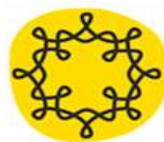
RISE & SHINE

Community Health Learning Programme
2022 - 2023

AWARENESS ON MENSTRUAL HEALTH HYGIENE MANAGEMENT ON ADOLESCENTS GIRLS

School of Public Health Equity and Action (HEA)



sochara
building community health

DR. DHIVYA SHANMUGASUNDARAM

ACKNOWLEDGEMENT

I believe in the Law of Attraction conspiracy theory which is based on the belief that thoughts are a form of energy and that positive energy attracts success in all areas of life, including health. Life is all about the people whom we meet and the things which are happening around us. Life is all about curiosity, learning and celebration. I am humbled and express my gratitude to Dr.Ravi Narayan, Dr. Thelma Narayan, my mentor Hariramamurthi, Dr. Denis, all my facilitators and the backbone of CHLP - Mr.Karthikeyan, Ms. Radhika, Ms. Uma, Ms. Ranjitha, Ms. Maria and finally my co-fellows. It's unbelievable that an online fellowship programme with so much connectivity has been made possible. I thank the Government Girls Higher Secondary School, Mogappair, Chennai for providing me the space and my stakeholders enthusiastically to involve in the Health Awareness Programme. I am grateful to my stakeholders (adolescent girls) who really brought out my inclusiveness and strengths. They really made me grow and mature. I dedicate this Fellowship Programme to my late father. SOCHARA-COMMUNITY HEALTH CELL is one which offers a forum with plenty of scope for interactions, discussions, books and scientific data to refer to. This fellowship programme has in a way contributed to a paradigm shift inward and outward. We can dwell on it for hours. Receptive people and the ecology of the place invites everyone of our fellows again and again. This is the beginning of a new era in my life. SOCHARA has come close to my heart. I speciallybow to my facilitators and the team at SOCHARA. Last but not the least, I am grateful to my parents, my sister and my well-wishers, who accept me the way I am. They allow me to explore my life ahead despite my struggles and chaos. They are always behind me and support me as a ladder both physically and mentally.

PART A

A GENERAL OUTLINE ON COMMUNITY BASED HEALTH ACTION ANDREFLECTION

INTRODUCTION

The Society for Community Health Awareness Research and Action (SOCHARA) through its School of Public Health Equity and Action (SOPHEA) offers a unique Community Health Learning Programme (CHLP). Initiated in the year 2003, it has evolved and grown in strength through a process of review and evaluation. In 20 years, 500+ participants have transformed their lives and that of the communities they worked with. Most of them have taken on senior and leadership positions in their organizations. The programme is unique as it encourages participants to explore the social paradigm of community and public health based on community needs and first-hand community experiences. Established mechanisms such as Academic and Research Council (ARC) for curriculum design and SOCHARA Institutional Scientific and Ethics Committee (SISEC) for review of research proposals support the programme. Participants will have access to the resource center at SOCHARA, Bangalore and a wide range of partners and networks. Mentorship and a person-centered approach to learning with a justice orientation to health are the core components.

Participants conduct a community-based enquiry or initiate action on areas of felt needs in community health. These could include any one but not limited to following:

1. Child Health
2. Communicable Diseases
3. Disability
4. Geriatric Health
5. Health and Environment
6. Mental health
7. Non-Communicable Diseases
8. Nutrition
9. Pandemics (including COVID-19)
10. Rural Health
11. Sanitation
12. TribalHealth

13. Urban Health
14. Women's Health

CHLP participants have returned with a rich experience to work in organizations across India and are working enthusiastically in community health. The current CHLP commencing from May 2022 adds on to the understanding of impact of COVID-19 on communities and equip the participants to build appropriate strategies to tackle the emerging challenges. Duration of the programme is 9 months with 30 learning modules delivered through live online sessions and a community-based project to enhance the learning experience.

Key features

a. Part time - Participants can continue with their current employment
b. Blended learning - Weekly live classes with recordings made accessible
c. Mentorship - Continuous mentoring by experienced subject matter experts and community health practitioners through the programme and after.
d. Community based field projects - with the participant's current organization or SOCHARA'S Partner organizations

(https://www.sochara.org/sophea/Community_Health_Learning_Programme_Bengaluru).

Why did I join the fellowship?

Since childhood I had a continued interest in working with civil society and volunteering. At 38 years, I got this opportunity to join CHLP, a turning point in my life. In my career, I have expanded my learning from a narrow to a broader perspective. I have found a new definition and dimension of life. Thirst for knowledge and passion for civil society have helped me to move out of my comfort zone. Enthusiasm to learn more about community health and to pursue Public health and above all to explore my inward feeling motivated me to join this fellowship program. Being a Siddha Practitioner, I am blessed to be a community health learner and I am curious to unlearn old dimensions, learn new dimensions of life and health.

"Be the change you wish to see in the world" by Mahatma Gandhi is the most influential quote of mine. And the road less traveled which I usually pick up to make difference from others happens instinctively. Here I am into the community health learning experience. With the guidance of my Chief Siddha Physician, Dr. Sivaraman, who knows my strengths and weaknesses, my personal and professional status, encouraged me to join the Society for Community Health Awareness, Research and Action (SOCHARA) - Community Health Fellowship Programme. He asked me to check with Mr. Ameer, an active community health activist. Surprisingly, it was just a few weeks before I searched for a university to join the Master of Public Health (MPH) certification program.I am now into a Community Health learning Programme. The Paradigm Shift started here.

I have been practicing Siddha, an Indian system of medicine, for the past 10 years as a Siddha medical practitioner. I wish to reach out to this practice at Community level as a strategy to attain "Health for all". This Community Health Learning Programme had a certain strong urge in me i.e. how to reach out to the community, how to address health socially, economically, politically, culturally and environmentally in an experiential way. First of all, I wish to mobilize myself and involve myself at grass root level in order to actually learn the community needs and how I can help them and how I can learn from them. During the Community Health Change maker Confluence where Dr. Denis said we need to unlearn many old lessons and learn many new lessons I started thinking as to how to interact with the community, learn from the community, and then how to give back the benefits of my learning to the community in all aspects as per their needs. I wished to know more about the Government policies, act and talk to the people about their rights to. I wish to travel to places and explore new things about people's culture, their food, their way of living, infrastructure, and so on. Health is not only about medicine. The constitution of the World Health Organization states "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." According to the World Health Organization , the main determinants of health include social and economic development , the physical environment and the person's individual characteristics and behaviors. Health is access to a safe environment , access to proper food , sanitation , shelter, education and literacy ,personal health practices and coping skills , healthy child development , health care services and social support networks . This is the main reason why I chose to do the Community Health Learning Programme.

As interviewed with Dr. Pruthvish and Dr. Radhika was such an awful experience, i.e. my first question was Why the CHLP? What is health and its determinants? From day one of my interview, the definition of health started changing in my mind. I started thinking about the social determinants then onwards. Dr. Pruthvish threw me the seed for the health definition, "Health as a Social determinant". As a siddha health practitioner in the AYUSH codified stream, I focused on preventive and promotive aspects of health.

The bottom line of my career was very clear to me: health for all, for the most underprivileged and marginalized communities who have less access to healthcare. But like everyone else, I was asking for answers to the questions such as where to start or how to start. The interview that I attended in SOCHARA showed me that I am making the right decision to move on into my career and life goals.

Participating in the Orientation Programme, (Community Health Changemaker Confluence) on 23.5.2021 at St. John Medical College, Koramangala, Bengaluru Karnataka. The campus itself has many overflowing moments and memories filled, having its own history, warm-pleasant atmosphere surrounded by medicinal plants herbs and trees, lush green in the mid of campus, life started with new perspectives, new vision, new way of understanding of health, power, politics, information, knowledge and wisdom. I started realizing new life is on the way.

I chose community health as my future career and felt a new door is opened right in front. It is a challenge and opportunity; it is a new journey indeed. Journey of learning inward and outward began from day one in confluence. Dr Ravi's insightful teachings, a story teller, a passionate public health consultant, emphasized on empathy towards community rather than sympathy, his value teachings, his mentioning about Shirdi and ANANDHA book took the orientation Programme to greater heights of wisdom. Dr. Ravi and Dr. Thelma graceful in their thoughts and action, empowered my thoughts and expanded my scope of profession from a doctor centric model to a community health perspective in their actions and their real life stories confluence is filled up with many interesting stories, games, developing friendship behind borders with the fellows, celebrating the diversity and values of each fellowship member from 2021 and 2022.

Mr. Prasanna's presence in the confluence, his power hierarchy stimulation games are still fresh in mind. Our people's status on social, economic, cultural and political aspects determines their health. Mr. Ameer spoke on health as politics and introduced himself as a health politics activist.Mr. Magimai Prakasam talk on communication skills enlightened the young minds to talk to myself and relate with inner-self. The effect of communication skills was listening to understandwith patience, with interest with our senses. Applying, community based thinking wherever we go. He created the deeper root of communication skill within me when I addressed my community, my family members and neighbours which improvised my relationship with them. The participants from previous fellows shared their personal experience and presentation aswell. Mr. Ankit's journey as a traveller, Dr. Sejal and Dr. Nithin active movements in Yametha foundation, Dr. Aravind and Dr Abirami net India, Dr. Shilpa on physical changes and challenges in mental health was a brainstorming session.

Ms. Maya as facilitator, panel discussion with THI, Sittilingi representatives, ACCORD from Gudalur representatives panel discussion took the confluence to another level, where I met the real grass-root heroes, real community health workers. Street play by Maya bazaar team on alcohol de-addiction are the real potential volunteers, real warriors. Dr. Radhika, Ms. Uma, Mr. Karthikeyan, Ms. Janelle was a boon to me, such an unbelievable team who was always beside me throughout the fellowship Programme, immense strengths and ideas, caring attitudes, professionalism, down to earth, heartening persons. I would like to travel with them throughout the rest of my life. Their encouragement words always boosted me, in my tough times indeed. I never missed the recorded sessions. Each module is very collaborative, with video lectures, must read and optional reading books, articles and so on. I realized myself a slow learner but an active field worker in later periods of fellowship Programme. I developed my reading habit again with these modules. Each module triggered me with a lot of questions and discussions. I can feel the inter-connectedness and inter-sectoral approach in each module and social determinants of health.

GENERAL LEARNING OBJECTIVES

1. Thorough knowledge about the principles and ethics of community health and how the Indian system of medicine and practice (Siddha) can be implemented in sorting out the community health issues.
2. To choose a community for example the tribal community or Adivasi community or the people from my nearby locality who really needed community service and work on them efficiently in all aspects of health like socially, mentally, physically, economically, culturally, and politically. Also to increase awareness about menstrual hygiene to the adolescent girl.
3. To know about government policies and how these policies can be put in action.
4. Documentation and Research in an experiential manner besides academic learning.
5. Communication skill, interacting with dynamic, intellectual personalities which will improve my way of thinking, my attitude and approach towards community.

AREAS OF INTEREST - OBJECTIVES BUILT AT BEGINNING

1. Indigenous medicine – siddha medicine in community health
2. Social and preventive medicine –creating awareness
3. Women's and adolescent 's health
4. Tribal welfare
5. Environmental health
6. Documentation – field work – at a particular community
7. Government policies
8. Interested in sustainable living, engaging communities to utilize locally resource materials, organic farming, earthen block buildings, sanitation, hygiene, engaging women to become entrepreneurs and help the community in overall health.

EVOLVING INTO

Reflective writing, minutes of writing importance of documentation, communication skills, active participation as a field-worker, looking inward, for a catalyst/enabler, a good listener, revive health for all, community health enthusiast .

LOOKING AHEAD

Policy and health development Programme and implementation health movements universal access to health care.

MODULE 1

My CHLP class started on 4th May through online mode. Day 1 - learnt about SOCHARA and itsactivities. SOCHARA- Society of Community Health Awareness Research Action. I learnt a new word: Reflection and started using that word from then. On 7th May - we were asked to write a para on Personal learning objectives & Areas of interest. Reflection about Mr. Karthick live session - On May 7 I am a structured professional. But I am so delighted that a paradigm shifts in the learning and teaching process is adopted in SOCHARA. Paulo Freire's philosophy alternate learning techniques- study, reflection, action is the take home message I took from this live session. This is a cycle. SOPHEA - started in 2011 - Vision - to build up a critical mass in a constructive manner with Community Health practitioners as Health for All. I would like to actively participate in live sessions, interact with the facilitators and participants as well and want to learn more things. Unique about CHLP - 118 PH programs, deals with strengthening and engaging the public health system with societal understanding and community based approach. I am waiting for creative learning.

LEARNING BY DOING - PHILOSOPHY OF SOCHARA.

On May -9, Session on Understanding Community Health -Facilitator Rajeev addressed Community Health as time tested, which works, sustainable in various modules. I learnt a new vision of health- “Health is Community centered”. It is a superstructure with no hierarchy, Learned about power dynamics, cultural dynamics and decentralization. Thus the Community

Health approach is Sustainable, flexible and Action oriented and not only healthy. Understanding community health pre-recorded video by Mr. Rajeev.

MY REFLECTIONS

Rajeev explained about the vulnerable tribes of Gudalur district, Tamil Nadu. Due to human rights violence, exploitations and alienation of adivasi land, the tribes of the community faced tremendous problems in their health and livelihood. In such a situation NGO ACCORD came into play. Action for Community Organization rehabilitation and development. Their main objective is to fight against the unjust alienation of adivasi land and promote health as rights and entitlements, promote health through building the community within the community and empowering the community as Health for all, improving their health, education, and also economically.

He spoke about 10 axioms of community health.

1. Rights and responsibilities
2. Autonomy over health – community participation. 4 A's – accessibility, affordability, adaptability, availability.
3. Integration of health and development activities - preventive, promotive andrehabilitation development -New Adivasi school opened.- growing tea which improvedtheir livelihood status
4. Decentralisation of democracy at community level - frequent gatherings tookplace which involved health animators, finance, economists, doctors and teachers.
5. Equity empowering community behind social conflicts - Recognize the differences recognize the voice of the unheard even though they are from different sectors of a group.
6. Promoting and enhancing the sense of community - by encouraging their cultural celebrations, their confrontations and giving them their identity.
7. Confronting the biomedical model with new attitude skills and approaches - usinglocally available resources.
8. Confronting the existing superstructure of medical health care - by connecting traditional doctors with healers already existing in the community.
9. New vision of health and health care and not a professional package - mobile clinic, village visit.
10. Effort to build a system in which health care for all is implied.

According to these Axioms of community health ACCORD in Gudalur, Village health workers were selected within the community. Developed rights and responsibilities within the community, decentralized, accessibility for the people within the community. Health infrastructures improved Health animators within the community were mobilised, health promoted, immunisation given, antenatal care given, health educators conducted meetings and gatherings. Rights to health were demanded. New adivasi schools opened, education made accessible, fear among the community went off, economic status of the community improved - tea plantations, supply of goods, like spice tea made accountable. New hospital was built - ASHWINI involved prenatal, postnatal care. Health for all is sustained by intervention of Accord and Ashwini within the community People were empowered. By Axioms of community health as mentioned by Rajeev in pre-recorded videos.

My depth reflections about understanding of community health through axioms of community health is about

1. First of all we need to identify the community.
2. What the community actually needs and start working from a bottom level approach.
3. Working along with the community to solve their issues.
4. It is time consuming, we need to build a rapport within the community but following theseAxioms will make the community health approach a sustainable one.
5. I learnt about power dynamics and cultural dynamics.
6. How caste and power within the community brings conflicts and how to deal with these in thecommunity to bring a sense of community.
7. Learned about empowerment - empowering within the community with no hierarchy.
8. Community health approach not only deals with health.
9. It is an orientation about policies, insurance schemes, legal, how we align with the government and so on

LEARNINGS FROM GROUP ASSIGNMENTS

RAHA - Axioms of community health We discussed RAHA. This RAHA community I was able to understand how to address health from a different perspective. Again health is not biomedicine alone. Ethnomedical practice was involved in the RAHA Programme. First group discussed the ACCORD community in Gudalur, Tamil Nadu. Second group ASHA - Their problem

was the cholera outbreak. Rather than illness, preventive and promotive models were undertaken.

The Pediatrician addressed the issue at grass root level. How hygiene became a part of illness. Water, Drainage, Garbage were the main issues. Open defecation was stopped. Decentralisation was done from beginning to end, starting from community health workers to doctors and all exercising their rights and responsibilities. Housing was done. Thus I understood Community Health as how Hygiene played an important role in ASHA. Ameer Khan video reflections Community health approach - socially, economically and politically.

He stressed about key principles

1. Active participation of the community is essential.
2. Institutionalizing the community is most important.
3. Importance of ASHA, male health workers, and village health workers were stressed - neglecting ASHA is the main reason for the dengue outbreak in the states of TN, where Dengue is a man-made disaster.
4. Village health committee, if not appointed, where the mechanism of the system itself fails. No politics built in TN.
5. These ASHA or MHW or VHW have to deliver the Programme and give feedback to the public health system on what they actually need.
6. Deepening democracy - Program of health by the people where extra measures from equity principle (what actually community needed) were representatives from marginalized people, SC & ST, sub-castes of SC & ST's, to specifically focus on their needs to bring equality. The process is also fully democratic.
7. Equal stakeholder - power shifting. Power shifting should be within the community with no hierarchy. Community mobilisation, doctors training, president support like funds, and food should go hand in hand and This is not actual power shifting. Power shifting is political. Community needs to own, control and manage where the Government appoints this specific person who is highly responsible. Power shifting is Right point of view. Community needs to decide what kind of service, facilities they want.
8. Health is a fundamental right.
9. Thus health is not only socio economic, it is political also. For example, he explained about Dengue. Apart from providing medicine which public health activity does, controlling the

breeding of mosquitoes is important which is a political will. To summarise the principles of community health.

a. Active participation of the community
b. Institutionalizing - community health workers
c. Deepening democracy
d. Equal stakeholder - power shifting
e. Health is Right
f. Health is political struggle

These are the key principles of a community health approach to public health problems. I would like to implement all these principles if I get a chance to work with the community. These learning's I would implement in my field work in future Two shlokas what Ameer mentioned in live session.

a. Think globally and act locally
b. Build solidarity from below

MODULE 2

Understanding community health Janelle explained about the tool SEPCE analysis Overview Historical context growing support for action on SDH Social paradigm framework. Health is holistic in nature. Health is dynamic. Health is subjective in nature. SEPCE - determines where weare born, grow, work, live and age. Historical context 17th century colonization, 1946- 1970: Strengthening of PHC Post independence - community based development. 1978- WHO - Alma Ata Declaration- Health for All. 1970- 1980: Civil society organization. 1980- 1990: Rise of Global - Neo liberalization. CHC - 1984 - SOCHARA- 1991 Social paradigm of health. Framework for rights and responsibilities. Health for all - ICMR and ICSSR- alternative model of health care. 2000: People Charter for health and SDH on social agenda. 2005 - 2008 Commission for Action on SDH. 2009 onwards SEPCE analysis. 2010- CSDH - WHO - Conceptual Frameworkfor Action in Social Determinants of Health. Growing support for Action on SDH Alma Ata Declaration - 1978 Research based publications ICSSR and ICMR - Alternative model of health care. Dr. Banerjee - socio- cultural and political process Prof. Rose - economic and social. Medicines and politics cannot be apart.

People Charter for Health 2000 by PHM

1. Socio, economic and political issues.
2. Fundamental human right
3. Inequality, poverty, illiteracy, exploitation, violence and injustice.
4. Health for all - challenging and changing political and economic priorities
5. Voices from poor and marginalised
6. People develop their own local solutions
7. Encourage people to hold accountable their own local authorities, national governance, international organizations.

MODULE 3

Social paradigm of health SEPCE/SDH Concepts of equity and social justice - Social justice - unequal treatment of inequalities to equalize the opportunities which social justice is just liberating. Create equal opportunities despite inequities, address barriers that exist which will lead to liberate people. Commission on SDH is a broad partnership. CSDH - Why? SDH influence inequity barriers to health for all social phenomenon Inter-sectoral policy action. Goal - advance health equity, reduce health differences within and between countries. Framework for Action On SEPCE determines

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1. Sepce analysis - guide epidemiology in PH and CH.
2. CSDH - guide intersectoral policy and programme

SEPCE analysis focuses on interrelationships and dependency between different factors that impact health. CSDH - created by WHO, 2 types of SDH ie., SDH inequities and SDH - direct impact onhealth via group assignment. Covid 19 pandemic and right to food crisis - discussed

MODULE 4

EQUITY POLITICS is Right to health. It treats health as a human right this talks on fundamental, sense of ownership and same for all. It has several types such as, right to freedom of speech Right to follow one's religion right to movement, Equity - Unequal treatment for unequal conditions to move in the path of fairness and justice. From just where we are born our life expectancy depends. Poorer - mortality rate is increased to reduce the child mortality rate; female literacy is important. Equity framework depends on education, income, caste, wealth networking etc. Politics and health politics - Acts of government Autonomy over one's own health. Politics is power. Politics to search for common good and just society seeking justice is ultimate politics. Rights- fundamentals defined by constitution. Sense of ownership, Freedom to choose. Fighting forour own freedom. Freedom to choose Entitlement. Rights are always claimed, demanded. not given. Charity is given, volunteered

How to get rights?

Rights are done through Acts of Parliament. Acts of parliament is implemented by CLAIM HOLDERS and DUTY BEARERS Rights - Constitution - Act of parliament (Government) Implemented by civil society - Bureaucracy through policy. Whenever ACT is formed in parliament we need to frame RULES. From rules POLICY is framed. Rights go with responsibility. Fundamentals of Human rights Universal declaration of human rights- 1948. Right– LEGITIMACY, Characteristics of human rights

1. Rights of individuals
2. Rights of being a human- inherent
3. Applicable to ALL people around the world
4. Relationship between state and individual

Right as a legitimacy - international agreements ratified by National Governments Constitutionally guaranteed/amended. Claim holders - group/ public/ individual Should be respected, protected and fulfilled. Duty bearers- Government/public authority. Duty bearers- Monitoring and Enforcement mechanism through courts of law. If any violations occur, the court

interprets. Health - fundamental human right World-wide social goal - health is socially determined. Declaration of Alma Ata 1978. Determinants of health. Health + health care Health is human right, inclusive and positive right. Health care - preventive, promotive, curative and rehabilitative, Concept of Claim holders fixes accountability mechanism that I should be responsible. Am I entitled for nutrition, employment, voice to the vulnerable etc., Public health action involves three process for Duty bearers- They are,

1. Assessment of health needs - whose needs? Develop policies for priorities- whose priorities? Programs to implement -whom does it reach? Duty bearers- exercise people to claim their rights.
2. Dual loyalty
3. Employer is someone and the beneficiary is someone. How to take forward the agenda ofHuman rights? or How to operationalize health as Human right?
4. 5 essential standards of implementation State obligations are,
    a. Availability
    b. Accessibility
    c. Affordability
    d. Acceptability
    e. Quality

Four A's and Q - State obligations rights and responsibilities. Idea of,

1. Social mobilization
2. Campaigns/ innovations/ strategies
3. Engagement with state
4. Move towards a responsible and accountable health system.

Do we have Right to health care in India? Of course YES Article 21 - Right to life states that Supreme court gave orders interpreting Right to medical facilities for workers. But every time right to health is denied. No Right to health care ACT. Cannot go to court. Can one realize the right to health care in private facilities? During covid crisis, Bangalore municipal corporation allocated 50

% bed allocated to the private sector. In the U.K in the private sector, GPs are free of cost, the Universal health system enables people to have health care. So even private sectors can provide facilities if they really wish health for all.

MODULE 5

Social determinants of health /Action on social determinants of health / Social vaccine. Core values - Health for all Elements of WHO conceptual framework Approaches / tools / mechanism for action on SDH social vaccine. Understanding the SDH and putting them into context revisiting the concept and putting them into context. There are 2 types of social determinants of health. Oneis structural determinant and intermediary determinant Structural determinants have 2 types: one's socioeconomic political context and socioeconomic position. Socioeconomic political context includes governance, policies and values. Socioeconomic position includes education, occupation, income, gender, and ethnicity Intermediary determinants consist of material circumstances like lifestyle, psychosocial factors, behavior, and biological factors. Intermediary determinants directly related to health. Health is a complex structure. Structural determinants include the context and position. Determine the inequalities.

Understanding the power mechanism is important. If health is affected socioeconomically, political context is also affected. Social cohesion and social capital act across both structural determinants and intermediary determinants. For interventions to make a change we need to network the entry points, look at the specific needs of the population, reaching more unreached people and not isolate the other groups. Any intervention whether policy or Programme interventions first place the determinant, sepce analysis, cash framework, community health approach. Research documents on SDH, barriers on SDH. Social capital is the social network band relationship. 2 types of social capital: structural and cognitive social capital. Structural social capital lies in resources, information. Funds, financial support, networks, community participation etc. Cognitive SC - characteristics of social organization, cohesiveness, norms, trust, quality, characteristics of relationship within the individual in that group. Social cohesion implies in depth connections and perception of belongingness of individuals or groups to their community. Cultural determinants of health - Culture and role in promoting equitable access to health and health care. My learning experience and how I applied in my work - Go with the community, live with the community, learn from them, and make them do things on their own. I opted to choose a vulnerable community adolescent from government girls school as my stakeholder. I advocate that menstrual health is their right and sensitize them by building a rapport with them.

MODULE 6

Week 8 - Comprehensive Primary Health Care by Thelma Narayanan - Live session briefly explained her journey in Community Health and the emergence of Primary Health Care and her role in active participation in PHC and PHM. CPHC ensures health care services, enabling its goal of HEALTH FOR ALL. PHC is universally accepted, accessible to all individuals and family members through their active participation. It is a practical approach indeed. The objective of this session is to enhance the understanding of the CPHC approach in the Indian context. In 1975 - WHO, UNICEF - study - alternative approach. 1976- Se. Kenith nuel - Health by the People - Book.

Alma Ata - WHO - 1978- paved way for studies. In India, Smallpox and the NTP National TB Programme, these studies influenced the PHC. Anthropological studies based out of NTP in Bangalore. In 1976 ICMR - there was an alternative approach to health care. For example, in Mallur cooperative linking rural economy with health. At present it is an AYUSH center. In the 1978 Alma Ata declaration, stressed comprehensive primary health care stated health for all in 2000AD. In 1979 meeting in Italy (UNICEF) There was a shift from CPHC to Selective primary health care SPHC. GOBI - Growth monitoring, ORS, Breastfeeding and immunization, Family planning. All these plans were from the distant Bureaucracies and not from the community needs. People lost faith in the government in 1980. Privatization of health services across countries grew during more troubled times. 1982 - National health policy Accountability mechanism came to NRHM. 18 networks in 1998/1999 People health assembly - Dr. Ravi was the co-organizer. 2000 in Bangladesh meeting landed up in Calcutta football stadium were People's Health Charter adopted NHP -2002. At that time JSA gave feedback to NHP in 2002. 2004 Karnataka integrated state health policy. Global health charter adopted. NRHM was a rural disaster since it focused on selective primary health care only.

The NRHM Comprehensive Primary Health Care is the 7th objective, which is also in NHM. Communitization includes 6 components in which ASHA is also included. Under the Ayushman Bharat programme Health and wellness centres opened by the government which included community health officers. Village health sanitation committee Patient welfare committee in Tamil Nadu some of the committee People representative in a committee in Maharashtra and Rajasthan were typical examples Patient health charter - rights of health CAH - community action for health talks about the accountability of the health system. Operationalize PHC, In national level policy processes.

NHP in 2017 revamped PHC and got a CPHC component. The PHC s are needed for developed countries also. Patient welfare system 118 NPH Programme. Thelma pointed out the counter-bailing power realized during the 1980s as part of PHM local as well as international. Strengthening of PHC in and around 2000s Operationalize PHC is important for equitable access. Each one should engage in PHC. Karthik felicitation about CPHC approach -

MODULE 7

WHO called for all countries for PHC to respond to inequities between countries to promote and protect the health of all by 2000. Alma Ata declaration 1978 -12th Sep WHO and UNICEF 134 nations have a scientifically sound approach. Declaration of Alma Ata Health for all - fundamental right - social goal. Governments have responsibilities, social justice in health. Political will to mobilize country resources. Socio and economic development, Health inequities are not acceptable. Inter-sectoral coordination is required. Goal - Strengthening PHC. Primary health care principles include accessibility appropriate technology Inter-sectoral coordination comprehensive Relies on local and referral system equity prevention, promotion and rehabilitation.

Components of PHC include,

1. Education
2. Food and nutrition
3. Safe water and sanitation
4. Maternal and child care
5. Immunization
6. Prevention, control of endemic
7. Appropriate treatment
8. Provision of essential drugs Tap turners off and not floor moppers.

Strengths of PHC

Comprehensive - address the main problem in the community, Equity - must be accessible to all specially marginalized and vulnerable communities. Community participation - Individuals and families are responsible for their own health. Services should be empowering rather than just providing. Attitudinal shift is necessary for people as participants. Appropriate health technology methods techniques and equipment Inter-sectoral collaboration. Decentralisation relies at local and referral system Community health workers trained within the community. Chosen by the

community. Health team will support. Supportive referral system made available PHC key Health for all. Integral part of socio and economic. Ayushman Bharat Programme had 2 components

1. CPHC
2. Insurance scheme

Why CPHC

The PHC moved to Selective primary health care which was top down approach. The SPHC were limited to MCH/ infectious diseases Growing burden for NCDs 62 % deaths in NCDs. No multi-sectoral approach Fragmented care. Increased burden over secondary and tertiary facilities, lack of resources, drugs. Exclusion and marginalization - poor accessibility to the poor. Not reaching migrants, SC, STs and persons with disabilities. India NHP 2017 aligned with vinced of universal health coverage. Ayushman Bharat Programme 2018 -2019. Announced in the union budget, it aims to carry the NHP proposal forward. The Ayushman Bharat announced by the government in 2018 had 2 components.

1. HWC to deliver CPHC
2. PMJAY Pradhan Mantri Jan Arogya Yojana - Access to hospitalization services at secondary and tertiary levels + insurance schemes.
3. The HWC component of ABP ensures CPSC through upgrading existing PHC / UPSC goals - 80% health care needs.

Reflection on health for all book. What is PHC Alma Ata declaration CPHC vs SPHC What shift has to do with Malaria and tuberculosis. Health is a fundamental right. The Bhore committee reported India's charter on health that no citizen should be denied a shortage of healthcare. PHC's key principle is health for all. After the Alma Ata declaration there was a change in PHC but that was not at all enough. Everything seems to be stagnating. PHC is fixed on targets. Health priorities were from distant Bureaucracies. No community participation. No referrals. Fragmented health sectors.

What has to be done?

Build up people's consciousness, People intervene in decision making process Policy changes with minimum infrastructure. Opening PHC with affordability, acceptability, adaptability, accessibility, and quality. Drugs of minimum supply, Stronger referral system Broad base secondary health care to intervene in high risk cases decentralization. Ensure community, panchayats and local health officers equipped to plan for health needs in their area and demand their needs. Resource support, monitoring programmers, inter-sectoral approach capacity building. Special focus on unreached women and weaker sections create organized structures for women focusing on local health traditions. Malaria and filaria are not two different programmers. Instead of a vertical approach, a horizontal approach is needed to eradicate malaria and filaria. Implementing controlling the vector borne, controlling mosquito breeding, water sanitation, removing stagnant water all have to be considered in treating these diseases instead of biomedicine intervention alone.

"Health for all is a broader context.Health is fundamental"

"Health is a social goal". Hence we need to be a part of PHC, need to start working with HWC and be a part of CPHC."

MODULE 8

Equity in health: Carers worldwide - Dr. Anil Patel**,** I am touched and moved by this video. Since it is very much related to my own life experience. My father was sick and bedridden for nearly 4 to 5 years and today is his first death anniversary. I am writing this reflection. The whole process of his treatment was taken care of by my wife and myself. My amma has been a caregiver for so many years with no expectations. She also had so many health issues both physically and mentally. So many caregivers are there across this world. But none thinks about them. But these caregivers play a huge role in family and community. This video highlighted to me empathetically what the government is taking steps for these caregivers worldwide. What health policy is there for these caregivers? In the Indian context what steps have to be taken by the community health practitioners to recognize these care-giver. In India do we recognize these caregivers? Dr. Anil Patil caregivers worldwide taught me a deep understanding of how these caregivers in each family should also be nurtured and taken care of.

MODULE 9

Health systems in India by Dr. N. Devadasan briefly explained about the Health system in India, itselements, connection and purpose. Health system's primary purpose is to promote, restore, and maintain health. The elements of a health system include health care service, information, health staff, governance, infrastructure, financing, context medicine, values and community involvement, education, job, opportunity, environment, clothing. Health care services include the PHC, RMNCH, TB control, malaria control programmers etc. Financing includes the money, hospital taxes, Insurance coverage. Community should be participatory, involved. Values include equity or solidarity. Governance needs to be appropriate, to fix policies monitoring the performance and accountability. Infrastructure of PHC, CHC, Sub-centers monitored with adequate equipment and dispensaries, pharmaceuticals. The elements of the health system are always interconnected to one another. The purpose of the healthcare system is accessibility to quality care, keeping health as a goal and being responsible to the community both socially and financially. To conclude the health system framework always works in a comprehensive manner. Quality health services assure availability of drugs, diagnostic services and human resources.

Primary health care comes under 3 categories: PHC, CHC and Sub Centers. Health service is the key output of the health system. In India for 1 GP 30000 population under primary healthcare where the workforce, burden of GP is increased. Health services include primary care. Secondary, tertiary health care. Primary health care is comprehensive, preventive, promotive, rehabilitative. Primary health care includes primary health centers, clinics, and dispensaries. Secondary health care includes hospitals and medical colleges at district level where specialist doctors only are available. Tertiary Health care is comprehensive and no focus on preventive or promotive aspects of health. Only specialists and surgeons are available. As per government health service in India since PHC is a comprehensive 1GP for 30 k population, there is a referral unit which is not formal. PHCs conduct National health programs, have a connection with district health teams, conduct ICDs for nutrition, and NCD care, but the training remains robust. In private sectors in India there is one to one care for individual patients but the referral system is very weak and the monetary expense is too high, and the referral is decided by the practitioner. National Health Policy in 2017, stated the need for strengthening of PHC. When people's demand for PHC increases, the government may take more steps in strengthening the PHC. We ourselves have to ask questions about how we people utilize PHC. Are we aware of national programmes done in PHC as a health service? Hence it is the duty of health workers to know about these programmes, new schemes, policies in the health sector and create awareness among the community. This will be the first step indeed as my reflection.

The doctors whether in public or private should know about the role of VHNSC, ASHA and Rohit kalyan samithi. And try to fill the gap between the public and private. Funding for tertiary care is more than in primary health care. Primary health care is comprehensive. Increasing the funding in primary health care is very essential, where many diseases need preventive and promotive care. Medical pluralism comes here. Traditional medicines and modern medicine integrity in primary health centers is crucial in treating patients where TM and complementary medicine focus largely on preventive, promotive and rehabilitation. Health workers and the community should build a cohesive trust among themselves. There is a lack of cohesiveness among the health workers and community. My reflection is there are so many PHC where Alternative systems are left as such. Filling these posts and equipping these traditional and AYUSH practitioners in each PHC level would be more comprehensive, less costly, and efficient in treating patients at primary health care itself. The incentives of such health service providers should also be considered. This will intensely reduce the funds on tertiary health care, workforce, human resources etc. A political will is needed to bring all these into consideration.

The revised guidelines of IPHS Indian public health standards briefly explained about the citizen charter, infrastructure, diagnostic equipment, the elements of health system, financing and governance, workforce, community monitoring aspects, quality assurance, accountability and in service delivery, capacity building, drugs and medicines adequacy, equity, context, health staffs, health workers, administration, human resources, referral aspects and so on.

SWOC (Strengths, Weakness, Opportunities and Challenges), analysis primary health care. There is always opportunity in health care- human resources, filling the gap between private and public, creating awareness, screening at primary health centers to stop catastrophic or disaster. Strengths- Comprehensive, accessible, reaching the underserved, accountability (VHNSC and ASHA).

Primary health center into a health and wellness center. Twelve services provided. Integrative Complementary and modern medicine. Challenges - Funding in PHC is reduced. Underutilization of PHC, since NHP policies, are not even known to public and private doctors. Less paid health workers and health staff, overburden in the workforce. Commercialization in private practice. Weakness - Governance, funding either underutilized or not sufficient, infrastructure, health worker and community involvement is less, no training, referral network not recognized, target oriented, not patient centric. To add my personal experience, in a monthly doctors meeting held at our institution, I wrote my reflection, perfect minutes and was able to do a SWOC analysis of that meeting. This improved my personal learning both inwardly and outwardly.

MODULE 10

Pluralism in health care in India and AYUSH. This module is closely related to me and I was waiting indeed for this module to know more about AYUSH and what could be done as a AYUSH practitioner in the community as a community health approach and to meet the needs of the people and bring about the policy interventions in this sector. The module gives a brief explanation about the local health traditions, traditional healers, codified and uncodified practitioners, and the AYUSH community. National health policy in 1983 stressed the integration of traditional and modern medicine. AYUSH and stakeholders workshop in 2009 with SOCHARA and FRLHT created a social dialogue to strengthen AYUSH, and validate AYUSH in community health situations. In the 12th year plan, AYUSH groups recommended quality insurance, up-scaled funding of Ayush initiatives towards National integrated health care mission with 10% of the total health budget.

In our nation the dependency of traditional medicine is about 60 to 80% but are we using these traditional medicines, and are we recognizing these traditions or giving them acceptance is a big question. This pluralistic system or LHT is ethnic community, ecosystem specific, bio-geological cultural diversity, inter general learning process. Written document is Materia Medica. The need for documentation is to conserve, stimulate innovation, protection and conservation of culture and diversity. This traditional knowledge has to be preserved, and documented as evidence-based. That is the only way to prevent unauthorised exploitation. To bring a change it should be at the policy level. ™ strategy - 2005 to 2007 ™ and CAM to integrate into the national health care system.

MODULE 11

Universal health coverage. Individual Assignment, Universal health coverage is when all individuals and communities receive the health services without any financial hardships.

MODULE 12

Facilitator Dr. Ravi Narayan What is civil society and role of voluntary organization. This module created more impact on me. It is very relevant to the topic of the project which I chose. Morality is about action and not consequences. As a catalyst I approached my stakeholders, and I developed my communication continuously with them which showed improvisation at my work, using the 5 values of civil society by reaching the unreached community with gender equality, Rights to my community stakeholders, with integrity and quality and representing what my community wants. Enabled my stakeholders to exercise collectively their responsibilities to

maintain their health and demand health as their right. Menstruation with a lot of stigma and taboos, and different context and social status, regular dialogue with the stakeholders made menstrual health hygiene possible with many challenges ahead. Human development begins from solidarity with a new health approach of simple, accessible and promotional health care, my stakeholders are now the craftsmen of their own development. Civilian roles are played by everyone. We are a civil society. These young minds are now in civil society, they come together to do work. This is a visual change, a social transformation and a social movement indeed. Continuous dialogue, affirmations, acceptance with solidarity in a small group will create a critical mass- A social movement. These stakeholders gave me confidence and made me understand how small groups can bring a massive change. Civil society in India Deepening democracy Be in touch with reality Raising issues from grounds Rights oriented, Constitutional values and framework.

PPP - discussion on public private partnership the center p is public, people. People public health policy discourse. Policy behind should be people, professionals, providers in the system also involved. Scaling of process is important and not the scaling of models. Policy should be supported by educational effort and that is what movements are all about. Creating consciousness that the government should pitch into the health sector at larger means. I learnt about what is civil society in India, the role of voluntary sectors, what can be done individually, as an organization and as a movement. Catalyzing change some examples include JSA, Some of NGOs.

MODULE 13

Food and Nutrition Facilitators- Dr. Rav D'Souza and Nidhi sukla. Food and nutrition is one such interesting module, a major social determinant. Dr. Ravi D Souza explained about ICDS - A national nutritional Programme addressing from 0 to 6 years old. It had one anganwadi worker and1 helper which runs 6 hours a day, 6 days a week. I visited the nearby anganwadi center close to

my locality, Chennai Mogappair and addressed them and had a dialogue with them. That center was well maintained, good infrastructure, they provided mid-day meals to the kids and the kids were from 1 year to 3 years old. Toilets were neatly maintained and the mothers, pregnant ladies were provided take home ration and 2 eggs were given for 3 days in a week. 1 teacher and 1 helper were there. Monthly ANM visits were there. Growth monitoring chart was maintained. These were some findings when I visited them.

In my project interventions I addressed anemia, promoted girl's education, talked about health education on dietary diversity, healthy lifestyle and iron rich food intake and taught more about our traditional functional foods. Protein rich ladoos were taught, prepared and given to the

adolescent girls. Yet more to sensitize about the National Adolescent Health Programme RKSK in detail. Eating disorders, deworming, lifestyle modifications were facilitated by me in this context. POSHAN ABIYAN, ensuring every girl child with sanitation is the major concern in my project - Millennium development goals MDG2 in school context.

MODULE 13

Dr. Prahlad and Dr. Prutvish facilitated this module. Lack of sanitation and toilets a social determinant affecting the mental health of young adolescents with low school performance**.** There is definitely a need for sanitation. Biomedical waste management - Dr Prutvish**,** Dr Prakash – low cost methods of safe drinking water using copper pot.

MODULE 14

WOMEN'S HEALTH - Facilitators include Dr. Amitha, Dr. Subashini, Dr. Bhuvaneshwari and Dr. Padma. In this module discussions were so much interactive and had a good learning experience. Women's health objectives Discussed about life cycle approach, rights perspective and gender. Women movement in India in struggle for Right to health. A topic on Maternal health – and maternal death watch discussed. Reproductive health and health conditions in Reproductive health? Services available in reproductive health programmes and What is reproductive rights? Reproductive health is far more than medical or health issues. What is Family planning and contraception, Family planning Programme in India which is a target observed Programme. Barriers to accessing safe abortion due to lack of information, lack of decision making and power, stigma in unmarried women, poor service in public sector, lack of financial resources and so on. Gender based violence, - DILASSA - raising awareness about violence against women. Women health movement in India Women health care workers and gender.

This session really addressed the in depth understanding of sexual and reproductive health, right from birth through a life course approach and also the community led approaches to address the issues involving women's movement in India. We need a continuum of care as WHO insisted.

MODULE 17 & 18

This module impacted me a lot and I had a lot of key learnings which I applied to my personal life as well as professional life. A person's mental status determines the health of a person. Mental health is a public issue and addressing mental issues with a community approach is needed. Self-care, gratitude, work life balance, personal relationships, staying connected, being mindful all contributes to mental health. The facilitators include Dr. Rajaram, Dr. Mohan Isaac, Dr. Naveen Kumar, Dr. Shared Philips. Exploring policy and legislative landscape for persons with mental illness was discussed with Dr. Sharad and Dr. Naveen Kumar. We had an overview of mental illness, understanding common mental disorders like depression and anxiety and came to know about YAM youth awareness mental health Programme SPIRIT- Suicide prevention and implementation research initiative. Understanding about suicide was taken by the facilitator Dr. Kaustaub.

The live session by Dr. Rajaram was a soothing experience and he explained the nook and corners of counselling and how counselling plays an important role in mental health. As a community health worker, we all should know about counselling and it is an art. I developed my counselling attitude and knowledge and improvised my way of counselling methods by Dr. Rajaram. Mental health is a positive state, reducing stigmas, enhancing literacy, changing the attitude and behavior change are the key learnings I took from the facilitator Dr. Mohan Issac. Thus a counsellor should require skills, qualities, attitude, conduct and convictions.

MODULE 19

Communicable diseases are always a major public health priority and even more so after COVID storms. Communicable diseases, Facilitators Dr. Ramani and Dr. Ravi Dsouza, There are so many public health programmes addressing specific diseases like TB, Leprosy. We had a brief discussion about vector borne discussions at the live sessions. Social determinants include overcrowding, education, socioeconomic and nutritional causes. Community health approaches in VBD include behaviour change, personal protective measures, education, safe drinking water and housing, sanitation and access to health care. In the contest of behaviour change and sanitation, my stakeholders composed and wrote songs with catchy tunes by themselves. This is a small initiation, a community participation in the young minds of girls. I started sensitizing the teachers and developed a school parliamentary committee where teachers and children keep in regular touch. Children complain to the teacher that there is no soap in the hand station. As a community health worker just sensitizing and educating is our job. The lead will be done by the stakeholders itself.

Thus determinants such as poor nutrition, unsafe drinking water, improper sanitation, poor hygiene practices have many influences in the spread of communicable diseases.

MODULE 20

Non communicable disease: Facilitator - Dr. Pruthvish and Sundar, NCDs are wider topics. Physical inactivity, unhealthy and sedentary lifestyle, Alcohol and Tobacco use account for the risks of NCDs. Many interesting and necessary topics were covered during the session. National health mission - ASHA on communicable diseases is a good read. Most of the NCDs are preventable with a healthy lifestyle. Integration of AYUSH in a proactive manner will reduce the burden of NCDs in our context. The most important strategy is behaviour change and implementation at school level is the best way to control NCDs. It's quite interesting to know about the NPCDCS Programme. CPHC components and Ayushman Bharat NCDs are added.

MODULE - 21

Palliative Care: Chronic illness who needed physical and psychosocial support, improving their quality of life. Palliative care is one such which is seen in every individual house. They need special attention and care. The aspects of pain may be physical or psychological or spiritual or socioeconomic. Good quality service and improving their quality of life is essential. Pallium India A primer of palliative care - Dr. Sree Devi explained her experiences in a depth way.

MODULE 22

Climate change and health: Environment is a determinant of health and how climate change influences health. Facilitated by Dr. Adithya is one elaborative module and the session was very interactive. Approaches to address climate change are mitigation, adaptation. My next area ahead is adaptation. Talking about climate change in local development planning and mitigating climate change. By creating awareness and strengthening the capacity of the health care system to reduce disease and illness. In my institution, I have recommended renewable resources like energy saving solar panels.

MODULE 23

Health technology and innovation: Technology and health care - resource paper by Dr. Ravi Narayan, is a very interesting paper. Appropriate technology concept - ORS in diarrhea treatment, readings for national Rational drug policy, prescription and pharmaceutical policy by Dr. S. Chinu Srinivasan is a good read. Appropriate technology is one among the principles and axioms determining health.

MODULE 24

Communication for health: Facilitator - Augustine vellaiath, this module gave the ideas, values, methods, tools for communication. Listening is the art of communication. Developing communication skills in advocacy, health development programmes and implementation is the major role of community health volunteers.

MODULE 25

Globalization and health: Facilitated by Prasanna, It is a wide chapter yet to be evolved. Dealing with equity political economy, politics and economics. Health is a market failure. Neoliberalism - specific political economy free trade Discussed about privatization and commercialization. More about PPP. Neoliberalism talks about globalization. Life expectancy increases when GDP per head increases. Discussed about SEZ - tax free zone. It is a huge content module yet to be explored and evolved.

MODULE 26

Child and adolescent health: One of my favorite modules is child and adolescent health. Facilitated by Dr. Antony. Lot of information and data was shared by Dr Antony in this module. Right based approach to child UN convention on rights to children Survival, Protection, development and protection. Critical periods are the first 1000 of children. - National health mission RBSK - foundation for a brighter future is a good read. Healthy lives of all children - SDG 3 states, explained the 30 medical conditions and 4 D's. SDG 2 to end hunger, achieve food security and improve the nutrition of all children. I have been handling adolescent counseling, keeping the childcentric. This session guided me about the WHO core life skills and the way counseling can be done efficiently. Addressing grama panchayat to promote child's health by monitoring the services and implementation of government programmes to address the gap areas actively plan keeping it child centric.

BALANCE BETWEEN WORK, LIFE AND CHLP

It's a challenge for me but still life, work and my career I consider it in a holistic way. I enjoy doing field work and keep updating with newer things. I utilized my lunch time to meet my stakeholders and the stakeholder's interests pulled me over to them. Even if I miss some live sessions, I never miss to see the recorded sessions at night. Each module and facilitators made me feel more connected, creative and energized and collaborative. I practiced mindful breathing, frequent movement exercises to balance my mood and work.

MENTORSHIP PROCESS AND REFLECTIONS

I am amazed to see their availability, their experiences and their advice. Mentors delivered their communication in such a way that could be easily understood by everyone. My mentor Mr. Hari Ramamurthy guided me and we had a few sessions of elaborative discussion about my objectives, he approached and gave me clarity about my project. He was so flexible in communication and had phone conversations and visited him in person twice. I am thankful to CHLP for giving me a wise mentor.

PROJECT LEARNING EXPERIENCE

The project is a new learning experience for me. I have been handling adolescent kids at a clinic level but addressing them with a community approach is quite different and interesting with varied determinants of health. It has extended my community engagement, analyzing a situation, listening skills, networking, sensitizing and mobilizing skills. CHLP has changed my thinking. Usually I love to volunteer but I understand now our job is only a catalyst / enabler. The lead should be from the community and finally they should say they have done it. My next move would be with the Child Education Officer and different stakeholders from different schools, making Menstrual Hygiene Management and WASH hygiene practices at school curriculum and development in the school monitoring committee for regular feedback. Sensitizing every stakeholder in Siddha context of promotion of healthy lifestyle. I thank CHLP for bringing out my strengths and confidence to reach people at community (grass root level) and pursue my dream of becoming a public health activist.

MY EXPERIENCE DURING COVID PANDEMIC

The Covid 19 pandemic has brought the world to standstill and was definitely a challenging situation for everyone. In spite of all chaos, fear, anxiety, uncertainty, as a private siddha practitioner and as a front line healthcare worker, I immensely, tirelessly stepped forward as a Covid warrior providing medical assistance in combating the virus. Telecommunication has been an important tool in the fight against covid 19. With the help of technology i have been able to reach people from remote places by reducing their strain to reach hospitals and healthcare facilities.

Volunteered with a NGO organization @connect and delivered services, consultations, provided awareness about the preventive and proactive measures of Covid 19 pandemic through online sessions.

PART B

COMMUNITY BASED HEALTH ACTION REFLECTION PROJECT

BACKGROUND

India is the second most populous country in the world with more than 113 million adolescent girlswhich is the highest in the world. These adolescent girls are particularly vulnerable groups at the time of onset of menarche. Adolescence is a phase of transition towards womanhood and its beginning is marked by menstruation. According to WHO adolescent groups are defined as the age group of 10 to 18 years in India. Age 12- 18 years is the time period where children do more complex thinking and logical operations and decision making. This is the right time to encourage and educate them about Menstrual Health and Hygiene. Menstrual hygiene is both a human rights and health issue, where adolescent girls are entitled to a life of dignity and for which we need to ensure educational opportunities about basic health and hygiene practices, well-being, availability and sustainable management of water and sanitation for all. The United Nation in (2014) declared May 28 th of every year a Menstrual Hygiene Day that aims to create awareness and highlight the importance of Menstrual Health Hygiene (MHH) to different stakeholders. Menstrual hygiene depends on the educational, socioeconomic and cultural status of family. School curriculum has a main role to play in menstrual health. Inadequate puberty education, poor water and sanitation, lack of hygienic absorbents cause girls to experience menstruation as shameful and uncomfortable.

CONTEXT

The community chosen were 16 adolescent girls between 11- 14 years old from Government girls higher secondary school, Mogappair east, Chennai, Tamil Nadu, India. Education and Awareness on Accountability for proper use and disposal of sanitary napkins, general aspects of menstruation and healthy lifestyle are the key highlights. They are unaware about their menstrual health and hygiene practices. This not only ensures menstrual health issues but also a route for any ailments.

SWOC ANALYSIS

STRENGTHS

1. The school principal and the class teachers encouraged the participants to actively participate in the health awareness sessions. Their untiring support made them more responsible.
2. These participants were enthusiastic, responsible, and respectful.
3. The staff gave me space to build self-esteem, confidence among children.
4. Children were receptive and were very curious to learn and spread this awareness to their peers,their parents, their relatives, and neighbors about what they have learned in sessions.
5. They ask many questions, and keep the sessions always interactive.

WEAKNESS

1. Poor knowledge about managing pain during menses.
2. Non-availability of counseling services &
3. Inadequate information of MHM
4. No preparation before menarche
5. Cannot expect a quick response initially, taking time to execute and act.

OPPORTUNITY

1. Can develop a school model for menstrual hygiene management
2. Building leadership by framing school management committee
3. Create healthy generation
4. Building capacity
5. Community participation

CHALLENGES

1. Poor hygienic conditions of toilets and no mugs for washing in toilets
2. Lack of soap and dustbins with no lids
3. Girls in school threw away sanitary pads in toilets or wrapped pads in toilet corners.
4. Attitude of children made teachers frustration to discuss about this topic
5. Non - functioning of incinerators.
6. Physical and psychological changes

SITUATIONAL ANALYSIS

The key areas were generated which included knowledge and skills about menstrual health hygiene, social support, facilities and services, access to right information, access to water and sanitation, access to toilets and hand washing facilities, menstrual waste disposal and access to other menstrual support like emergency clothing, soaps and basins and psycho - social support.

OBJECTIVES OF COMMUNITY HEALTH ACTION INITIATIVE

1. To increase awareness about menstrual health and hygiene, its management, build self-esteem,among adolescent girls.
2. To ensure safe disposal of napkins in an environmentally friendly manner -ecosystem of children.
3. To overcome the challenges of menstrual hygiene management both physically and mentally.
4. Improving water and toilet facilities.
5. Pandemic - Covid preparedness

COMMUNITY HEALTH ACTION INITIATIVE

As a clinician and aspiring community health enthusiast, the action plan was initiated to assess the status of menstrual hygiene management among adolescent girls in Government Girls Higher Secondary School, Mogappair East, Chennai, Tamilnadu after prioritizing their needs. They were considered mature enough to talk about a socially sensitive issue like menstruation.

COMMUNITY PARTICIPATION AND RAPPORT BUILDING

The initial meeting was made with the head of the school and permission was obtained from her and the corresponding school teachers by directly visiting the school. The initial meetings gave me an idea of what I should emphasize on. The respective class teachers of 6 th, 7 th and 8 th std randomly selected girls from each class and a total of 16 students gathered in a classroom. Initially a good rapport building was done to them by good introduction, active listening to them with positive attitude and in a comfortable atmosphere. These students hail from economically and socially backward communities with very little knowledge about menstruation, menstrual health and hygiene practices and general health practices. So there was a need to empower them. But instead of going directly into health awareness sessions, as i learnt from CHLP, I first had informal gatherings with the children and enquired about their issues and was shocked to hear the behavior attitudes of their seniors of the same school, by throwing the used sanitary napkins in the corners of the toilet and inadequate toilet facilities for about 900 children only 6 toilets are available. I started understanding their priorities and started working to meet their needs and issues. Initially we planned 1 hour meeting on Mondays and later periods we had meetings on Monday and Tuesday without disturbing their curriculum activities. I fixed my lunch break to have regular conversation with the participants.

DESCRIPTION OF INTERVENTION/IMPLEMENTATION, COMMUNITY ENGAGEMENT PROCESS

Initially they had some embarrassments opening this topic. But acceptance, affirmations, and affection towards them developed a trust among us which made my works easier by gaining their trust and cohesiveness.

FIRST SESSION - YOGA, BASIC PRANAYAMA TECHNIQUES AND CANDLE GAZING

The first session started with YOGA and EYE exercises with candle gazing to increase their focus and concentration. I made this as a regular one for every session. Every session started with 5 mins of yoga, basic breathing exercises and 2 min Candle gazing.

NEXT SESSION

Once the trust is built I further proceeded by assessing their knowledge and practice regarding menstruation, menstrual health, menstrual hygiene by open ended questions.

QUESTIONNAIRE METHODS

1. Their Age
2. Age of start of periods / menses?
3. Do you have periods, for how many days and after how many days?
4. Any physical symptoms or mental symptoms during periods like headache, stomach pain, moodswings, cramps, anything else
5. What absorbent material do you use during periods?
6. Were you informed prior to menarche before menses?
7. Do you have a toilet at school / home?
8. Do you change pads at school facilities?
9. How many pads do you change in 24 hrs
10. Any social taboos by parents / teachers during menses.?
11. Is there provision of water and sanitation facilities at school?
12. Is there a provision of hand washing soap at your school?
13. Do you wash hands after taking care of your menstrual hygiene at school / home?
14. Is there provision of emergency sanitary pads at school 16.. How do you dispose of sanitary pads in school / home? 17.. Is there provision of emergency sanitary pads at school?
15. Do you get support from school during your periods?
16. Do you have access to sanitary napkins near your home.?
17. Do you have a private place to wash / dry and dispose of sanitary napkins at home?
18. Have you been sensitized in the school regarding periods?22.Do you know how to manage period pains?
19. Do you know what is meant by menstruation and menstrual cycle / which organ blood comesfrom?
20. Any embarrassing self-accounts during menstrual periods in school?
21. Do you know about healthy food habits and the ill effects of junk and packed foods?

From their responses to questionnaires out of 16 students 2 of them didn't attend puberty and the other 13 students have menses regularly. 1 student had severe bleeding for more than 7 days. All students reported about the common symptoms of stomach pain, cramps and lower back pain. Theyalso have problems with staining in clothes or not changing their pads at regular intervals. All the students used disposable pads at school like stay free and whisper brands and 3 students alone used cloth pads at home. None of them used other menstrual absorbent materials due to lack of awareness. They were not priorly informed about menses. Out of 14 students just 2 of them take an oil bath after their periods. And all 14 students are not allowed to go to the temple. All 14 students have difficulty in disposal of used sanitary napkins at school due to open dustbins and inadequate water supply. They change 2- 3 pads in 24 hours. 4 people do not change their pads at all.

Toilet facilities are available at school and homes. 3 students have the habit of flushing their pads intoilets without wrapping them. 6 students dispose of it in a plastic bag with domestic waste. 3 of them burn it. The other 2 students used to throw the pads in the toilet corners. Out of 14, 12 students wash their hands after disposing of napkins. There was no proper sanitation facility and inadequate water supply. Embarrassing movements in the school - the seniors threw the used menstrual pads at toilet corners and the juniors also followed the same. There is provision of emergency sanitary pads in school. All of them were unaware of vaginal infection due to poor menstrual hygiene. 3 students reported having itching during periods. None of them have proper knowledge about washing in a private place, association with menstrual cycle and organs.

After gathering their knowledge and challenges regarding menstruation a brief and elaborative session was conducted to educate them about menstrual health, menstrual health hygiene practices and menstrual health management and to overcome the challenges. They had difficulty in disposing of napkins due to lack of awareness about proper disposal methods. The session mainly focused on managing menstruation and disposal of sanitary napkins.

The sessions of the topic included

1. Health
2. Menstrual health
3. Puberty education
4. Information
5. Access to period products

6. Water and sanitation facilities
7. Supporting school environment
8. Disposal (waste management) system
9. Healthy lifestyle practices implementation of siddha principle
10. Nutritional and traditional foods
11. Medicinal herbs and plants
12. Home garden and
13. Covid pandemic measures

The key points discussed are as follows:

1. Menstrual health is defined as complete, physical, mental and social well- being in relation to menstrual cycle
2. Menstruation is a normal and physiological process and it is not a shameful process.
3. Available menstrual materials were discussed.
4. Material cloth
5. Reusable pad
6. Disposable pad
7. Menstrual cup and tampons
8. In addition, advantages of using organic cotton pads and skin friendly pads were also discussed.
9. Personal hygiene during menstruation was explained in detail
10. Changing napkins 2 to 3 times a day to prevent infections
11. Washing hands with soap and clean water before and after changing pads.
12. Proper disposal of pads at home and school was explained with a demo section.
13. Sixteen students were divided into 4 subgroups for monitoring other students so that theyfollow proper washing and disposal of napkins.

The class teachers were also trained and was advised to monitor the students regarding the MHM. To overcome their pain during menses, having a warm bath or placing a cold towel in the stomach region can comfort or ease pain or taking, fennel kashayam (Anise Decoction) will give relief to pain / cramps. One student reported anemia due to over bleeding during menses hence suggested taking murungai keerai (Moringa leaves soup) and vazhaipoo (plantain flower). To build strong and healthy uterus and for regular menstruation suggested 2 gruels namely black urad dhal gruel with palm jaggery for 1 to 15 days of periods and fenugreek gruel from day 16 to 30 th days of periods to be taken as their regular breakfast. Preparation of traditional foods like sesame balls ladoos, groundnuts and ragi ball ladoos, drumstick leaves soup, vegetable salads were taught to them and even administered to them.

1. To increase their interest in the session, a few more health tips regarding healthy lifestyle was also discussed with them.
2. Separate oil bath session was conducted to know the importance of oil bath and how it effects the body, and menstrual health also was discussed. Introduced some raw drugs and taught some medicines to be prepared at home to overcome seasonal flu and respiratory illness. Few games were played in the middle of the session to keep them actively involved. Especially we playedsnake and ladder games in addressing the ill effects of junk foods and packed foods.
3. A generalized health class was conducted by an optometrist.
4. Initiation of home garden.

GENERAL HEALTH TIPS

1.Pandemic awareness

2.Eye health awareness

IMPACT OF COMMUNITY HEALTH ACTION

1. Improved awareness on menstrual health hygiene (MHH) and menstrual health management (MHM)
2. Improved access to easily available siddha medicinal preparations.
3. Improved knowledge regarding general health, food and nutrition and pandemicprecautions.

LEARNINGS AND REFLECTION

1. Built rapport with the community
2. Understood the needs of the community and their challenges.
3. Dialogue with the community, making small groups with quality, and enabling them well developed a behavioral change.
4. Solidarity - community coming together, interactions and active participation was developed.
5. Participant's mental health was assessed.
6. Proper education at the right time is the best tool for MHM (Menstrual Health Management).
7. These participants have more potential. The only thing is it needs to be streamlined not by demands but by actions, affirmations, acceptance and affection.
8. Health is determined not only about health and health care it's more about 3 A's and Q
9. Affordability
10. Accessibility
11. Acceptability
12. Quality

REFLECTIONS

1. The participants actively participated in the sessions by asking doubts regarding menstruation and general health.
2. Due to developed knowledge they made charts related to menstrual hygiene and sanitation and placed it near their toilets and soap and sanitation area to be noticed by all.
3. They also discussed with other classmates, friends and parents regarding the sessions.
4. They obtained proper knowledge about MHM (Menstrual Health Management) and its impact on general health.
5. A WhatsApp was created by the students itself in which they posted the healthy recipes taught in sessions.
6. This group is common to parents and students. Due to trust, few parents came forward to ask their doubts regarding general health issues.
7. The participant who was suffering from anemia followed the instructions given and had her regular periods with normal flow for the last 2 months. And she ensured to follow them regularly.
8. Home garden was started by many participants.
9. Surprisingly they created and composed a poem of what they have learnt in sessions as a theme and sang it during the sessions.
10. The participants will take the lead role now for proper disposal and enable others in their school and the process will continue monitoring support from their teachers and school principal. I will be meeting them once a month to ensure students' implementation of menstrual hygiene.

Axioms of community health applied in the project

1. Enabling the adolescent girls to exercise their responsibility for their health and prioritize their health needs.
2. Increasing the knowledge on health specifically menstrual health and making them aware of menstrual health management with community participation.
3. Integrating menstrual health with WASH (Water and Sanitation Hygiene and waste disposal. Preventive measures for general health issues and COVID. Organized health related activities and workshops.
4. Making them empower as an individual and as well as a community - we had frequent conversations with teachers, school head.
5. The participants are from vulnerable communities and underprivileged hence focusing on equity in health benefits with no stigmas and taboos.
6. Making them aware of Siddha medicines and home remedies for their health issues and preventive measures in COVID.
7. They responded to them by encouraging their talents, beliefs, and gave them their identity.
8. Promoting Yoga and Breathing techniques, home-made remedies, with locally available resources rather than biomedical models.
9. Making them aware of public health facilities and role of ANM in distribution of sanitary napkins at low cost.
10. I understood that professional packages alone are not important but identified new health innovations and skills are important and we had a regular WhatsApp group created by the participants itself and used this one for regular follow ups.
11. SEPCE analysis at each stage is important.Of the 10 axioms I focused mainly on:
12. Autonomy over their menstrual health- educated them about menstrual health, hygiene practices and management and safe disposal of used sanitary napkins.
13. Integration of other health services - Introduced them with traditional food and siddha medicinesand other medical departments were also involved.

PARADIGM SHIFT

1. Physical, pathological - psychosocial, cultural, ecological
2. Individual - Community participation
3. Drugs - Enabling education and promotion of health
4. Teacher - Catalyst, Empowering, Building capacity
5. Clinical - Social determinants of health

SEPCE ANALYSIS

SOCIAL

- Lower education
- Lack of awareness
- No access to toilets
- Inadequate water supply

ECONOMICAL

1. Lack of awareness
2. No enough access to toilets
3. No sanitary products
4. No adequate toilets

CULTURAL

1. 1.Limited knowledge
2. Stigma / taboos
3. Traditional beliefs
4. Personal attitude

POLITICAL

1.No information on MHM

2.Not enough access to toilets

3.No networking

ENVIRONMENTAL

1.Poor psychosocial support

2.Stigma/ Taboos

3.No ecosystem concern

ANNEXURES

IDEA DRAFT

TITLE OF COMMUNITY BASED ACTION PROJECT

Awareness on Menstrual hygiene and its management in Adolescent girls.

INTRODUCTION / BACKGROUND

India is the second most populous country in the world with more than 113 million adolescentgirls. These adolescent girls are particularly vulnerable groups at the time of onset of menarche.Adolescence is a phase of transition towards womanhood and its beginning is marked by menstruation. According to WHO adolescent groups are defined as the age group of 10 to 18 years in India. At this age is the time period where children do more complex thinking and logicaloperations and decision making. This is the right time to educate and encourage them about Menstrual Health and Hygiene. Menstrual hygiene is both a human right and health issue where adolescent girls are entitled to a life of dignity and for which we need to ensure

educational opportunities about health and hygiene practices, well-being, availability and sustainable management of water and sanitation for all. The United Nation in 2014 declared May 28th of every year a Menstrual Hygiene Day that aims to highlight the importance of Menstrual Health Hygiene (MHH) to different stakeholders. Menstrual hygiene depends on the educational, socioeconomic,cultural status. School curriculum has a main role in menstrual health. Inadequate puberty education, poor water and sanitation, lack of hygienic absorbents cause girls to experience menstruation as shameful and uncomfortable. The theme of World Menstrual Hygiene Day 2022 is "to create a world where no woman or girl is held back because they menstruate by 2030"

LITERATURE REVIEW

1. Universal declaration of human rights instrument
2. International journal of collaborative research on Internal medicine and public health (2012) **www.standfordchildren.org**

RATIONALE OF THE PROPOSED PROJECT

Menstrual health and hygiene is a life course approach. And menstruation begins at adolescent girls aged 11 to 15. These adolescent girls in schools have lack of information, knowledge on menstrual health, hygiene and its management, and poor school environment and social support making menstruation a distress. Hence it is crucial to address their needs and educate them on menstrual health and its management and pay a way for their betterment of their menstrual health that will improve the ecosystem with the children as well as their overall health.

PROJECT SCOPE

1. Enabling the stakeholders to exercise collectively their responsibility to their own healthand right to education.
2. Involved the increasing of their individual and community autonomy over health and over the organization, the opportunities, knowledge and supportive structures that make health possible (CHC axioms - red book).
3. Adolescent students from government girls school for promotion of menstrual health and hygiene
4. School management committee
5. Enabling school parliament action

PROJECT TIMELINE: -

Sep -2022 to Nov 2022.

1. Ethical clearance
2. Meeting the community
3. Community action initiative
4. Community Engagement

COMMUNITY VOLUNTEERS

- Principal
- Teachers
- Students
- Sanitary staff

GOAL

1. Promotion of menstrual health and hygiene management
2. Covid preparedness
3. Promotion of healthy lifestyle practices

OBJECTIVES

1. 1.Awareness on menstrual health hygiene, and its management
2. 2.Proper disposal of sanitary napkins
3. 3.Preventive and promotive measures of pandemic

COMMUNITY CONTEXT

Adolescent girls from government girls higher secondary school, which is about 5 kms from my place, Mogappair East, Chennai. The major issue is inadequate toilet facilities and poor menstrual hygiene practices as addressed by the school principal. They hail from socially and economically backward communities with low information and knowledge about menstrual health and hygiene and use and disposal of sanitary napkins and sanitation measures.

STAKEHOLDERS

1. School
2. Principal
3. Teachers
4. Students
5. Sanitary staff

COMMUNITY BASED ACTION

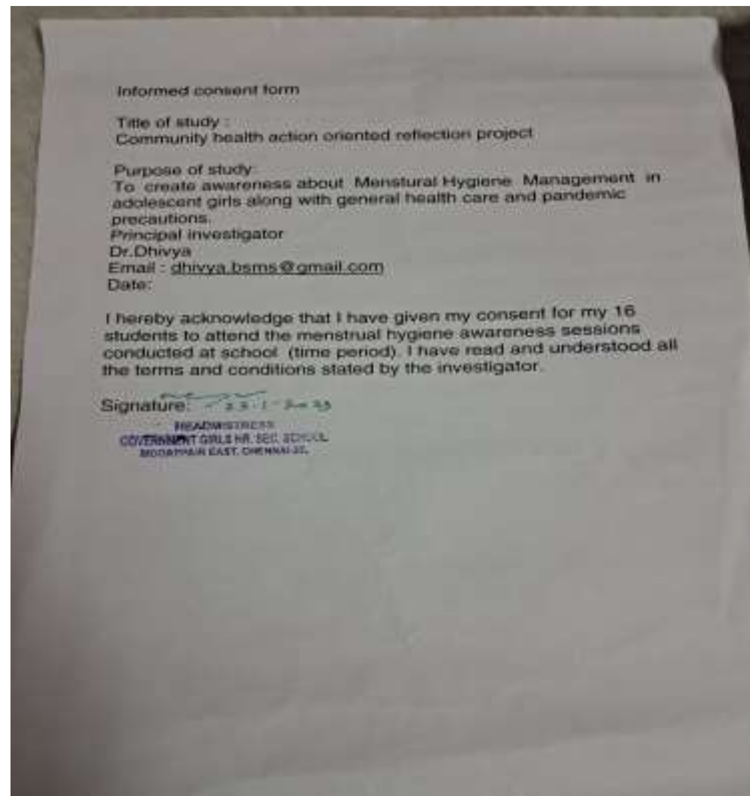
At the beginning, I approached the Principal for school promotion and health. After having a dialogue with the participant and school principal and teachers, I identified their needs. Their major concern was menstrual health and hygiene and poor hygiene practices and poor disposal of waste. In this way my learnings from CHLP were very useful indeed by understanding their needs and starting to initiate action as per their needs led by the principal and participants with community participation and involvement. A questionnaire method will be prepared assessing their knowledge on menstrual hygiene and management. Assessment sessions will be conducted and brief awareness will be given on menstrual hygiene, health, and practices for proper disposal. The participants will be monitored by the concerned teachers and the teachers will report to the school principal. The knowledge that they receive will be made to be spread to remaining school students too. The school would become a menstrual hygiene friendly school and the participants will lead.

Field based Ethical Considerations

Clearance from the Ethics Committee will be obtained.

Informed consent will be made.

CONSENT FORM



Informed consent form

Title of study :
Community health action oriented reflection project

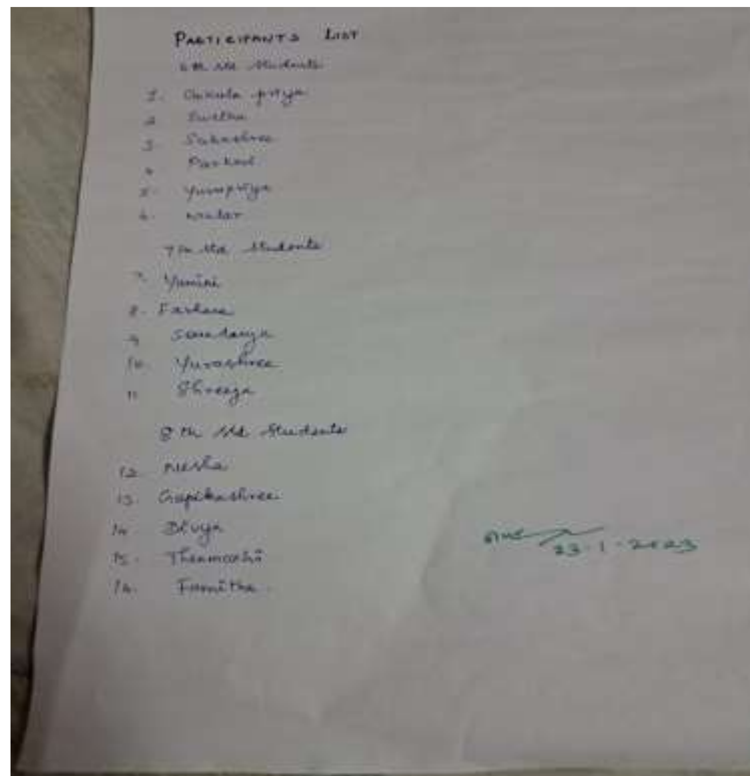
Purpose of study:
To create awareness about Menstural Hygiene Management in adolescent girls along with general health care and pandemic precautions.
Principal investigator
Dr.Dhivya
Email : dhivya.bsms@gmail.com
Date:

I hereby acknowledge that I have given my consent for my 16 students to attend the menstrual hygiene awareness sessions conducted at school (time period). I have read and understood all the terms and conditions stated by the investigator.

Signature: 23-1-2023

HEADMISTRESS
GOVERNMENT GIRLS HR. SEC. SCHOOL
MOGAPPAIR EAST, CHENNAI-37.

PARTICIPATION INFORMATION SHEET



PARTICIPANTS LIST

6th std students

1. [illegible] priya
2. Swetha
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]

7th std students

7. Yamini
8. Farhana
9. Soundarya
10. Yuvashree
11. Shreeya

8th std students

12. [illegible]
13. Gopikashree
14. Divya
15. Thenmozhi
16. [illegible]

23-1-2023

TRAINING MATERIALS

PRE-EVALUATION

QUESTIONNAIRE METHODS

1. Their Age
2. Age of start of periods / menses?
3. Do you have periods, for how many days and after how many days?
4. Any physical symptoms or mental symptoms during periods like headache, stomach pain, moodswings, cramps, anything else?
5. What absorbent material do you use during periods?
6. Were you informed prior to menarche before menses?
7. Do you have a toilet at school / home?
8. Do you change pads at school facilities?
9. How many pads do you change in 24 hrs
10. Any social taboos by parents / teachers during menses.?
11. Is there provision of water and sanitation facilities at school?
12. Is there a provision of hand washing soap at your school?
13. Do you wash hands after taking care of your menstrual hygiene at school / home?
14. Is there provision of emergency sanitary pads at school 16.. How do you dispose of sanitary pads in school / home? 17.. Is there provision of emergency sanitary pads at school?
15. Do you get support from school during your periods?
16. Do you have access to sanitary napkins near your home.?
17. Do you have a private place to wash / dry and dispose of sanitary napkins at home?
18. Have you been sensitized in the school regarding periods? 22.Do you know how to manage period pains?
19. Do you know what is meant by menstruation and menstrual cycle / which organ blood comesfrom?
20. Any embarrassing self-accounts during menstrual periods in school?
21. Do you know about healthy food habits and the ill effects of junk and packed foods?

OBSERVATION

Aggressive behaviour

Improper usage of amenities provided.

Menstrual Hygiene

- Change Sanitary napkin every 4-6 hours.
- Wash your undergarments properly.
- Discard the sanitary napkin properly and environment tally friendly manner.
- Do not hesitate in discussing it.
- Keep yourself clean.
- Use sanitization products such as pads
- Access toilet with clean water

Snake and ladder games

Handwash and Sanitization

Training Videos:

POST EVALUATION

1. The participants actively participated in the sessions by asking doubts regarding menstruation and general health.
2. Due to developed knowledge they made charts related to menstrual hygiene and sanitation and placed it near their toilets and soap and sanitation area to be noticed by all.
3. They also discussed with other classmates, friends and parents regarding the sessions.
4. They obtained proper knowledge about MHM (Menstrual Health Management) and itsimpact on general health.
5. A WhatsApp was created by the students itself in which they posted the healthy recipes taught in sessions. This group is common to parents and students. Due to trust, few parents came forward to ask their doubts regarding general health issues.
6. The participant who was suffering from anemia followed the instructions given and had her regular periods with normal flow for the last 2 months. And she ensured to follow them regularly.
7. The participants will take the lead role now for proper disposal and enable others in their school and the process will continue monitoring support from their teachers and school principal. I will be meeting them once a month to ensure students' implementation of menstrual hygiene.

HEALTH AND HYGIENE
EARTHWORM CLUB
THINK ABOUT THE
POOR BEFORE YOU
WASTE THE FOOD

USE THE
BIN
TO PUT WASTE

CLOSE THE TAP
CORRECTLY &
SLOWLY
ARTHWORMS CLUB
HEALTHY & HYGIENE

GALLERY

CANDLE GAZING:

YOGA SESSION:

FOOD and NUTRITION

HERBAL DECOCTION

DANCE ACTIVITY

DEMO ON SANITARY NAPKINS DISPOSAL

Shot on Y15
Vivo AI camera

Home Gardening

Community Health Poem

Health for all
Happens to all
Be the change
You want to change

Health is Right -
Rise your voice
Health is Complex -
Make it surplus
Health is Public -
Join hands together
Health is Diverse -
Reach the unreached
Health is fundamental - Prove its credential
Health is politics - Analyse Critiques
Health is Demand -
Be it a Domain

Health for all happens to all .

Health is determinants - Vibing with the community
Health is Sustainable-
State its reliable
Health is Goal -
Empathise the soul
Health is justice -
A way to consciousness
Health is well-being -
Provoke Inward feelings
Health is a feast
Celebrate at its feet

Health for all
Happens to all .
Being the change
A Social Change .