and she is telling what she eat what she not eat she is caring baby, bathing baby, it's all for all my for my new learning, my research help to my one learning, I learn with community, ANC and PNC its very impotent for in heath sector mother is healthy child also healthy medicine give a treatment hospital also give a service for blood test BP checkup and ever in checkup and tablet, but community, family, and environment, culture give a sport, consoling, care, spirit, all are very good related to mother and child good health. my interested field give a SOCHARA.org, and more sport MYRADA,org , more coo prêt pregnant woman and lactating mother, and local ASHA worker, MYRADA staff, Anganavadi worker, and PHC Dr. nurse, and my village community people and my DAYA, my friends, a very big thank you.

Annexure - 1

In-depth interview guidelines for pregnant woman :

1. Name
2. Age
3. Sex
4. How many months pregnant are you now?
5. How did you come to know that you were pregnant?
6. What was the reaction of your husband and family
7. Since the time you are pregnant what changes have been adopted in your routine life
    a. In the area of household work, what can you do what you can't do why?
    b. Rest- what changes taken place in your resting pattern who suggested this why
    c. Food intake – what food you can take and what you cannot take why
    d. What special diets are given to you, when and why
    e. What rituals are done to pregnant women while they are pregnant and why
    f. What has been done to you so far?
    g. Where will the delivery be taking place? why
    h. who will decide

Annexure - 2

In-depth interview guidelines for lactating mother :

1. Name
2. Age
3. Sex
4. How old is the baby now?
5. Where was the baby born?
6. Who decided it?
7. What was the reaction of your husband and family when the child was born
8. What changes have taken place in the care given to you soon after delivery
9. What work you can do and what you can't why?
10. What food you can you eat and what you cannot why? who suggested this
11. What changes in your resting pattern?

12. What rituals done to you at home soon after delivery, why?
13. Can you explain about the child care
    a. What are the various things you do for the growth and development of the child
    b. What rituals done for the child from birth to till the reach five year and why
14. What is the belief about colosturm, who gives it to the child who doesn't why?
15. What food is given normally to children
16. What special food is given, why
17. What food is restricted, why?
18. What do people do normally when child is sick before going to the hospital why

Focus Group Discussion Guideline

Can you list the various practices undertaken at home for the care of the pregnant women?

1. Reasons why these practices are undertaken
2. Who undertakes these practices and who doesn't why
3. Can list the various practices undertaken for the care children below five years
4. Reasons why these practices are taken
5. Who undertakes these practices and who doesn't why
6. Can you list the practices under taken for care of the recently delivered mothers?
7. Who undertakes these practices and who doesn't why
8. Who undertakes these practices and who doesn't why

Consent Form

The Principal Investigator Ms.Asha Begum**, Fellow-Community Health Learning Programme (CHLP) of SOCHARA, Bangalore has informed me about objective of the study** `An exploratory study on "community culture" linked with maternal health.' **and also informed me about the risks and benefits that are involved in this study .She said though study is for learning purpose, the findings will help MYRADA organization to take action wherever necessary. She has assured me that all data collected from me will be kept confidential. She will not quote my name of what said anywhere without my consent. She took my consent both for the interview and photographs for study purposes.**

Name:- _____

Date:- _____

Place:- _____

Signature or LTI

Participants information sheet

`An exploratory study an " culture practice" linked with maternal health.'

SOCHARA is an independent organization situated at Bangalore facilitate a Community Health Learning Program throughSCHOOL OF PUBLIC HEALTH EQUITY AND ACTION (SOPEHA). In this learning program fellows learn "community based "approach for community health awareness and action.

Principal Investigator **Ms. Asha Begum** is a fellow of community health learning program and as a part of her fellowship learning purposes she is expected to conduct a field study. She has chosen to conduct on pregnant and lactating mothers health related to community culture **in Nagnoor villages under the MYRADA organization** the purpose of this study is for learning as well as for initiating action wherever necessary. You may inform to persons whose contact details are given below for any adverse effect in connection with the study.

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References :

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

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

Field Photographs

Home visit for SAM children's

Home visit for Pregnant women's

Making tippy tap in SAM child's home

Conducting VHND program

Meeting with Panchayath members

Disabled home visit

Anganawaadi visit in Naganoor	During formers awareness camp by agriculture students
	
Involved in child fund India Programme	

Interaction with lactating mother

Interaction with pregnant women

In-depth interview with pregnant woman

In-depth interview with lactating mother

FGD with lactating mother

FGD with pregnant women

Anganawaadi visit

Kitchen garden

CMRC Annual program celebration

Tippy tap	
	
Monthly staff meeting	

Asha begam