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Community Health Learning Programme

A Report on the Community Health Learning Experience

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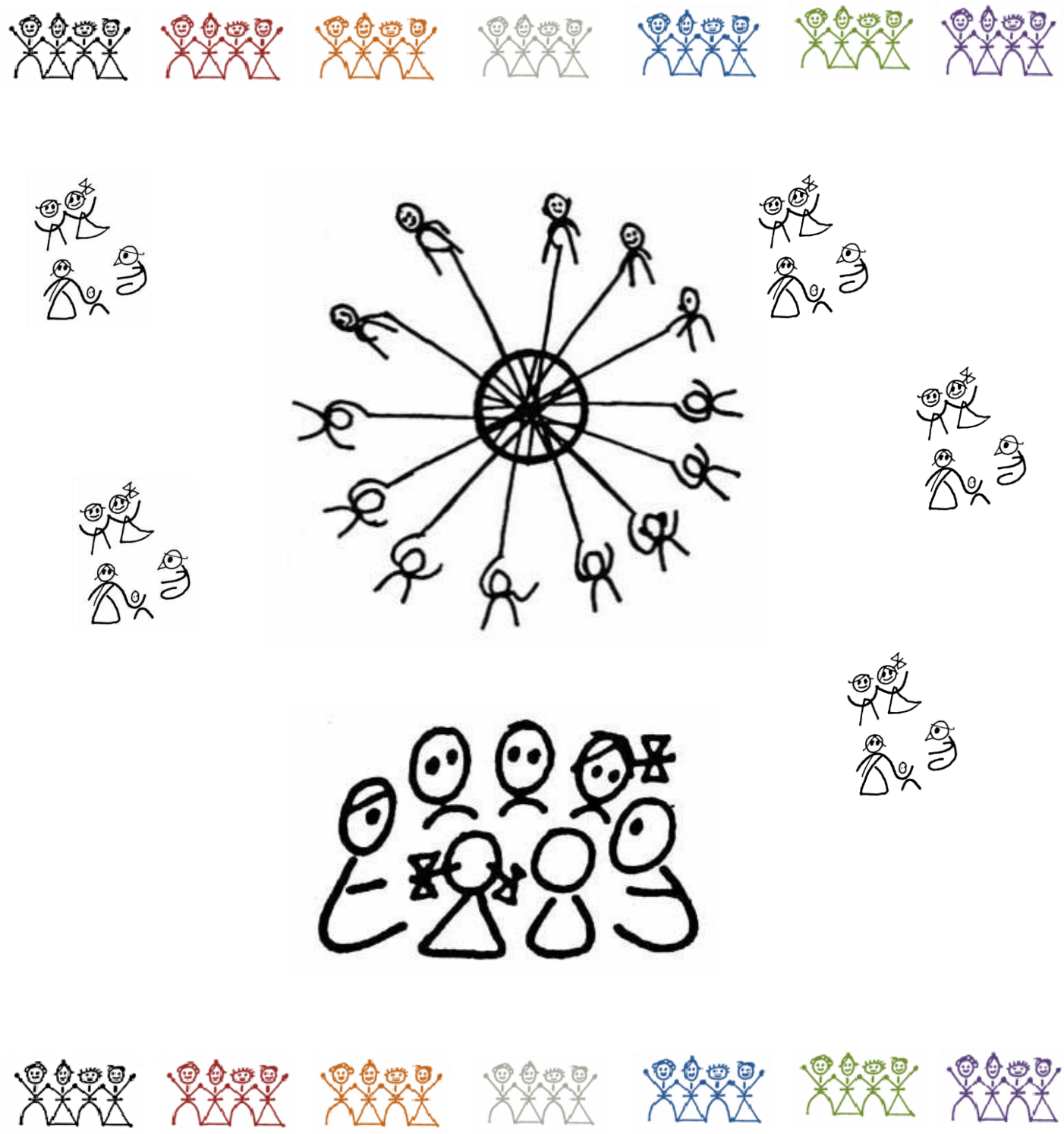

sochara
building community health

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PART- A

CHLP LEARNING

1. WHY DID I JOIN THE FELLOWSHIP?

I am a Public Health Dentist who has been working towards Public Health problems using the Public Health Approach. One of our Post Graduate Alumni forwarded to me the details of the Community Health Learning Program(CHLP) of the Society for Community Health Awareness, Research and Action(SOCHARA). She had also recommended it as a good program.

I was initially sceptical about enrolling for the course. But when I went through the work of SOCHARA and details of what this fellowship had to offer, I realized that getting an opportunity to be a part of this fellowship would be a real eye-opener for me, my Learning process and my work.

I felt that this fellowship would enable me to transition from the public health approach to the community health approach for public health problems with the involvement of the community and other stakeholders.

I felt that being a student of SOCHARA will help me to learn from their community health practices. This program will empower me to explore the social determinants of health based on community needs and experiences. It has also allowed me to interact and learn from others' rich experiences and practices as the other participants come from diverse backgrounds working towards the common goal of health for all.

2. WHAT WERE MY LEARNING OBJECTIVES AND WERE THEY MET?

My Learning Objectives:

By the end of this programme, I wanted to acquire knowledge and develop the skills to Capacitate the communities to plan and implement oral health promotional activities

My Strategies to achieve the learning objectives included:

Identifying the oral health needs of the community and barriers to oral health care in the community

Identify and train some of the community members to carry out oral health promotional activities in their community

My Area of Interest was:

Oral Health promotion

Were the Learning Objectives Met?

Yes, the modules and the community health action project empowered me in achieving my learning objective.

3. LEARNING FROM MODULES AND HOW I APPLIED THE LEARNING

The modules comprised of various aspects of community based action approach. This was a new learning process for me and initially it was difficult for me to understand the distinction between public health approach and community based action approach. The modules comprising of educative videos, live interactive sessions, reading materials on various topics helped me understand the theory and practice of community based action approach.

REFLECTIONS ON SOME OF THE MODULES:

REFLECTIONS: MODULE 2: UNDERSTANDING COMMUNITY HEALTH

This module introduced us to the Community Health Approach to solving public health problems.

The key principles of the Community Health Approach and the Axioms of Community Health were explained in this module with practical illustrations, to facilitate better understanding.

The Axioms of Community Health were explained with the example of the Adivasi Tribal population of Gudaluru.

Axiom 1: Rights and Responsibilities

The community exercises their responsibility to attain good health and demands health as its right. People need to understand that health is their right and they need to demand collectively for it. Without the active participation of the community, any healthcare system is bound to fail. It is the momentum which keeps the health care system in motion. As explained, in the example of the Adivasi Tribal population, the Health Animators meet and the Anti liquor demonstrations are examples of people coming together to ask for their rights. As evidenced in the video about the Tribal population,

it has been told that initially the tribal people were scared to look at other people or venture out, but gradually they started to fight for their rights.

Axiom 2: Autonomy over Health

The community health approach believes in capacitating people and the communities in making their own informed decisions about their health and healthcare. It involves community participation and improved accessibility, affordability, adaptability and availability of health care services.

Axiom 3: Integration of health and development activities

For better community health, it is better to have intersectoral coordination with different sectors like education etc. Improving education, providing job opportunities, marketing products manufactured by the Tribal population and making them self-reliant is also necessary.

Axiom 4: Decentralized Democracy at the community level

There should be integration between the community and the health sectors. There should be no hierarchy in accessing healthcare. The Community Health approach should be a people-building, people empowering and people participating activity.

Axiom 5: Building equity and empowering community beyond the social conflicts

There is usually a social hierarchy which exists in a community, which will prevent full participation in health care by a community. It is essential that such a social hierarchy must be removed and people of different social groups must participate together to achieve health.

Axiom 6: Promoting and enhancing the sense of community

Various social, religious, cultural and political differences divide the society at large. Various cultural events, gatherings or confrontation with other entities brings unity among people of a given area and brings a sense of WE feel.

Axiom 7: Confronting the Biomedical model with new attitudes, skills and approaches

Using locally relevant resources should be used and the social dimensions of health should also be explored

Axiom 8: Confronting the existing superstructure of Medical/healthcare to be more people and community-oriented

The people from the community should be trained to provide or promote Healthcare in the community. For example, Tribal Animators or traditional healthcare workers could be the messengers of health-promoting activities.

Axiom 9: New vision of health and healthcare and not a professional package of actions

Community Health Approach is not just a speciality or just a new discipline. It is a new perspective of healthcare, less technical and considers the social determinants of health and believes in reaching out to the community. It is made by the People, For the People.

Axiom 10: Effort to build a system where Health For All becomes a reality

Community Health Approach tends to build a new system where Health For All becomes a reality. It believes in removing the barriers to access health for all. They are the means to achieve health and not the end, hence they are flexible enough to be modified or reorient.

The community health approach believes that as the determinant of disease is mainly economic and social, its remedies should also be economic and social. (Prof. Geoffrey Rose, 1992)

The key principles of the Community Health Approach involve:

1. **Community Participation**

Community participation is an important component of a healthcare system without which healthcare services will fail. Community-led action and empowering the community to take leadership in health matters are essential. Bare Foot Doctors in China and Village Health Guides in India are classic examples of improving community participation.

2. **Community Health Workers**

Village health committed and voluntary health workers from the community itself are needed who neer suitable training. Accredited Social Health Activist (ASHA) workers help to promote access to improved healthcare at the household level.

3. **Deepening Democracy**

A fully democratic process is required for achieving Health For All. A Decentralized Democracy at the community level should be built, with equal representation from all the sections of the community without any social hierarchy.

4. **Equal stakeholders- power shifting**

Communities Should be involved in the designing, staffing and functioning of the local Primary Health Centre.

5. **Health as a right**

People have the right to participate individually and collectively in the planning and implementation of healthcare services.

Reflections on the Community Health Programmes of SOCHARA with the Community Health Approaches (Group exercise)

TRAINING COMMUNITY HEALTH WORKERS

"No permanent improvement of public health can be achieved without

the active participation of the people in the local health programme... (Bhore Committee, 1946)

• 1997 to 2001 -Jan Swasthya Rakshak Scheme and Its Evaluation

• 2001 – 2005 - The Mitanins of Chhattisgarh

• 2007 - CHW - Pedagogy and Practice

Community participation was improved by training unemployed rural youth, the healthcare workers

• Community Healthcare workers were trained to improve access to healthcare

• A people-centred paradigm for health and development was promoted, envisioned through a community health movement and a community health approach to public health problems

COMMUNITY MONITORING – COMMUNITY ACTION FOR HEALTH IN TAMILNADU

• This project addresses Community Participation, Training of Community Health Workers and also the formation of village-level committees.

• It also addresses the principle of Deepening Democracy, Equal stakeholders and Health as a Right.

• Here people are actively participating individually and collectively in the planning and implementation of healthcare.

DISASTER RESPONSE

• Over the years SOCHARA has responded to a range of disasters in South Asia and it can be seen that Health is a political struggle.

• Here we can see that Efforts toward policy changes were taken

• Community participation was improved by preparing volunteers before heading for a disaster response

• Community Healthcare workers' training was also carried out for Disaster response

ENVIRONMENTAL AND OCCUPATIONAL HEALTH

• In SOCHARA's response to Environmental and occupational health we can see that the challenges were met by an interplay of various principles of Community Health Approach

• Action undertaken by the team led to experiences in participatory research, lay epidemiology, policy advocacy, health promotion, communication, networking, capacity building, multi-stakeholder dialogue, governance, legal and ethical issues and the challenges of representing the voice of the people

CONTROL OF VECTOR-BORNE DISEASES

• In their action for Control of Vector-Borne Diseases we can see that Community Participation was improved, Deepening of Democracy was seen, and Health was seen as a right.

• The community was encouraged to participate, they were trained and empowered and capacity building was carried out

IMPROVEMENT IN SANITATION

• SOCHARA has tried to improve community participation in rural areas of Karnataka by conducting training through "Community-Led Total The sanitation" method is a process of facilitating participatory

exercises using different tools

PREVENTION AND CONTROL OF SUBSTANCE ABUSE

• SOCHARA has worked towards policy issues, which highlights that health is a political struggle.

• Students of schools and colleges and street children have been involved in controlling and preventing substance abuse as they are a vulnerable population. This approach helps in improving community participation and making them realise that Health is a right and they can contribute to achieving the given health objective.

URBAN HEALTH

• SOCHARA has been involved with urban health work since its inception

• They have worked towards improving community participation, training of community health workers and working towards implementation of health policies.

CONCLUSION

• In conclusion, it is evident that SOCHARA has adopted the Community Health Approach in tackling various issues affecting the public.

• Community is an active participant in their approaches to health.

• Various educational, training and policy actions have been undertaken by the organisation

REFLECTIONS: MODULE 2: UNDERSTANDING COMMUNITY HEALTH – PART II

In module 2 of understanding Community Health, the Social- Economic- Political - Cultural- Ecological Determinants of health were discussed in detail. The interconnectivity of various Determinants in causing a given health Problem was reflected. The Determinants for Covid-19 and the food crisis were also discussed. Controlling the determinant which caused most of the health issues would lead to the maximum resolution of the problem. Priority was given to the liberalization of health services by removing all barriers rather than equity. Special mention was made of the nutcracker effect where a top-down and a bottom-up approach with the involvement of different stakeholders and sectors was essential for achieving Health For All.

The videos on Community Health Approach to COVID-19 and the Sanghamitra Project highlighted the importance of the involvement of the community for the successful implementation of any health program. The work of the grassroots level primary healthcare workers was highlighted. How community participation plays a vital role in providing momentum to the health programs was explicitly shown.

In my field of work, we regularly see that certain target populations like rural populations, elderly people, migrant workers, and slum dwellers face a lot of barriers in accessing oral health care. It could be accessibility issues, affordability issues, or awareness issues. Learning about the SEPCE Determinants of health will enable me to apply them to public health problems, analyse the problem and formulate sustainable solutions to the same.

I have been a part of activities where we have trained ASHA workers, Anganwadi workers and school teachers to be channels/leaders of change to promote oral health and to work towards Tobacco Control, in the communities where they live and work with. It is essential to Assess the barriers they would have faced in the implementation of the same which has not been analyzed. This module will guide me towards the planning and implementation of future programs so that suitable modifications can be made based on the needs of the community and for better involvement of the community.

We had an assignment of reflecting on THE COVID-19 CRISIS AND PEOPLE'S RIGHT TO FOOD using SEPCE determinants. The Reflections of the assignment are as follows:

- The COVID-19 crisis in India and the impending Lockdown brought to the limelight, above all other issues people's struggle to satisfy their basic necessity of life –"FOOD".
- Every individual has the right to food.
- It is a component of the physiological needs forming the base of the pyramid, in the hierarchy of needs.
- A statement commonly heard was "Forget COVID – We will die of hunger."
- A vast number of migrants in the country feared death from Hunger than Death from Disease (COVID-19).
- In the COVID-19 crisis and people's right to food, the SEPCE Determinants were as follows:

SOCIAL DETERMINANTS include:

Lack of education, lack of employment, lack of assets, Migration, Seasonal work and income, Poor work and living conditions, Delay/loss/non-payment of wages, lack of access to relief, Poor health and lack of access to health, Identity issues, Many families members to feed and support.

ECONOMIC DETERMINANTS include:

Lack of education, lack of employment, lack of assets, Seasonal work and income, Delay/loss/non-payment of wages, poor health and lack of access to health, Poor living conditions, and No Bank account.

POLITICAL DETERMINANTS include:

Ration card issues/Non-portability, Non-linking of Aadhaar and Bank, Lack of Transport,

Lack of good PDS, Lack of access to health care, Lack of workplace regulation and monitoring.

CULTURAL DETERMINANTS include:

Lack of education, Migration, Exploitation, Poor living conditions, and Male dominance.

ECOLOGICAL DETERMINANTS include:

Seasonal Income, Seasonal Employment, Poor Living Conditions, No assets, Poor health and healthcare access

COVID-19 and the food crisis were just an eye-opener to the already prevalent conditions of the migrants in the country. Liberalisation and the nutcracker effect are required for sustainable changes to take place.

REFLECTIONS: MODULE 4- RIGHT TO HEALTH AND ACCESS TO HEALTH CARE

The right to health is a fundamental human right. The World Health Organization has always upheld this right to health. Health has been defined as a state of complete physical, mental and social well-being and not merely the absence of disease. Several countries have ratified the same. Many countries have adopted the right to health within the constitutional framework of the country. Until and unless the right to health is adapted to each country's constitution, it may not be enforced in the country.

Systematic planning has been carried out for healthcare services delivery in India since the formation of the Bhore Committee, but the right to health is not a part of our constitutional framework. There is no explicit mention within the constitution, though it has been considered an integral part of Article 21 of the Constitution, which upholds the "Right to Life". Time and again the Judiciary system of the country has upheld that the Right to Health is a part of the Right to Life and the States should take responsibility for the same.

Repeatedly the loopholes in the healthcare system of the country have been obvious to us, but the COVID-19 pandemic bared the inadequacies of the healthcare services in providing Health For All. We have seen people struggle for the treatment of emergencies, and people not able to get treatment for other infectious or chronic diseases. We have seen the horrors of the struggle for a bed for treatment, lack of oxygen and ventilators, and the never-ending inflating health care costs pushing the already poor people into the abyss of no return.

India lacks the healthcare workforce and healthcare facilities and infrastructure. There is a lack of community-oriented training for physicians. It is people going in search of accessible and affordable healthcare rather than healthcare coming to people's doorsteps. For people already living in poverty, accessing healthcare is a loss of work hours and wages for their bare minimum necessities. Though there are a lot of Government schemes available, many eligible people are not aware of such services and many more are ineligible for want of documentation like Aadhaar, Ration card etc. The Government health services/schemes are not functioning effectively for varied reasons. The private health sectors which work in coordination with Government health sectors are not always cooperative towards the implementation of Government schemes for the needy due to reasons such as the non-release of funds by the government, as these sectors work for a profit.

When it comes to the middle-income group, they are the worst affected when it comes to accessing healthcare in case they have not enrolled on any health insurance schemes, as is the case with the majority of the population of the country. The health care costs are expensive and they aren't eligible for many of the government health schemes. Solving a health problem is usually catastrophic to such families.

As health is a basic right of every individual, health care should be accessible and affordable for all without discrimination based on gender, caste, region, religion or socioeconomic status.

REFLECTIONS: MODULE 9- HEALTH SYSTEMS IN INDIA

India is the second most populous country in the world and the healthcare system is overburdened as the healthcare system is insufficient to meet the needs of the growing population.

This imposes a set of health challenges unique to the country.

India's Healthcare comprises of Primary, Secondary and Tertiary Healthcare.

The Healthcare system should focus on the local health conditions, provide sustainable solutions which are accessible, affordable, acceptable and suitable to the local needs.

Continuous evaluation and suitable modifications are necessary.

Here is a reflection on the country's Healthcare Delivery:

LEADERSHIP AND GOVERNANCE

STRENGTH

- Good number of health policies, programs and services
- Commitment to enhance budget for health.

WEAKNESS

- Poor enforcement of health policies, programs, services
- Lack of awareness about the facilities available
- GAP in situation analysis and policy implementation
- More out of pocket expenditure
- Inequity
- Schemes not working effectively – claims not paid

OPPORTUNITIES

- Commitment of the government to improve the present situation

- Policy of the government towards decentralization presents the potential for bringing about the desired changes

CHALLENGES

- Lack of Faith in people in the existing healthcare system
- Political interference

HEALTH WORKFORCE

STRENGTH

- Continuous increase in number of doctors and other medical professionals
- Very large workforce of volunteers
- Good number of oncologists in the country

WEAKNESS

- Lack of skilled workforce
- Shortage of manpower
- Skewed distribution
- Lack of long term retention of workforce
- Rural shortage of staff
- There is shortage of surgeons, gynaecologist, physicians and pediatrician in rural India where 60% of population reside.
- There is a shortfall of specialists at CHCS
- Shortage of trained Paramedics
- Majority of oncologists are in rural areas, hence there is a shortage in rural areas.
- The WHO recommended Doctor to Patient ratio is 1:1,000 but in India it is 1:1,511.
- The WHO recommended Nurse to Patient ratio is 1:300 but in India it is 1:670
- Healthcare workers suffer from stress and burnout.

- The staff are Overburdened

OPPORTUNITIES

- Large employable population
- Large number of Medical colleges
- Posting Undergraduates and Postgraduates in Government sectors
- Reorientation of Medical Education
- Support local Healthcare Workers and provide suitable incentives

CHALLENGES

- Private sector, which is lucrative is very inviting for the medical and allied health workers
- Private practice
- Overburdened staff

INFORMATION

STRENGTH

- Rising health awareness among some population groups
- WEAKNESS
- Lack of updated guidelines and training to the health care workers
- Lack of information about Healthcare services available

OPPORTUNITIES

- Create Awareness about prevention of diseases, hygiene, Government schemes, services and policies
- Reorientation of medical education
- Updated and Regular Training for Healthcare Workers
- Utilize technological advances for awareness

CHALLENGES

- Reaching out to the hard to reach population

FINANCING

STRENGTH

- Presence of a large network of all kinds of banks, financial institutions, life and general (including medical) insurance companies
- Commitment to enhance budget for health by Government
- There are several Government backed schemes

WEAKNESS

- High out-of-pocket expenditure
- Low budget allocation/inadequate public spending on health
- Failure of states to utilize funds
- Low insurance coverage
- Problems of tracking in schemes for utilisation
- Ineffective auditing
- Inequities
- Lack of Resources
- The Government schemes are not functioning effectively, only 65% claims are paid.

OPPORTUNITIES

- Availability of funds
- Opportunity for states to spend
- Government should spend more on healthcare
- Integrate with NGOs, Private Sectors and other agencies working towards public health
- Rising importance of health insurance

CHALLENGES

- Corruption
- Neglect
- Expenditure for private Hospitals are more among people

MEDICAL PRODUCTS, VACCINE AND TECHNOLOGY

STRENGTH

- World class medical technology, equipment's and facilities
- Domestic Production of generics at low cost
- Domestic capability to manufacture most medicines

WEAKNESS

- Inequitable distribution
- Poor Supply
- Difficult to co-ordinate and regulate the pharmaceutical sector

OPPORTUNITIES

- Increasing domestic market for production of devices, diagnostics, technology and equipment
- Increasing domestic focus on generics
- High demand for drugs
- Rising purchasing power
- Untapped potential of the rural markets
- Reset research agenda and involve medical colleges, private practitioners and Government Doctors

CHALLENGES

- Lack of faith in local products/technology

- Ethical issues

INFRASTRUCTURE

STRENGTH

- Emergence of number of hospitals and facilities
- There is continuous increase in number of hospitals, diagnostic centres, doctors and other medical professionals
- Numerous medical colleges

WEAKNESS

- Inequitable distribution
- Problem of supporting infrastructure like road, transport, power, water etc
- Inadequate number of hospitals
- Poor maintenance
- In India, 60% of hospital beds are in Private sector
- WHO recommends 5 beds for 1000 people, India has 1.4 beds for 1000 people while the Government sector has 0.5 beds for 1000 people.
- There is a shortfall of Sub centres by 23%, Primary Health Centres by 28% and Community Health Centres by 37%

OPPORTUNITIES

- Large number of Medical colleges
- Healthcare services should be accessible in Medical colleges
- Medical Colleges should be based on requirement of the District
- District Hospitals should be strengthened

CHALLENGES

- Lack of resources

- Medical colleges focus mostly on needs of education rather than needs of healthcare services

HEALTH SERVICE DELIVERY

STRENGTH

- Elaborate and functional structure and system

WEAKNESS

- Not meeting the Growing Demand for quality in healthcare
- Lack of inter-sectoral coordination and convergence
- Unregulated commercialisation
- Lack of monitoring and evaluation
- Lack of Data
- Inequity
- Not accessible
- Mental health is neglected
- Focus is more on curative less on Preventive care

OPPORTUNITIES

- Massive domestic demand for healthcare services
- Many involved departments, if coordinated, can help achieve better health
- Must be made appropriate, accessible and affordable
- Equitable distribution
- Planning to attend to the Gaps observed in healthcare delivery
- Should focus on prevalent public health conditions on tests and treatment which are more cost effective and locally available.

CHALLENGES

- Political interference
- Redefinition may face pressure from Professional bodies, regulatory agencies, corporate hospitals and pharmaceuticals

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REFLECTIONS: MODULE 10- PLURALISM IN HEALTH CARE IN INDIA - ROLE OF LOCAL HEALTH TRADITIONS AND AYUSH

Pluralism is the use of more than one healthcare system for the treatment of illnesses. Pluralism has been very common in Healthcare in India since ancient times. It might be prevalent due to the limitations of the allopathy-based health system like inadequate mainstream health infrastructure, lack of manpower, lack of resources, lack of access and quality of care. Pluralism comprises multiple views of efficacy, cure and care. The presence of Indian systems of medicine are generated and sustained due to the lived experience of the people, the local needs and availability of resources. In India there are codified and non-codified systems of Traditional medicine. The existence of pluralism suggests the need to develop an integrated approach for healthcare services.

Integrated Systems of Medicines were included in the National Rural Health Mission launched in 2005. Later, in 2014, a separate Ministry of AYUSH was instituted. The National Health Policy 2017, had pluralism as one of the ten core principles of Indian health systems.

It is essential to increase validation, evidence and research of the different health care systems practised in our country. It is also essential to reach a common ground where practitioners of each system of medicine are sensitised and they understand the other healthcare systems to enable effective care for the patient. There should be an enabling environment for the practice of different systems of medicine, an enabling regulatory framework and cross referrals across these systems with increased access to health care for patients. Health is not just the absence of disease, but also includes physical, mental and social wellbeing. The Traditional systems of medicine in India includes the social

component and the cultural context in patient care. More often, in India, People depend on Traditional medicine for their healthcare needs as it is accessible, affordable, comprehensible and culturally appropriate.

Literature suggests that, in India, traditional medical disciplines have also been used in the management of oral diseases. It treats a patient as a whole, not as a group of individual parts. They are also materials which are readily available to people. But among them only a negligible percentage of herbal plant extracts are used in routine clinical dental practice and rest of others are not practised because not much is known about their efficacy, effectiveness and toxicity. The lack of evidence has been a challenge to recommend the use of Traditional medicine. Hence efforts should be focused to encourage research to build evidence for the effective use of Traditional Medicine.

The Disadvantages of medical pluralism is lack of scientific evidence, concerns about safety, efficacy and quality of medicines available, lack of updation. These can be overcome by promoting education, research, scientific evidence and practice of traditional systems of medicine and having a strong regulatory authority to oversee the training, research, implementation and production of drugs required for the practice of traditional medicine.

In a country like India where there are deficiencies in the healthcare system delivery, traditional systems of Medicine can play an important role. Traditional medicine can make significant contributions for effective pluralistic health care. If the need to support

medical pluralism is appreciated and work towards this is initiated, it will be able to address many healthcare needs of the population.

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REFLECTIONS: MODULE 11- UNIVERSAL HEALTHCARE AND UNIVERSAL HEALTH COVERAGE

Universal health coverage (UHC) means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

Majority in the world do not receive the health services sought. A lot of people are pushed into extreme poverty due to out of pocket healthcare expenditure, especially in India. India's commitment towards achieving UHC is clearly reflected in policies and institutional mechanisms, which are directed towards increasing coverage and access to health services. India has launched *Ayushman Bharat* - one of the most ambitious health missions ever to achieve UHC. *Ayushman Bharat* encompasses two complementary schemes, Health and Wellness Centres and National Health Protection Scheme. Health and Wellness Centres are envisioned as a foundation of the health system to provide comprehensive primary care, free essential drugs and diagnostic services, whereas National Health Protection Scheme is envisaged to provide financial risk protection to poor and vulnerable families arising out of secondary and tertiary care hospitalisation to the tune of five lakh rupees per family per year.

The World Health Organization (WHO) has identified four key financing strategies to achieve UHC - increasing taxation efficiency, increasing government budgets for health, innovation in financing for health and increasing development assistance for health. Unfortunately, all of these measures fall beyond the control of Ministries of

Health (MOH). Measuring progress towards UHC is equally important. The three core dimensions of UHC proposed by the WHO are "the proportion of a population covered by existing healthcare systems, the range of healthcare services available to a population, and the extent of financial risk protection available to local populations". In India there are equity concerns with regards to healthcare access and the contribution of public health expenditure is also low.

Healthcare needs are not only uncertain and unpredictable but also catastrophic to families living on the margins. Poor and vulnerable families not only spend money out-of-pocket (OOP) due to ill health but also have to suffer wage loss to seek healthcare. One of the reasons for the high rate of OOP expenditures is limited access to

With increased longevity, an epidemiological transition towards non-communicable diseases such as hypertension, diabetes, mental illnesses and other comorbidities is inevitable. These conditions require long-term care and are best managed through comprehensive primary care provided in an outpatient setting. Any health scheme favouring hospitalization alone over comprehensive outpatient care and coverage may not be an appropriate product for health needs of the society.

Health indicators have been gradually improving in India, but health for all is yet to be achieved. "Prevention of diseases" is a more cost-effective strategy than the popular approach of "Treatment."

According to experts, Universal Health Coverage requires adequate healthcare financing and human resources to provide financial protection to the underprivileged

by covering their medicine, diagnostics, and service costs. UHC strategies should enable everyone to access the services that address the most significant causes of disease and death. Moreover, it should ensure that the quality of those services is good enough to improve the health of the people who receive them.

REFLECTIONS ON THE DOCUMENTARY SICKO

It was very interesting to watch this documentary. It gives us a birds' eye view into the different types of Healthcare systems in different countries.

The healthcare system in the US relies basically on Health Insurance. Everyone needs to have Health Insurance. Not having Health Insurance is catastrophic for people falling ill or requiring emergency services as healthcare is very expensive. You may or may not get the healthcare you seek as you may not be able to afford it. Many People lacking Health Insurance die owing to Non-accessibility and Non-affordability to Healthcare services. The life of those having Health insurance is no better. You still have to shell out quite a lot of money out of pocket for health insurance as co-payments, and deductibles, especially if you are suffering from some chronic illnesses requiring frequent healthcare services. There is also the possibility that many may not be eligible for health insurance claims due to pre-existing conditions which may often be the case for many. Though there is quality healthcare available it is not accessible to a large number of people. Even those who volunteered their services to the nation and its people in times of great tragedy were denied healthcare at the expense of the Government.

On the other hand, through this movie, we have been exposed to Non-Profitable Healthcare services in UK, Cuba and Canada accessible and affordable to all irrespective of your nationality, financial conditions, age, citizenship, religion, region, political affiliations or socioeconomic conditions. No matter who you are, whatever your healthcare problems, you will be able to access and afford healthcare if you are in these Nations. The true essence of the Right to Health and Universal healthcare is realised. Available medicines at a basic cost if you can afford it and arrangements to provide medicines for free if you cannot afford it, is what was observed. Quality healthcare services were provided free of cost which would not otherwise be afforded by many. We could also see how Health-Related Quality of Life was also given priority. Every nation must strive together to achieve Universal health care.

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4. REFLECTIONS ON USE OF THE LMS, VIDEOS AND PARTICIPATION IN LIVE ONLINE SESSIONS.

The Learning Management System was very user friendly. Initially it was web based. Later, to help us to access it in our mobile devices, an app interface was used. This initiative from SOCHARA was well appreciated because we could access the LMS at our convenience. The LMS comprised of various modules with learning materials being uploaded on time, a few days before the live sessions. This was done to help facilitate more productive discussions during live sessions. The learning materials in each of the modules had videos, reading materials, and the recorded videos of the live sessions for the benefit of those who have missed out on the live sessions. Most of the live sessions were quite engaging and interactive.

5. HOW WAS A BALANCE BETWEEN WORK, LIFE AND THE CHLP MAINTAINED?

It was difficult for me to maintain the balance between work, life and CHLP, due to certain unanticipated family commitments. The facilitators at CHLP were very encouraging and helped to keep me motivated in my learning process of CHLP.

6. MENTORSHIP PROCESS AND REFLECTIONS

I had a great mentor in my learning process at CHLP. He has been very encouraging and has taken the time to discuss and make me understand Community Health Action Approach. He has helped me to understand its distinction from Public Health Approach. Through the discussions he has enabled me to orient towards understanding how empowering the community, to help take action towards their

health is more sustainable and effective than any other Top-Down method. He has also helped me to understand reflective writing.

My Project idea draft was initially not oriented towards the Community Health Action Approach. Through discussions and communications through mail, he has helped me to get a better picture of what exactly I need to do for a more sustainable health action plan. There has been a lag from my side in interacting enough number of times with my mentor.

7. PROJECT LEARNING EXPERIENCE

My project was on Exploring oral health promotion in Anganwadi Centres. This project helped me to understand the oral health needs of young children visiting the Anganwadi centres as perceived by the community and the barriers they face in accessing Oral health care. I was also able to carry out oral health promotional activities for the Anganwadi workers and the family members to empower them in taking care of their children's oral health. This project has enabled me to partly put community health approach to practice, though I still believe I have a long way to go in completely understanding and implementing the same.

8. TAKE AWAY FROM CHLP AND LOOKING AHEAD

I have been able to understand and apply Community health approach which I have learnt through Community Health Learning Programme.

I have been able to understand the community needs better through this course.

I am hoping to implement Community based health action in future projects taken up by me in my profession.

9. IMPACT OF COVID-19

Covid-19 had a major impact on me. It changed the way I thought, to the way I behaved. I had only read about discrimination and stigmatization. I did not realize that I would be a part of expressing discrimination and experiencing stigmatization due to a viral disease. Though in India, we have many more basic issues bigger than the impact of Covid-19, for at least 2 years, Covid-19 received all attention. I read stories of how humanity was all forgotten and also stories of people expressing humaneness even in their worst times. A complete lockdown, followed by harrowing stories of people infected or suspected as being infected, being isolated and allowed to die alone for the benefit of many had a grave psychological impact on me personally. The expenses for healthcare shelled out by patients towards hospitalisation for Covid-19 shocked me. If ever me or my dear ones required hospitalisation during the peaks of the pandemic, I did not know if we could manage to access or afford the overburdened healthcare facilities.

I lost a grandmother and aunt to Covid-19, where they had to die all alone in a hospital. In the first lockdown seeing a human being on the road or hearing the doorbell ring brought me panic. In the second lockdown, hearing the sirens of ambulance brought fear. Whenever I sat alone, I spent it in feeling depressed about the unpredictable future. Family life got disrupted as well. It took time for all of us to come out of the isolation of our homes to being a social being once again. Though things are near normal, I do realise Covid-19 has left its mark psychologically.

I am Public Health Dentist, working as a faculty in the Dental Institute. For nearly two years' student learning was impacted, as majority of the learning was online. Theory could somehow be managed. Virtual or Online learning, definitely could not be a

replacement for clinical learning. The staff salary of our institute was also impacted. For half a year, both teaching and non-teaching faculty of our institute worked for half the salary. Patient care was compromised, as all public health activities carried out in the form of outreach programs had to come to a standstill due to the rules of lockdown. Patients who started visiting for their oral health care had to bear additional expenses for the PPE to be worn by the Doctors. Things on the professional front has now recovered.

Prior to Covid-19, I would never have preferred to learn anything online, as I strongly believed that face-to-face learning was the best form. Covid-19 has changed that thought process for me. I was able to join CHLP as they offered the course online, when it was most required. CHLP has managed to make online learning as engaging as possible, with interactive online sessions and user friendly Learning Management system.

PART- B

COMMUNITY-BASED HEALTH ACTION-REFLECTION PROJECT

TITLE

EXPLORING ORAL HEALTH PROMOTION IN ANGANWADI CENTRES

BACKGROUND

The Integrated Child Development Scheme (ICDS) is a comprehensive and multidimensional program in India especially for young children for their early childhood development.[1] Services are delivered at community levels for children below six years of age, pregnant women and nursing mothers. It provides services like, pre-school formal education, health education, supplementary nutrition, referral services, immunization and health check-ups.[1,2,3,4,5] The Anganwadi workers have regular trainings on behaviour change communication and capacity building strategies along with health education.[2] The Anganwadi centres face lot of issues such as unlimited duties for Anganwadi workers, lack of community involvement and participation, irregular supervision and lack of competitive salaries.[6]

RATIONALE FOR THE PROPOSED PROJECT

Oral diseases like dental caries are serious public health problems especially among young children, which affect their overall health and quality of life.[1,2,3,5] The lack of available and affordable oral health services results in worsening of the oral health problems, and also increases the cost of treatment and care.[1,2,3] As the oral health and oral health behaviors of the child is set in the pre-school period, orientation of the

parents and family towards preventing dental disease and developing good oral health behaviors among their young children around this age, will be helpful in determining the person's oral health for many years to come.[1,2,5] Anganwadi workers are grass root workers responsible for early childhood education, development, health and well-being.[1,2,3,4] Educating and Empowering them and the communities they serve helps to provide oral health promotion to the community.[1,3,4,5]

The Operational Guidelines for Oral Health Care at Health and Wellness Centres given by the Ministry of Health and Family welfare states that Oral Health is an Integral part of General Health. The ASHA workers and Multipurpose workers must Co-ordinate with Anganwadis for ensuring daily tooth brushing among children by incorporating a toothbrushing rhyme/jingle in pre-school teaching at Anganwadi centres. The Dental Assistant/Hygienist must also coordinate with Anganwadis and must provide oral health education and preventive demonstrations wherever possible. Platforms such as Anganwadi centres should be utilized for conducting health promotion activities with regards to oral healthcare.[7] Thus the Anganwadis can play a major role in oral health promotion of children.

GOAL AND OBJECTIVES

Project Goal:

Promote Oral health among children attending Anganwadi Centres.

Project Objective:

- To understand the barriers faced by Anganwadi workers and the communities in promoting early childhood oral health.
- To understand the determinants for Early Childhood Oral Health.
- To empower the Anganwadi workers and Communities towards promotion of oral health of young children

DESCRIPTION OF THE IMPLEMENTATION OF THIS PROJECT

Five Anganwadi Centres were involved in the implementation of this project.

Mapping of stakeholders involved was carried out by having a discussion with the Anganwadi workers.

Discussions were carried out among the Anganwadi Supervisors, Anganwadi workers and with family members of children attending the Anganwadis to identify the felt needs in terms of children's oral health.

Discussions were carried out to discuss the oral health needs of young children, possible solutions to address the oral health issues.

Oral health Promotion of children was carried out with active involvement of family members and Anganwadi workers. Oral health awareness sessions were carried out for the parents and Anganwadi workers. IEC material on oral health promotion in the form of flipcharts and posters were provided to the Anganwadi centres. Discussion was held

with Anganwadi workers and family members to understand the barriers faced by them in accessing oral health care for children. Oral health screening was carried out for the children, family members and Anganwadi workers to help the community realize the normative needs. Referral for Treatment was provided to the Dental Institute.

PRINCIPLES OF COMMUNITY HEALTH ACTION APPROACH ADDRESSED BY THIS PROJECT:

- **Axioms of Community Health**

  Axiom 2: Autonomy over health

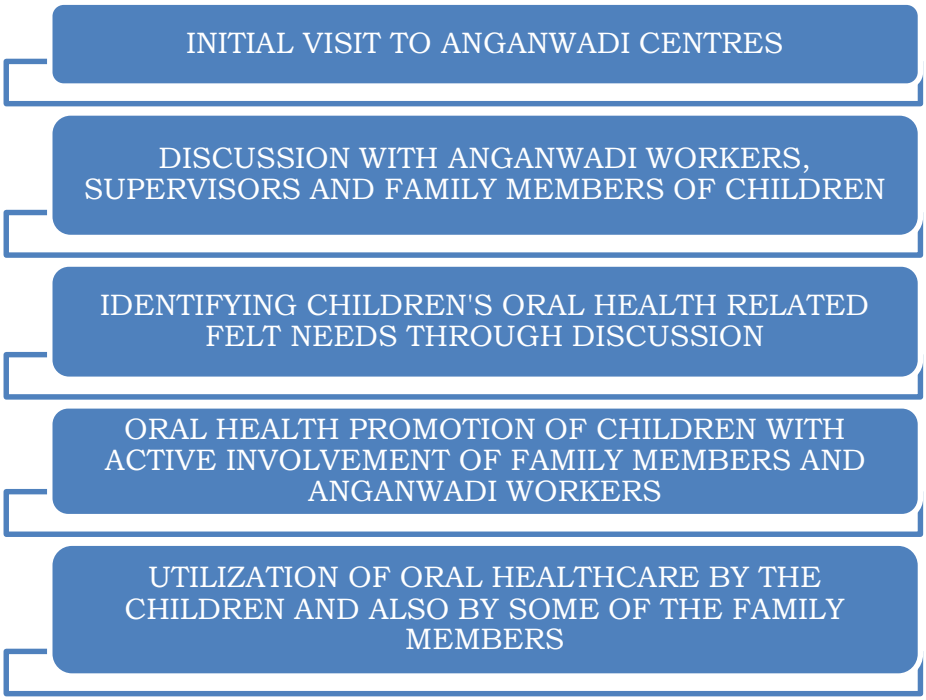
  Axiom 3: Integration of health and development activities

  Axiom 5: Empowerment of the community

THEMATIC AREAS OF THIS PROJECT:

- CHILDREN'S ORAL HEALTH

COMMUNITY BASED ACTION



IMPACT OF THE COMMUNITY HEALTH ACTION

It was observed that lot of parents utilised the oral healthcare services for themselves as well as for their children. Some of the parents even got into an active discussion on the oral hygiene care products, that should be utilised for their children, implying their concern regarding early childhood oral health. Anganwadi Supervisor of one of the Anganwadi centre, suggested that we should extend the oral health promotional activities to other Anganwadi Centres coming under her supervision.

LEARNING AND REFLECTION

This project was carried out for a period of three months and I have been able to involve 5 Anganwadi Centres, during this period.

I had conversations with Anganwadi Supervisors, Anganwadi workers and Family members to understand the oral health needs of children as perceived by the community, their understanding of early childhood oral health and the barriers faced in accessing oral healthcare for children.

My reflections from each of the Anganwadi centres are presented below.

Anganwadi centre 1:

The Anganwadi teacher is a resident of the same area. The Assistant comes from a place close by. I also met the Supervisor. She is the supervisor for around 25 Anganwadi centres in the area. She also had additional incharge duty of Supervising Anganwadi centres in another area. There are 25 students in the Anganwadi. There is a room for teaching the students which looks adequate for 25 students, room for cooking and storing food and a toilet.

They receive water supply from corporation and there is a tank for storing. They receive food materials on time delivered to the centre and have enough teaching materials. The children usually eat at around 11:30 AM at the Anganwadi centre and leave to their homes by afternoon.

When I visited the centre, some kids, the teacher and the helper were already there. The supervisor also reached there. At around 11:30AM the children were served a dish made from green gram to eat and milk to drink. The children's height and weight were also being assessed on the same day.

The Anganwadi supervisor also opined that most of the parents didn't want to cause distress or pain to their children in the name of Dental treatment. She also wanted similar programs in other Anganwadi centres that she supervises.

Anganwadi Centre 2:

The Anganwadi teacher travels every day from Pakshikere to Mullakad (around 20 kms). She has an assistant. There are 13 students in Anganwadi. There is a room for teaching the students which looks adequate for 13 students, room for cooking and storing food and a toilet.

They receive water supply from corporation and there is a tank for storing. They receive food materials on time delivered to the centre and have enough teaching materials. The children usually eat at around 11:00 AM at the Anganwadi centre and leave to their homes by afternoon.

When I visited the centre, some kids and the helper were already there. As the Anganwadi Teacher had to visit another centre for some administrative purpose and since she had to travel from far, she was a little late. At around 11AM the children were served a dish made from green gram to eat and milk to drink. Among the family members present, a Father of a child stayed through the entire day at the centre and he knew each and every child and their family background.

There was one child who used to brush his teeth twice daily. His mother said that the child insists on brushing his teeth in the morning before he eats anything and he never goes to sleep without brushing his teeth. The reason for this good behaviour is that, he

has an elder brother who follows the same routine. The father of the child insists on good oral health behaviors for the children. In the mother's words "My husband doesn't allow the children to sleep without brushing their teeth". The importance placed by the father towards good oral hygiene behaviors are reflected in the children. The child had good oral health, with no sign of Dental disease in his primary dentition.

In this Anganwadi centre, during the oral health screening, it was observed that one of the mother had significant pallor, indicative of anemia. I bought it to the notice of the mother. She said her haemoglobin was very low. She was not undergoing treatment for the same, though she did not express the reasons for the same. I suggested her to visit the nearest Primary health Centre or the Urban Training Health Centre of our Institute, whichever was convenient to her. Even the Anganwadi worker encouraged her to visit the health centre.

I also noticed a very young girl, who said she was 18 years old, but she was a mother of three kids. She stayed with the kids at the Anganwadi Centre and also ate a little of the children's food. She was from another district, who has shifted with her husband to Mangalore recently. Her husband has shifted here in search of work.

Anganwadi Centre-3:

The Anganwadi Teacher travels every day from Tannirbhavi to Marakada (around 11 kms), where her Anganwadi is situated using her two wheeler. She has an assistant. There are 30 students registered in the Anganwadi Centre and she usually has an average attendance of 22-25 students. There is a room for teaching the students, room for cooking and storing food and a toilet.

The room for teaching students looks small for 30 students. They receive water supply from corporation. They receive food materials on time, which are delivered to the centre and they have enough teaching materials. It appears that there is no appropriate space to place the teaching materials. The children usually have lunch at the Anganwadi centre and leave by 2pm to their homes, though the Anganwadi Teacher and helper have to work till 4 pm. Previously the Pregnant women used to visit the Anganwadi centre for prepared lunch. The Anganwadi Teacher said that, currently they need to make home visits in the afternoon. They have to deliver food materials to Pregnant women and new mothers.

The day I visited the centre, the Anganwadi Teacher was busy with work as she was getting the Aadhaar details of parents and community members for registration to Ayushman Bharath. The helper had to leave for a meeting. Hence the children left to home early on the day of our visit, as there was no food provided on that particular day to the children, as the Anganwadi Teacher had extra work and the helper also had to attend a meeting. It shows that the Anganwadi workers are burdened with lot of work.

The Anganwadi Teacher also said that most of them did not know the importance of maintaining good oral health in early childhood, especially deciduous teeth. She said that it is not just teeth, it is also difficult to convince some parents to get their child immunized on time as they did not want to cause unnecessary pain or suffering for the child.

Anganwadi Centres 4 and 5:

I met the Anganwadi workers and family members and children of two Anganwadi centres, which were close to each other. One Anganwadi centre had 20 children, another had 30 students. Both centres had adequate space for children, cooking, stores and toilet. One was functioning in a rented premise. They were getting food materials on time. They give eggs, boiled green gram and milk to kids. Many were children of daily wage workers and maids. The parents of the children often didn't have time to cater to their oral health needs due to their work priority. They often used to drop the kids to Anganwadis so that they could go about their everyday work without worrying about the children.

Reflections and Activities common to all Anganwadi Centres:

At all the Anganwadi centres, it was observed that the parents or grandparents reached the Centres at different time periods, though the Anganwadi Teacher had asked them all to come at the same time. This was owing to their family and work commitments.

I met the family members of the children, Anganwadi Supervisor, the Anganwadi Teacher and the helper.

I discussed with the family members regarding their children's oral health. Majority of them were brushing their children's teeth once daily. Most of the children were used to having sugary drinks, sweet and sticky food especially chocolates, in between meals. None of the parents had taken their children for a dental check-up as they felt oral health was not a priority especially for milk teeth as these teeth will eventually fall off and new teeth will replace them.

The importance of maintaining the children's oral health was explained to the family members and Anganwadi workers using an educational flipchart/poster prepared by me in the local language. There were mothers, fathers and some grandparents present. The role of family in promoting the oral health of the child was discussed. How certain Preventive behaviors and simple screening by parents could help prevent and control dental caries was explained. Some of the parents discussed about the oral hygiene aids that needs to be used for their children.

Oral health screening was carried out for the child and the family member present. Referral was provided to the Dental Institute for further care. The Anganwadi Teacher and the family members were taught to identify the early signs of Dental caries in children for early treatment.

The flipchart/Poster on Early childhood oral health promotion was given to the Anganwadi Teacher for her reference and for her to provide information to family members of the children.

Barriers faced

- Oral health was not a priority for many
- Lack of Importance to Primary dentition (Milk teeth) as they exfoliate and get replaced with permanent teeth
- Lack of time due to work and family commitments
- Lack of time among the Anganwadi workers to give priority to oral health promotion due to multiple work responsibilities.

PHOTOGRAPHS


CAMP


ಮಂಡಲ


BOX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