Report on the Training Fellowship at Community Health Cell

October 1, 2002 to April 21, 2003

By

Dr. Anant Bhan,
Community Health Cell,
367, Jakkasandra,
I Main, I Block,
Koramangala,
Bangalore – 560 034.
Phone Nos. 55 31 518 / 55 25 372
Email : sochara@vsnl.com
Website : www.sochara.org

Dr. Anant Bhan: anantbhan@sify.com

Background

I was born in Srinagar (J&K) and raised up in Madhya Pradesh where both of my parents were working. It was a very sheltered middle class upbringing. I completed my schooling in 1996 by which time I was interested in joining medicine and got through the All India Entrance Exam that brought me to BMC. I had not been to Bangalore before and was looking forward to college life as well as the city. The location of BMC was the first grounding factor- located in the midst of the bustling City Market area that has a mass of humanity at all times of the day, we were daily exposed to the vagaries of everyday life for the masses running around for daily survival. I also found the first year course outdated in many instances wherein we were made to pith frogs to tear them apart on the pretext of physiology practicals (interestingly, the instruments and the practices had not changed in many years). The dissection hall with its omnipresent formalin smell was also used by more of us as a discussion board than to study or learn.

It was during the early part of my second year that through some friends who were in the field of social work, I got in touch with some voluntary organizations on an informal basis. I would volunteer with them whenever possible- help the patients referred by them, collect drug samples for their clinics; visit their outreach areas etc. I was also on good terms with the community medicine dept. of my college, which ordinarily my classmates despised. I would participate in the programs that they conducted and interact with the faculty and postgraduates wherever possible.

By the time I started my internship, I had developed a liking for the field of community health and wanted to explore it. I had heard of Community Health Cell on a regular basis, it being one of the foremost health NGOs in the country and had interacted with the various team members at events like the JAA mobilization in 2000 and the World No Tobacco Day related activities.

At the end of the internship, I decided to spend six months with a voluntary organization to expand my knowledge and gain valuable hands on field experience. CHC was my first choice and Dr. Thelma, Coordinator, CHC was very supportive of my foray and agreed to let me work in CHC to help in this process. I joined CHC on October 1st 2002 as a result of this meeting.

Month 1: October 2002

The first day of work at CHC- I reported to the AO Mr. Gopinathan and met Dr. C.M. Francis who gave me an overview of the work that CHC was doing. I also met the various team members and discussed their areas of interest with them. I had a brief meeting with Dr. Ravi – I was already feeling at home with the warmth that everybody was exhibiting.

I started reading the journals 'Community Health: the search for an alternative process' and 'Health Action: the search for a new paradigm' that gave me an idea about the journey that had resulted in the birth of CHC. The process was quiet interesting though I could see that the academic world of Community Medicine had lost two good teachers when Drs. Ravi and Thelma had decided to leave SJMCH to start CHC. This was especially so because there was dearth of good teachers in the subject who could instill interest about community health in the minds of the medical students.

Dr. Ravi presented his experience at the INCLEN meeting at Trivandrum; that there was now an effort to network by the clinicians actively involved in epidemiology was interesting – hopefully they would not be exclusive towards research into clinical subjects and would collaborate with non-clinical specialists also to further the field of epidemiology; Dr. Ravi had come with an impression that the group was trying to some extent to do this.

I attended a workshop on 'The Joy of Parenting' conducted by Ms. Hema Srinivasan from the Kamaraj Balamandir Foundation at the St. Joseph's convent at Doddaballapur; the ease with which Ms. Hema mingled with the groups, which consisted of sangha women from the surrounding villages, was a pleasure to watch and the way she explained the concept using the local language and involving all the participants was interesting. Parenting was a skill that would benefit all members of society, as all of us needed care at some point of time or the other. (Appendix 1)

In the following week, Chander and I conducted a Tobacco Awareness session for about 250 students of the Catholic Pre-University College, Richmond Road. While speaking to large audiences was not new to me in any way, but the chance of using a session to impart health education, that too about a topic that affected these students directly was a challenge. We got a positive feedback form the students about the session and many of them explained that this had been an eye opener to them on the issue.

CHC had conducted a LSE training program for the students of Seva Sadan ITI College in the previous session. LSE was an area that I did not have much knowledge in. The opportunity to assist Dr. Mani Kalliath in conducting an evaluation in the subject helped me in getting an introduction to the subject and also in picking up valuable tips on the process involved in evaluation. I could also spend some time interacting with Dr. Mani and discuss about the field of public health. (Appendix 2)

A panel discussion had been organized on 'Pesticides and Health' at ISI in Benson Town. The panel discussed the disadvantages of the indiscriminate usage of pesticides that was prevailing and the deleterious health effects of the same. I found the heartfelt testimony of a farmer who had stopped using pesticides and was also trying to get the neighboring farmers to do the same the most important in the process because that was what the whole program needed to be geared towards - change at the level of the farmer through awareness to prevent further harm. As an old Indian proverb so succinctly puts it, 'The environment is not a gift from our parents but a loan from our children'.

Dr. Romy Quijano, a toxicologist from the Philippines who was part of the panel visited CHC the next day and shared his experiences including the hardships he had faced in advocating reduction in pesticide usage and the studies he had undertaken to link heath disorders with the pesticide usage in certain areas. His commitment to the cause was an inspiration and the knowledge gained valuable.

The beginning of the next week was also holiday season because of Ayudh Pooja and Vijayadashmi. Prof. Mark Nichter, a medical anthropologist from the University of Arizona had come down to Bangalore. He has had a lot of experience working in India especially in the coastal areas of Karnataka. Rajan and I visited him in his lodge in Majestic (he was staying in a simple room on the top floor which helped him, as he explained it, to keep a watch on the terraces of the neighboring buildings that were potential mosquito breeding sites). We spent almost a day with him as he shared his experience with us especially in the field of Malaria and Tobacco- it was food for thought and very interesting. We related the work of CHC in these fields and he expressed interest in collaborating with CHC. (Appendix 3)

At CHC, we were trying to for a network of NGOs working in the field of imparting education especially to the disadvantaged children so that we could work together for evolving Educational Strategies for Tobacco Control. As a part of this, we organized a meeting at INSA where the various related issues were discussed after presentations. All the organizations present expressed their interest in the area and committed to include the subject of awareness about Tobacco in their educational programs. (Appendix 4)

After the assessment of the previous batch had been completed, the CHC including Dr. Mani and me visited Seva Sadan to do a pre-course assessment of the new batch of students using a questionnaire method. After this, a meeting was held in CHC where the report of the previous program and the expectations in the upcoming course were discussed, a part of team building and sharing of strategies for the future sessions.

Ms. Shireen Haq from Nari Pokho, Bangladesh visited CHC in this period. Her account of the women's movement in Bangladesh and their struggle for getting rights of the women was moving. The indomitable courage exhibited by her and her colleagues in fighting the establishment and decadent social practices was also an inspiration.

I did some research for Drs. Ravi and Thelma's visit to Africa and this gave me the opportunity (with Dr. Ravi's guidance) to get an idea about international health, about the various indices used and about correlation of the health indicators of African countries with those of Indian states- a sort of homogeneity in the health status of populations across the Arabian Sea.

I attended a symposium on Leprosy Prevention, Control and Rehabilitation on 28th October 2002 organized at IMA where the importance of continued work in the field of Leprosy was brought out.

I also attended a 1 day national workshop on Medical, Legal & Economic Aspects of Road Traffic Accidents; the concerned experts spoke about the issues involved and the rising number of accidents; the workshop gave me a fresh perspective about the problem and the need for an all round effort to decrease the number of accidents which were causing deaths and disability on a large scale especially in the productive age group.

As a part of our networking in the field of Tobacco, I also attended a meeting at NIMHANS where the tobacco deaddiction program which had started there was explained and also an attempt was made to get the groups present to work together for tobacco supply and demand reduction.

Month 2: November

The time at home had offered me a well deserved break after a long time and also the opportunity to meet relatives that I had not been able to do while I was in medical college with the ill planned schedule.

I met the CHC staff after coming back and got updated on the plans for the month. I also met the SPANDANA group from Shimoga, which along with Naveen Thomas had done an interesting study in the tobacco growing areas of their district, and was in the process of dissemination of the same. Later I attended a meeting at Equations where the implication of GATS on the various sectors was discussed – this was an area which I was not much aware of and this gave me an opportunity to get some introduction to the same. Vinay Baindur form CIVIC shared about their work on the 74th amendment. (Appendix 17)

Medical Law and Ethics, a field in which I was undergoing a course was the subject of my discussion with Dr. C.M. Francis- his vast experience in the field and expertise helped me in clarifying a lot of my doubts and he also gave me an insight about the work that had been done by the Community Based Rehabilitation Forum. I also went with Chander and conducted a Tobacco Awareness course for a batch of students of Christ College who are always an interesting bunch to deals with because some of them look upon these so called 'moral values' sessions with disdain and so that extra effort has to be made to involve them in the process- a challenge every time.

The whole of 14th November was spent in attending the various functions associated with World Diabetes Day- here was a disease that had been blown out of proportions by the medical community and the press and the pharmaceutical companies were having a field day with the 'hazaar' drugs available for the same. The Chief Minister and the Health Minister made the usual perfunctory speeches and there was a rally to mark the occasion wherein the students from the various nursing colleges who had been herded and brought were made to walk with banners and the other paraphernalia. Health education in the real sense seemed to be the last thing on the agenda.

I had by now also begun to take sessions for the Hindi/English/Konkani speaking boys in the fresh Seva Sadan batch and this offered me the weekly opportunity to interact with these adolescents who were full of questions and did not mind asking questions as they occurred to them, thus making the whole process very informal, which was the way I liked it. Adolescent education had been an area of interest for me, and talking to these boys about health and life skills on a regular basis also helped me gain valuable experience in dealing with people their age. (Appendix 5)

Drs. Ravi and Thelma had by now returned from their trip to Africa and it was interesting to listen to their varied experiences in that diverse continent and the health situation prevalent there. Dr. Thelma also spoke about her contribution in changes in the health policy of Orissa where the govt was being supportive and many initiatives were taking place.

Dr. Srikala Bharat visited CHC to give an overview of the LSE program- needs and objectives and also the pilot program that the GoK was starting in some schools across the state to implement the LSE program. While I had already taken some sessions in Life Skills, I had not been exposed to the history of Life Skills and hence this session was of interest for me too. The same day, we also had a meeting where Naveen presented his analysis of the pharma policy and there was a discussion on the same.

We had been trying to get a tobacco network going for some time and we finally arranged a meeting at CMAI where many voluntary organizations and a few medical institutions came together and realized the need to work together in the field as there was a lot which needed to be done especially in Karnataka which was in a way the hub of the tobacco production and consumption in the country.

On the 23rd November, VIMOCHANA had organized a meeting to discuss Dr. Satish Agnihotri's exploration of the declining Sex ratio in the Indian population. A former bureaucrat, Dr. Agnihotri's analysis looked at the issue in a broad manner and had brought in interesting facets and aspects.

The following day, the DAF-JSA meeting took place at St. Martha's hospital where the National Pharma Policy/Essential Drugs were discussed. It was disappointing for us that in spite of enough advance information and personal communication also, not many were attending these meetings. However, for all of us present it was an opportunity to analyze and try to identify what could be done about the loopholes in the existing policy.

The Health Informatics Project had come to CHC by this time and we decided that we would as a team go and visit the project areas so as to get first hand info and to interact with the medical practitioners, Anganwaadi staff and Panchayat institution members etc. and give them an insight about what we proposed to do in the project. We managed to get a fair idea about the local healthcare system and the dynamics that were prevalent in the local conditions and made some inroads in what in many ways was a new area for all of us. We also attempted to network with local organizations to make the project feasible and successful.

The following day Dr. Ravi share about the Mallur experiment and it was in many ways inspirational the way the project had been run bringing in the components of community participation and self sustenance- I could see how many of the ideas and experiences from that experiment had stayed and had now percolated into the functioning of CHC.

I along with Prahlad was visiting the Hakki Pikki colony in Bannerghatta and we were trying to devise and health intervention for the members of the hamlet there with the help of VIMOCHANA team that had been working there for quite some time. While accessible health care was available nearby in the form of a well-equipped charity hospital, the people in these hamlets were not taking benefit of the same. Their nomadic habits and also the rampant alcoholism in both the sexes was also a problem, as we could not follow up regularly. Prahlad and I spent some time trying to understand this community and this led to some interesting findings. Unfortunately, our visits were ending up becoming treatment camps when we wanted it to be a program, which would train local volunteers to become health workers and help their own community. This process would obviously take more time.

I attended the Dr. Jaishree Thomas memorial oration at SJMCH on 29th Nov along with Drs. Ravi and Thelma – I found that a lot of alumni had come together to remember an old friend – these kind of meetings were rare in BMC where the alumni association was sort of defunct and only occasional met for 'banquets' at the Bangalore Golf Club.

CHC was by this time was going into the preparation mode for ASF/WSF by this time and there was a sense of expectancy in a lot of us about the upcoming event at Hyderabad. I was closely following the web based activities in the ASF website for CHC and I could see that this was going to be a meeting point of a lot of issues.

December: Month 3

The whole of December had all of us in CHC busy with the ASF preparations as CHC had also taken the onus of facilitating the registration and stay of a lot of associates and friends of CHC.

Prahlad and I visited the Hakki Pikki colony again and tried to ascertain the social, economic, cultural and health dimensions of the colony so as to help us in devising any intervention. (Appendix 16)

MMB in Bangalore was organizing a festival on making Water Everybody's Business in Bangalore around this time and I had the opportunity to listen to Sunita Narain who heads the Center for Science and Environment at New Delhi – an organization that has done yeoman service for the cause of environment in India and brings out the respected journal 'Down To Earth' on a regular basis. The importance of Rain Water Harvesting and the immense benefits that the technology had to a nation like ours where many parts remained water starved for most of the year was imprinted on me.

Late in the month, I went with Dr. Ravi when he went to conduct session related to the Peoples Health Movement at INSA for their workshop participants. We also met a number of community health practitioners form around the country and this gave me an opportunity to gain insights into their work and what was the kind of work they were involved in. It was heartening to see such a committed group of people who enjoyed doing their work. I also attended the 20th anniversary celebrations of INSA and learnt about its inception and the way the organization had grown.

We conducted a one-day workshop at Kanakapura on HIN, Tobacco and TB. The workshop for the paramedical staff was fairly attended but the attendance in the evening session, which was for doctors, was not satisfactory. We gave an introduction to the issues; the local milieu with regards to the relevant topics was analyzed which would form the background for the future HIN activities.

Shobha John from PATH-CANADA visited Bangalore and we organized a meeting at the deaddiction center, NIMHANS where she spoke about the deliberations at the FCTC meetings at Geneva which was aiming to build upon the first Public Health Treaty to be drafted by the WHO – the networking idea and the formalization of CFTFK was also discussed here.

We also conduced a full day ASF preparatory meeting at Ashirvad which offered the space to various organizations conducting events in ASF to give a brief introduction about the same to other organizations – the aim was an united Karnataka contingent which would have solidarity with each other in the myriad issues being raised. After all, the whole process was to be a coming together and a support structure to refresh us in our areas of work.

The following day Anthony shared his experiences at Vimukti where there had been an incident of atrocities against Dalits, which he had investigated with Eddie from Vimukti. It was sad the way that the caste system after all this years was still a feature in our social fabric that was tearing us apart and that the Dalits were still living in oppression.

ASF preparations kept going on at a pace. I had the opportunity to attend a session on the alternative systems of medicine, which Dr. Tekur took. Himself a practitioner of various systems of medicine, it was an enriching experience to get to know about the systems of medicine in existence and how they looked at the concept of disease, patient and the treatment process.

The HP visits continued but they were becoming too treatment oriented which I was afraid of and I narrated this to Dr. Thelma – we decided to have a discussion with Vimochana about the way the intervention should be conducted.

We also had a meeting about the HIN workshop and put our thoughts down in the report about the workshop.

I had the opportunity with CHC's support to attend the annual meet of the Medico Friends Circle in Baroda. Dr. Ravi and Thelma had told me about the MFC in my discussions with them and I was looking for meeting the group. Also in the background of the communal outrage in Gujarat and the fact that my own family had suffered the same in Kashmir, it was also in a lot of ways a voyage of discovery into how religion was dividing and not uniting humanity in so many places. I liked the format of the meeting itself a lot because it was informal and there was an open discussion after every presentation allowing for clarifications and arguments. Also, the courage shown by a lot of those present in the face of rioters and their work in providing relief and succor gave us all hope while we tried to express our solidarity and unity with them. I also met a lot of interesting people who had different thinking streams; their openness to discuss with a much younger and inexperienced person like me endeared them all to me- I was already feeling like a MFCite.

I returned on 31st Dec as the final preparations for the departure to Hyderabad were underway and did a brief presentation about the MFC meet to the CHC team.

Month 4: January 2003

The beginning of a new year and after a day's break we all met in the evening as we prepared to go to Hyderabad for what was going to be a grueling but exhilarating week at the Asian Social Forum. (Appendix 6,7)

All of us who went to ASF returned with a lot of material and information and also the associated administrative issues that took us the whole day to deal with before we could even launch ourselves into a normal routine. There were also the accounts to settle, the reports to write which took another couple of days. I attended the CAMHADD meeting in Jayadeva Institute of Cardiology - I found their approach of trying to evolve a partnership between civil society, the public sector and the private providers in the field of health care for the urban poor interesting. but it was a process that would take time and was going to only benefit the small area in Yeshwanthpur that they were planning to concentrate on and develop into a model area while not dealing with the problems of the urban poor in a more comprehensive manner given the amount of effort already put in and the expertise that was being utilized.

The following week I helped Rajendran and Chander I conducting a LSE program at the Redemptorist congregation- these young men and women were very inquisitive and enjoyed the course and extracted the maximum information possible from the resource persons.

Immediately following this was a LSE course for the Jyoti Sadan scholasticates and this was an older all male group that was expecting help in developing their skills, which would help them when they went out to work in the community in their capacity as religious leaders. They were also very forthcoming with their appreciation & criticism

(the bouquets and the brickbats) about the course and hence helped all of us who took various sessions to do a critical analysis about the way we conducted the sessions. I was personally not satisfied with the way that I had conducted the session- the topic being 'Self Awareness' – there was a lack of background information on the topic, and also I had not spent enough time in preparing for the session. The session hence turned out to be a bit vague and technical, which I could gauge, from the response of those present. Nevertheless, a learning experience in the art of presentation.

Dr. Paresh Kumar also took a session on societal analysis and it interested me the way I he made all of those present think about their views on their role in society- as liberators, benefactors or as contributors which was I guess, a question all of us in community health have to keep asking ourselves when we deal with the population in our projects or field areas. Dr. Paresh was in the transition period before he joined CHC and I was looking forward to benefiting from his experience and insight.

Dr. Ravi took a session on male sexuality for all of us in the technical team after a couple of days so that we clarified our stand on a whole range of issues when we dealt with the subject and also for us to look into our own understanding and the biases that we still had which were preventing us from being objective in the programs we conducted. Male sexuality was an issue that was not much discussed in the Indian society and this could arguably be one of the reasons for the ever-increasing sexual crimes against women in our country.

Prasanna had joined on a trial basis by this time and he was trying to put the informatics and the documentation into a systematic classification- I tried to help him with this; this was a good exercise because it also gave all of us the opportunity to review what all of us done in the past and had documented. I also helped Dr. Rajkumar with the finalization of the first HIN newsletter and Maggesh with the content of the CHC website. All of these were opportunities for me to learn as I contributed- what could be better than this!

Month 5: February 2003

The month began with an interesting workshop conducted at NIMHANS where the whole range of issues related to the media coverage of the suicides in Bangalore was discussed- this also brought out the question of sensationalization of certain news stories in the media. (Appendix 8)

The following week I and Chander traveled to Doddabelavangala where we conducted a workshop for the health animators – it was a two way process to elicit the health problems of the villages in which they worked and also relate them to the various issues such as environment, hygiene etc. They had a good number of songs already in place for health education and it was a pleasure to listen to them especially the lead singer who in spite of being physically disabled and blind was the spirit of the whole troupe.

Drs. Praveen and Krishnamutry from BMC who had gone to Baran to investigate the hunger deaths there had returned by now and they shared their experiences with us. The fact that the situation was improving and that malnutrition was being addressed slowly was heartening, but the summer was coming up and that would be a real test for the whole support structure that had to be put in place. Hopefully the local groups assisted by others like OXFAM (Naveen was also part of this initiative by now) would be able to prevent the tragedy of human lives being lost again when our PM proudly was giving full pages ads that our grain godowns were full!- after all, it was going to be election year.

Prahlad was conducting a session for the EWRs of many parts of Karnataka on their responsibilities related to health and to see the huge group of 300 women, some interested, some not but all there as a proof of the vibrant democracy that our country still is. The explosive situation of HIV/AIDS and the stigma that it entailed in Northern Karnataka was apparent in the experiences that these women shared. I could vividly remember the fact that the greatest risk factor for women to acquire HIV was to get married and I was wondering if women's empowerment alone would be the answer if the long run- we also needed to encourage the activities that worked for behavioral change in the sexual behavior of men, who were predominantly spreading the infection.

I had attended the HIV/AIDS care group meeting organized by SAMRAKSHA on a couple of occasions and I found these to be quiet educative and a meeting point for the many groups working on the various aspects of HIV/AIDS.

I took a session for the students of the state govt. high school in Jeevan Bima Nagar- many of them already addicts of cigarettes and gutkha- as I tried to tell them the various health problems that tobacco usage could lead to, I was also realizing that they needed constant encouragement to quit and to stay away. That the percentage of people who could quit tobacco usage was very low was something we had to realize and, hence the need to work as hard as possible to stop these students from falling into the habit.

Mr. Meindert Schaap presented his study on the sexuality of street boys in Bangalore which was still going on- this was a group all of us encountered everyday and did not pay attention to unless we had newspaper reports of some of them being abused in the railway carriages; there would be a hue and cry for a couple of days and then the situation would come back to stage one; Meindert's concern for them and his extensive research that could help devise a program to help these young citizens of India in leading more comfortable lives, away from the fear of exploitation and violence was apparent.

I attended a few sessions of the Health and Hospital services Management course that CMAI was conducting at Ashirvad and found a lot of middle level managerial staff form various hospitals present; the sessions on medical ethics, CPA and insurance were helpful in updating my knowledge.

On the 15th and 16th, Prahlad and I visited the projects of India Every Child at Korategere (Tumkur) and Hassan and conducted session for the staff members of these projects on Primary Health Care and the role of functionaries in Pry. Health Care. We had the opportunity to do field visits in these areas; in Tumkur, the doctor in charge of the local health center was very forthcoming and told us about the problems in that area; we could also pick up a lot of fluorosis in some areas and saw many children with dental symptoms. The project staff was trying to bring this to the attention of senior health officials and we were hoping that would bear fruit.

The PHM office had by now been opened across the road from CHC and Dr. Qasem Chowdhury who had come down with a Bangladesh medical delegation came to the office to share the story of the GK project that had been painstakingly been built up and was testament to the fact that the Primary Health Care approach could work.

Dr. Olle Nordberg from the DHF also visited during this time and we shared the work of CHC with him as he told us about the work of the DHF.

We also conducted a session for the voluntary organization in the Bangalore rural district at Nelamangala organized by the Sandeep Seva Nilayam, a group that was among the first with which I had worked during my graduation. This was part of our commitment to keep the Janaarogya Andolana alive and kicking in Karnataka and spread the word around so more grassroots initiatives could take place.

Towards the end of the month, I and AP visited the GHE project of Mahila Samakhya at Koppal – AP was taking sessions for the staff members of the project in PRA methods but we also were doing field visits to the clusters and talking to communities at times which were convenient to them (early morning or late evenings) and trying to get the local populace to identify the health problems, the causes of these and fix up time frame for working on solutions for the same. The ground work done in facilitating the formation of womens' sangha, Kishori sanghas and the village health committees in may places made it easier for us to do this work.

Month 6: March 2003

The beginning of March 2003 was spent in preparing for the oral and poster presentation at the SDTC symposium on Acute Respiratory Infections, a national level meeting of researchers. Thanks to Dr. Ravi's encouragement and the willingness of Lt.Gen. Raghunath to accommodate a youngster like me, it was almost a dream come true for me. I had attended the previous symposium and had enjoyed the discussions thoroughly. Slightly skeptical if I would be able to do well in the midst of presenters with a whale of experience, I launched myself into the background research of the public health aspects. That the whole team of CHC stood by me and helped me in this endeavor assisted me in doing a presentation that was well appreciated. It was something to remember because it was my first formal scientific presentation. (APPENDIX 21)

I had earlier attended a seminar on the PNDT act organized by various groups in Bangalore and it seemed that the act was good enough only on paper as the conviction rate in this rampant practice of sex determination was very low. Hopefully, as the Governor put it, if such meetings would be organized in all the parts of the state and raise awareness about this practice which I sincerely believed was barbaric as it was like a death sentence on an unborn human being (without any valid indication). (Appendix 9)

I was helping in the training of the HIN volunteers – two bright young graduates who were my age and so easy to relate to – I tried to give them an insight into the world of the WWW which they could use for answering the health related queries of the people they met as part of the project.

With the upcoming tobacco legislations around the world, we decided to take the initiative of organizing workshops to raise awareness about the related issues in the heartland of tobacco agriculture in Karnataka, Shimoga and Dharwad. We also brought in the component of Primary Health Care into these. We had long sessions at both the districts and there was a positive response for our call for local action to reduce tobacco cultivation in the area.

A LSE program for training the trainers was organized by CHC at IYD and I attended the same; the sessions were very interesting, especially the way the facilitators like Dr. Sekhar Seshadri and Mr. Prakasam conducted theirs, making the audience comfortable. I also helped Chander in his session. The concepts of Life Skills and their necessity were clearer to me after this workshop. (Appendix 10)

Drs. Ravi and Thelma who had returned from their lecture tour of USA by now gave us an insight into the health problems that were prevalent in the Country which was now wanting to be the only superpower (and was inching towards it!). That there were so many citizens of the Big Sam not covered by medical insurance as the govt. spent more money on guns and weapons (media for destruction!!) was news that we knew of, but were not aware of the extent of. Also, as they so concisely put it, the anti-war sentiment demonstrated by many of the Americans showed that all the thinking did not emerge in America from Washington and the Pentagon but the citizens did differ with their govt. on many important issues.

I had the oppurtunity of visiting the AMCHSS at the SCTIMST, Trivandrum and interacting with the students and faculty about the course as I scouted for future academic pursuits. Thanks to the hospitality of Dr. Amar Jesani and Dr. Sukanya, I got a fair bit of an idea about the center and also traveled around Trivandrum. My discussions with Amar and Sukanya helped me a lot in my personal understanding of a wide range of issues.

The end of the month was spent in report writing and also in participating in the team meeting regarding the upcoming SEPC analysis of the Malaria prevalence in Chikmagalur, a process that interested me because of the way it was planned under the guidance of Dr. Paresh – a different approach.

Month 7: April 2003

After finishing six months with CHC, after a discussion with Dr. Ravi, I decided to spend some time as a technical volunteer with the Peoples Health Movement Secretariat, which had shifted to CHC from the beginning of the year.

I worked on collating all the ideas/suggestions from the 'Taking the PHM Forward' seminar at the Asian Social Forum; this was also partly to feed into the thinking that would go into the JSA-National Working Meet, to be held at New Delhi on 11th and 12th April 2003. After this, I worked on putting the content of the seminars and workshops that CHC facilitated at the ASF into order- this involved searching the old emails, requesting people, writing to some and was like the game of 'Beg, Borrow or Steal' that we used to play as kids.

On the 14, 15 and 16 April 203, I attended a Trainers Training program on Documentation and Rapid Assessment of Local Health Traditions conducted by FRLHT, Bangalore. This program helped me get an insight into the rich cultural heritage of health traditions that the local communities had been using for thousands of years and the need to work for preservation of these. It was also important to keep the rights of these communities over their traditional knowledge in mind before contemplating any commercial or widespread use of their traditions. (Appendix 11)

After this program, I spent a couple of days finishing the reports and the paper for submission to the SDTC center based on my oral presentation.

My stint with CHC/PHM formally came to an end with the presentation on 'Public Health Aspects of Acute Respiratory Infections' that I did on the 21st April 2003 at a team meeting.

A brief analysis of the time spent in CHC

Strengths

- Helped me move from a biomedical understanding of disease and health to also a social awareness of the issues involved.
- I feel that I have now deeper understanding of movements/ ideology and the role that major events play; I probably was much more superficially involved in these earlier as is the case with most middle class Indians today.
- I got a lot of chances to spend time in field projects with CHC team members and with the local staff and the communities' involved- I feel that this was very essential for me to experience community health.
- I could spend some time away from clinical medicine and concentrate on my other interests.
- All of the senior staff members were always very approachable and everybody gave me help, support and guidance as and when I wanted it.
- I learnt about the working of an organization on a day-to-day basis.
- I could understand that there was a great thirst for knowledge out there among the community health workers (at least the doctors have the chance to attend the regular CMEs) and organizations like CHC were helping them by orienting them at regular intervals.

Suggestions for improving the fellowship scheme

- A senior person should be asked to mentor the candidate on a regular basis; this would probably involve weekly discussions and feedback sessions from both sides.
- The candidate should be given material to read and discuss with the mentor/team to help in clarification regarding the various aspects of community health.
- The candidate should be especially given an insight into the broader issues involved like policy matters, LPG (Liberalization, Privatization and Globalization).

- The candidate can have one or two focus issues that s/he tries to understand inside out and also contributes in terms of viable alternatives, if required.

- The candidates can be asked to come out with a regular newsletter highlighting their work and learning experiences.

- Accommodation near to CHC would be a very helpful to candidates, especially the outstation ones.

- S/he should be asked to do regular presentations on topics that are selected in discussion with the mentor; this can be done in regular team meetings arranged for the same purpose.

- The amount of time spent with other partner organizations should at least be a quarter of the duration of the fellowship.

Post Script

I look back with great fondness at the time spent in CHC. I have found a sea of knowledge, good friends and inspiring mentors and guides.

I have undergone a paradigm shift in my understanding of health and its various components. From an initial biomedical understanding of disease that was taught and ingrained into me at the tertiary medical teaching facility where I studied in, I have slowly graduated to a deeper awareness of the social, economic and political mechanisms. The acute need for bringing about changes in the healthcare system through encouraging communities to get aware about their own health problems and devise solutions for it as well as demand action on the same from the responsible government bodies is very evident to me now. The lopsided distribution of medical services and the dwindling government support to health administratively and financially in the budget is a field of concern. The toeing of selective health care as advocated by the international 'lending' (they should not be termed funding) organizations like the World Bank and the IMF has had negative implications already. There is definitely a need for concerted social collective action to work for Health for All- it should no longer be a forgotten goal but a contemporary reality.

I hope to be able to be in touch, whatever may be my future endeavors and hopefully again be a part of the team someday and contribute to the committed work being carried out by CHC.

Anant Bhan
Bangalore, April 2003

Glossary

AMCHSS - Achutha Menon Centre for Health Sciences
AO - Administrative Officer
ASF- Asian Social Forum
BMC - Bangalore Medical College
CFTFK - Consortium for Tobacco Free Karnataka
CHC - Community Health Cell
CMAI - Christian Medical Association of India
CPA - Consumer Protection Act
DAF - Drug Action Forum
DHF - Dag Hammerschultz Foundation
EWRs - Elected Women Representatives
FCTC - Framework Convention for Tobacco control
FRLHT - Foundation for Revitalization of Local Health Traditions
GATS - General Agreement on Trade Services
GHE - Gender Health Equity
GK - Gonoswashtya Kendra
GoK - Government of Karnataka
HIN - Health Information Network
HP - Hakki Pikki
IMA - Indian Medical Association
INCLEN - Indian Clinical Epidemiologists Network
INSA - International Services Association
IYD - Institute of Youth & Development
JSA - Jan Swashtya Abhiyan
LSE - Life Skills Education
MFC - Medico Friends Circle
MMB - Max Mueller Bhavan
NGO - Non-Governmental Organization
NIMHANS - National Institute of Mental Health and Neuro Sciences
PHM - Peoples Health Movement
PNDT - Pre Natal Diagnosis Techniques
SCTIMST - Sri Chitra Institute of Medical Sciences & Technology
SDTC - Sir Dorabji Tata Center
SEPC - Social, Economic, Political & Cultural
SJMCH - St. John's Medical College
WSF - World Social Forum
WWW - World Wide Web

Appendix 1

Workshop on Joy of Parenting

Pindakurthimanahalli (Jayanagar), Dodaballapur
Date: 4th October, 2002

A workshop on 'The Joy of Parenting' was conducted on 4/10/2002 at St. Joseph's Convent, Jayanagar, Doddaballapur.It was targeted at representatives of self help groups and women's sanghas from the surrounding 20 villages. The number of participants was around 40 (including the staff of the convent). Mrs. Hema Srinivasan, a volunteer with the Kamaraj Balmandir Foundation, Chennai conducted it. Mr. Rajendran, Mr. Antony and Dr. Anant Bhan from CHC attended as observers.

Mrs. Srinivasan first gave a brief history about the topic – how it had originated in Canada and how it had been then modified for Indian conditions. She then asked the participants to introduce themselves using the opportunity to gauge their understanding of parenting roles. This served as an ice- breaker and some interesting viewpoints were put forward. The importance of a conducive atmosphere in the household right from the time of conception through the child's formative years was stressed as it led to the child being healthy- physically, mentally, socially and spiritually. The participants were explained the fact that stimulation plays a very important role in the child's growth and also how to foster a creative environment to allow the child to realize its full genetic potential. The importance of emotions, the need of proper communication and the use of proper language were emphasized. Furthermore the stages in the growth of a child were explained using charts and by learning through games.

A short lunch break was then taken which allowed the CHC team and Mrs. Srinivasan to interact with the staff of the convent and learn about their activities.

In the afternoon, innovative learning tools such as diagrams, use of folk songs and games was used to reinforce the morning lessons. An innovative game of 'Find The Partner' started the session. Another activity involved dividing the participants into groups of 5-6 women who were then asked to discuss the topics in the charts given to them and comment. There was an active participation in this from the Sangha group(s) women who ranged in age from teenage to grandmothers. At the end of the workshop, the participants were asked to clarify any doubts. Some of them gave their feedback. They then thanked Mrs. Srinivasan for enlightening them about Parenting Skills.

The CHC team and Mrs. Srinivasan then thanked the staff at St. Joseph's convent for their hospitality and left for Bangalore.

It was a pleasure to watch Mrs. Srinivasan 's skills at building up a rapport with her audience and using her experience as a child counselor in trying to encourage the target group to learn new skills, which they could share in their individual communities.

A few areas where improvements could be made for future sessions would be the usage of better audio-visual aids (like Color Xeroxes, OHP sheets etc). Also the husbands should be encouraged to attend such programs as the 'Joy of Parenting' is best explained to the couple as a unit.

Appendix 2

A **2-day evaluation of the health awareness program** conducted by the Community Health Cell at Sevasadan technical training institute was carried out on the mornings of 9th and 10th October, 2002 by Dr. Mani Kalliath, consultant with CHC assisted by Dr. Anant Bhan.

On the 9th October, 2002 , 2 batches of students from Seva Sadan were approached to give their feedback about the health programs that had taken place about a year ago for 3 months in 2001.

The first batch of students was from the carpentry division. This was a group of about 15 students. The first few minutes spent in familiarizing with the students The students remembered about most of the topics that had been covered in the program. The students especially liked and recollected the topics of cancer, malaria, cleanliness and personal hygiene, sexuality and condom usage. The students were of the opinion that the knowledge that smoking and oral usage of tobacco was harmful and could cause cancers had helped them; some of them divulged that they had stopped smoking as a result also and were trying to influence others to stop too. However, they did not remember about the other types of cancer besides the tobacco related ones. While a student said that he had dealt with his pimples by avoiding oily soap and using 'Cinthol', when asked what caused them, he said 'heat in the body'. The students were also concerned about cleanliness and personal hygiene and said they endeavored to keep themselves and their surroundings clean. The knowledge about HIV/ AIDS in terms of mode of spread, symptoms and window period was good. However, they did not know the difference between HIV and AIDS. They had fairly good knowledge about family planning methods- temporary and permanent. Also they said that they had realized the importance of discipline, friendship and helping others and how to deal with their emotional problems. This batch of students wanted the frequency of classes to be increased from once a week to twice a week and also the duration of course to be longer than 3 months. Also they felt the need for training on how to deal with their family backgrounds, which were traumatic in some cases. They also said that they preferred more audio- visual aids as that helped them to retain more information. They felt that they could not approach any of their teachers for personal problems but said that they trusted Brother Prabhudas and Bro. Paulus, for the same.

The 2nd session was with the welders and turners batch. This group was less forthcoming and very few students actually spoke. The topics that liked included sexuality, malaria, HIV, tobacco awareness. One of the students said that he believed that sex in young age group could cause birth defects in the child. However the students had very limited information about family planning methods and the concept of safe period. The students had lesser information about HIV/ AIDS compared to the first group and still had some doubts in the topic. A group of students said that they wanted more Kannada to be used in the teaching. They said that there was nobody among the staff or faculty whom they could approach for problems.

The next groups that we met were the teachers on the 10th of October 2002. They came across as a disinterested lot. They spoke about the adjustment problems that the students had when they joined the institution because of their diverse backgrounds. They felt that since 75% of the students came from a rural background, it would be better more time given for orientation and to overcome the language barrier as it would help the students to retain more. Also, one of them said that his students had told him that they found the health education classes boring! Most of the teachers seemed reluctant to take up additional responsibilities in guiding the students about the health issues. Some of them were however ready to volunteer to be trained in the program themselves to help the students as well as themselves and their families. Later on, we met the principal of the institution with whom we shared about our observations. He said that he was satisfied with the program but expressed his inability in making this a continuous process, as it would require permission from the higher ups in the organization.

We also later met the group of trainers and interacted with them. They said that they needed more support in terms of materials including audio-visual media as they felt that lecturing alone was not enough to sustain the interest of young boys. We also asked them about the topics that they liked teaching. They said that the students had given them good feedback.

Observations-
While the first group was quiet forthcoming and shared their opinions about the program quiet readily, the 2nd group seemed to be governed by the politics of language based formations where there was a leader whose opinion was paramount and hence prevented others from sharing their thoughts. Also there was a lot of negativity in the group.
Most of the students seemed to retain only a few topics well, which would ordinarily be of curiosity to them such as sexuality etc. also there were lacunae- e.g. while the students knew about HIV/AIDS, they had no knowledge about STDs. Also there opinion of sexuality seemed to revolve around it being as a tool for reproduction rather than something that two consenting adults could enjoy provided if it was practiced safely. Similarly while the students seemed to remember the other topics, they did not seem to retain the important content of the topics. The teachers seemed to not be much interested in the health awareness program and were not very forthcoming about being a part of any initiative to try to improve the program, there being only a few exceptions. Also, the management seemed to put the onus of conducting the program entirely on CHC not wanting to involve much in either conduction or long-term commitment.

Suggestions-

1) The sessions to be shorter – 90 minutes, maybe twice a week with more audio visual aids and also constant reinforcement of past topics to ensure more retention.
2) The interested teachers to be trained themselves so that they could help the students with their doubts when the CHC team is not around.
3) To take up the program as a continuous initiative with Seva Sadan rather than a yearly contract.

4) To ensure that there is mixing of various groups of students and the problems related to language are addressed.
5) To try to ensure structured learning- the program could run longer than 3 months.
6) The retention of the content of the topics and not just the topics alone to be more important.
7) To maybe expose the students to some community health initiatives.
8) To try to train some peer educators from among the younger teachers and staff to address the doubts and problems of the students.
9) To organize a health check-up for all the students on a regular basis.
10) To arrange for some type of counseling for the students to address their individual needs.
11) The trainers to be fixed according to their topics of interest.

Appendix 3

Rendezvous with Prof. Mark Nichter, Medical Anthropologist, University of Arizona on 14th October 2002 at Bangalore

Dr.Ravi had met Prof. Mark Nichter at the Indian Clinical Epidemiologists' Conference2002 held at Trivandrum. Since Mark had extensive experience in the field of medical anthropology especially in relation to India, Dr. Ravi invited Mark to Bangalore to interact with the CHC team and share his experience especially in the field of Malaria and Tobacco.

Unfortunately due to death of a friend, Mark was delayed in coming to Bangalore and visited on 14th October 2002, which fell between a series of holidays. Since most of the team members of CHC were either not in town or were not available, Dr. Rajan Patil and Dr. Anant Bhan went to meet Mark when he visited Bangalore and spent almost 7 hours interacting with him at his lodge in Majestic.

Initially after the introductions, Mark spoke about his active work in the field of medical anthropology, he being one of the pioneers in the field. He said he had 17 Ph.D. students working and researching in various parts of the world, few of them in India. He also said that he had a deep affection for India and he always looked forward to returning to visit India.

He spoke about the possibility of Urban Malaria and Dengue that was a outbreak waiting to happen in Bangalore and that this was the reason he preferred to stay on the top floor of a lodge / hotel so as to have a panoramic view of the roofs in the city which could be possible breeding grounds for mosquitoes.

While discussing institutional work, Mark said that while he respected CMC, Vellore as an institution, he did not like to work with them as he had differences with them about their work policy; he felt the grass root workers there were grossly under-paid and exploited.

Mark then explained about he became interested in the field of Tobacco after tobacco companies had rubbed him the wrong way during a televised debate on Tobacco and made him resolved to fight them back. He spoke briefly about the planned study that he and his colleagues (Harry Landow, Association for Nicotine Control, Dorothy, Pharmacologist, Myra who trains Community Health Workers and Keith, Methodologist and Mark's wife) were planning to start in Kerala shortly to address various issues related to Tobacco addiction especially cessation. However, he said that their scientific interest was wavering as ICMR clearance was still being awaited and precious time and money was being lost.

Mark said that in India, the concept of 'Toilet Cigarette' is unique wherein certain people do not get any bowel motions in the morning unless they have a smoke in the toilet. The

age of onset of Tobacco usage in India is also quiet low. The usage of Gutkha and other oral forms of Tobacco is increasing and is in the range of 15% in South Canara.

Mark stressed the importance of media in addressing the issue and he said that articles with catchy headlines like ' Saving the children for the tobacco industry' had been very effective in the U.S. He said that 'INFECTIOUS IDEAS' were needed to give any program a boost and said that there was a need to practise 'science for activism'. Prevention in the field of Tobacco was difficult; an effective way to prevent new starters was to show people they could relate to giving up tobacco.

There was a need to respect the tobacco industry for its effective marketing strategies. In Indonesia, there had been an economic recession and most of the industries had collapsed but the tobacco industry was going strong (60-80% of Indonesian men were chain smokers).

There was an inherent similarity in Tobacco and Malaria in the fact that in both there was a need to 'control the breeding sites'.

Mark drew a parallel with work in the field of STDs where it was important to target the environment and not the groups 'at risk' (similarly with alcoholism too), as environment was the chief influencing factor.

Mark said that while working with kids and adolescents and trying to educate them about Tobacco, it was important not to resort to the gimmicks that tobacco companies employ by using glamour/models/actors as they feel that then the educator is also manipulating them the same way that tobacco companies are; however, EMOTIONAL TESTIMONIALS from those adversely affected by tobacco are very effective as youngsters like them the most.

There was a need to reach out and talk to more people and anticipate the questions and the doubts the target audience might to have and be ready to address them. There was an urgent need to develop a package for schools and to make it specific to the environment- socially, economically, regionally etc. Also the quality of the program offered to rural Karnataka should be as good as that offered to urban areas. **It was important to invest in the process and document the steps.** Messages that cater to the people's imagination should be used. If other organizations want to take the program up for implementation, then they should be offered a list of options; they should be given choices so that they can evolve their own program.

Mark said that Tobacco is emerging as the second fastest game in public health after Antibiotic Resistance. Tobacco should be looked upon as a nicotine delivery device. To evolve a successful program, it is important to invest in the process and then make the product. We should talk openly about the mistakes you made (maintain a book); also its necessary to make tobacco an occupational health issue. There is a need for a good cessation program for any intervention in the field of tobacco to be successful.

Mark cited the example of T.B. saying that there is no good educational program for tuberculosis in India. He also said that there was a need to try to get the academic institution and NGOs to work together. When told that CHC was working towards this, he lauded the efforts and was impressed by the Fellowship Program being envisaged.

Mark had an extensive discussion with Rajan about the field of Malaria. He said that local panchayats needed to be involved in the process of malaria control so as to bring about input of new ideas. It is a good idea to encourage young kids as elements of change and to act as Mosquito Busters.

He stressed that SWAT (Strength, Weakness, Analysis, Target) analysis was an effective way to judge a program and the only way to defeat a paradigm is an alternate paradigm that is better.

There was also a need to increase community participation in health programs, which is now limited to 'they should listen to us' or 'they should pay for it'.

Mark said he would want to interact with Dr. Thelma and Chander especially regarding their work the field of Tuberculosis and Tobacco.

He expressed his interest in remaining in touch with CHC and helping CHC network with various organizations working in related fields at a global level.

Appendix 4

SEMINAR ON EVOLVING EDUCATIONAL STRATEGIES FOR TOBACCO CONTROL

A Report by Naveen Thomas & Dr. Anant Bhan

Date: 18th October 2002
Venue: International Services Association, Benson Town Bangalore

It is generally observed that while the use of tobacco is declining in developed nations, it is still quite high in India. A Global Status Report of the World Health Organisation (WHO) estimates that 65% of men in India use some form of tobacco, (about 35% smoking, 22% smokeless tobacco, 8% both). Prevalence rates for women differed widely, from 15% in Bhavnagar to 67% in Andhra Pradesh. However, overall prevalence of bidi and cigarette smoking among women is about 3%. The use of smokeless tobacco is similar among women and men. About one-third of women use at least one form of tobacco. Differences in tobacco use also vary among other groups; Sikhs do not use tobacco at all, and Parsis use very little, while tobacco use is permissible among Hindus, Moslems and Christians. Smoking rates tend to be higher in rural areas than urban areas. Smoking is a status symbol among urban educated youths, but most appear to be unaware of the hazards of smoking (Tobacco or Health: A Global Status Report, Country Profiles by Region, 1997).

With tobacco use so widely prevalent, can diseases be far behind? The estimated number of new cancer cases in India per year is about 7 lakhs and over 3.5 lakh people die of cancer each year. Out of these 7 lakh cancer cases, about 2.3 lakhs (33%) cancers are tobacco related. Tobacco related cancers accounts for about 52% of all cancers in males and 25% of all cancers in females. There would be about 1.5 lakhs cancer cases at any given time in Karnataka and about 35,000 new cancer cases are added to this pool each year. (Source: Kidwai Memorial Institute of Oncology, Bangalore)

It is estimated that Karnataka has about 8 million tobacco addicts including more than 60,000 children below 15 years of age and about the same number of youth aged between 15 and 25 years enter the pool of tobacco users in the state every year. Data from Karnataka shows that 91% of young individuals below 40 years who develop Acute Myocardial Infraction will have one or other risk factors including tobacco usage especially smoking. ("Prevention is better than cure", S.T. Yavagal. http://www.csiblr.com/index.html). At Sri Jayadeva Institute of Cardiology, Bangalore, a premier institute run by the Government, 3883 acute myocardial Infraction patients were admitted in 1997 alone. This reflects the gigantic problem of coronary artery disease in Karnataka.

Background

Community Health Cell (CHC) has been working in the field of tobacco control and awareness for the past few years. This includes conducting sessions on tobacco awareness for schools, colleges and corporate institutions. CHC is also involved in tobacco control activities at the policy level by playing an active role in organising rallies, protest marches, mobilising students and concerned citizens to create awareness throughout the year and especially on World No Tobacco days. CHC is involved in the functioning of the Consortium for Tobacco

Free Karnataka, which involves more than twelve institutions, including medical associations, hospitals, student bodies and voluntary organisations.

CHC has brought out a memorandum on tobacco control, which has been endorsed by more than 5000 school and college students and is to be presented to the Government soon. The memorandum calls for ban on sale of tobacco products to minors and implementation of the govt. Order prohibiting smoking in public places.

During the course of the above activities, CHC realised the importance of networking with other organisations working with children, adolescents and vulnerable sections of society to sensitise them about the extent of the problem, and to work together towards preventing the further spread of tobacco usage by evolving common educational strategies which are culturally specific and relevant to children, adolescents and vulnerable sections of society. A meeting was organised on 18th October 2002 at International Services Association (INSA) for which more than 25 organisations working with the above groups were invited to be a part of the deliberations.

Proceedings of the Seminar

The meeting was delayed for around half an hour as we were waiting for participants. Finally, the seminar started at around 10:00 A.M. with around 15 participants from a few organisations (see appendix for list of participants/ organisations). After a round of introductions, Ms. Edwina Pereira, Programme Director, INSA formally welcomed all the participants and wished the programme all success. Chander gave an introduction about the purpose of the meeting and began by conducting a quiz about various issues related to tobacco. He presented the global pattern of tobacco usage and its various implication (health, environment, economic, etc.). He highlighted the fact that tobacco was an addictive substance and gave figures to show that lesser the age of onset of tobacco usage, the harder it was to quit the habit. He also quoted industry sources that clearly were attempting to influence the younger people into taking up the habit by using the "catch 'em young" concept. This set the ground for focussing on children and adolescents as a potential group who needed to be educated and supported to prevent them from falling prey to the unethical practices of the local and global tobacco industry.

This session was followed by a session on Health Implications of tobacco usage by Dr. Rajkumar and Dr. Anant. They highlighted the scientifically proven association of tobacco with a range of health problems including lung cancers, heart disease, sub-mucosal fibrosis, oral cancer, sterility, and a range of problems associated with tobacco smoke (active and passive). The harmful effects of second-hand tobacco smoke/ environmental tobacco smoke (ETS) were explained. The fact that only 15% of the smoke was actually consumed by the smoker while the remaining 85% was ETS shocked the audience. This session was conducted using visual aids like OHPs and Slides.

After tea break, a session on economic implications of tobacco was held. Chander began by introducing the global economics and the unviability of tobacco trade (in terms of foreign exchange), while Naveen concentrated on the economic aspects at the local level. He spoke of the health costs, occupational risks, environmental costs, balance of trade costs and the costs of substituting essential crops/ nutrients at three levels (Government, Tobacco

producers and Consumers). He illustrated these with information from the latest study he jointly conducted in Karnataka and from studies on street children in Mumbai.

This was followed by a session on environmental implications, where the huge deforestation due t to production and curing was discussed. Naveen presented the findings of his study from Shimoga district in Karnataka including the occupational hazards the tobacco cultivators and beedi rollers undergo. The other aspect that was covered was the use of paper for rolling cigarettes, packing, etc. The aspect of ETS was reiterated here, which sparked off a discussion on how to work towards demand and supply reduction. The participants suggested various means like increasing taxes on tobacco products, decreasing accessibility, etc.

The group then decided to list down reasons for increasing tobacco usage among children and adolescents. Various reasons like peer pressure, rebellion, imitation, identity, symbol of adulthood, stress buster, to relax, to concentrate, feel the taste and to have something to do with their fingers were listed.
The last session then focussed on evolving strategies for tobacco control through an interactive session. The important strategies suggested by the group includes:

- Influencing parents, teachers and doctors to understand the issues involved in tobacco usage and the need to engage them in addressing the problem and supporting youngsters.
- To influence the media to avoid glorification of tobacco usage (especially in TV serials movies and advertisements)
- To ensure that tobacco products were not available near hospitals and educational institutions.
- The importance of life skill education so that youngsters could withstand peer pressure and say NO to tobacco.
- Scouts & Guides, NSS / NCC cadets to be enlisted as support groups in this campaign and peer educators/ influencers
- Use of testimonies (through direct interaction/ multi media, etc.) of tobacco users who had quit or people suffering due to tobacco related illnesses as powerful communication tools.
- To develop a module using locally applicable themes, which could be used to educate youngsters about harmful effects of tobacco.

22nd November was fixed as the date for the next meeting. CMAI tentatively agreed to host the next meeting, subject to availability of their hall. All the participants agreed to make presentations on "Tobacco use in their work areas and strategies to overcome them". It was also suggested that a meeting of the Consortium be convened on the same to discuss further strategies.

Dr. Rajkumar thanked all the participants on behalf of CHC and INSA for attending the meeting and taking a first step towards establishing a network of organizations working with young people to educate them about the ill effects of tobacco.

As an afterthought, since a meeting is being held in NIMHANS on the 31st October 2002 with the same objective (to establish a network), it might be a good idea to club resources and try to work with them and develop a module with their help.

Appendix 5

Seva Sadan Boys LSE Program
Session in Nov.

As a part of the Seva Sadan LSE program, AB took a session for the Hindi/ English/ Konkani speaking boys group numbering around 10. This was the fourth session being taken for this group.

The students initially recollected the last session wherein they were given an introduction to sexuality and the previous speaker cleared their doubts.

Objective

1) To assist the students to clarify doubts related to lust, fantasies, sex and to develop healthy opinions and attitudes to wards sex
2) To discuss the abilities related to decisions on sexual experience based on sexual needs and following the societal norms.
3) To make the students recognize in themselves emotions, which are sexual, identify sexual needs and accept them as healthy.
4) To help them decide to postpone sexual experience till marriage/ development of a stable relationship.

Techniques Used
Group Discussion, Brainstorming, Sharing ideas, Opinions and Attitudes

- Initially the boys were given a brief introduction about the sexual organs in males and females
- Some of the boys wanted to know why girls use sanitary pads so the menstrual cycle was given to them; it was also reiterated here that menstrual blood is not bad or dirty blood and also that ladies during their periods are not dirty or unclean. Rather it's a normal physiological change in a woman's body.
- When to have sex?

  The boys after discussion agreed that sexual activity with a person should take place only after they develop feelings of love, care and concern for the partner.
- The various ways though which couples demonstrate their sexual feelings including kissing, hugging, touching each other's bodies were

explained to the group. This was followed by a description of the act of intercourse.

- It was explained that sexual feelings are normal and all humans-male or female have these.
- The process of conception and the changes in a woman's body after pregnancy including the signs of pregnancy were then dealt with.
- The care of a pregnant woman during pregnancy was discussed.
- The boys were then asked about the methods of contraception they knew of and then all the methods available were explained.
- Myths and misconceptions related to sexuality were discussed; most of the boys still had a lot of doubts, which were cleared.
- Homosexuality was explained to the boys and they were told the need for developing tolerant attitudes and respecting the choices that other people make.

The session then concluded with a brief revision of the key points.

Appendix 6

Asia Social Forum- a Reflection - By Dr. Anant Bhan, CHC

The recently concluded Asian Social Forum held from January 2-7, 2003 was the first attempt at the Asian regional level at unifying all forces that have faith in the surmise that Another world is possible- another world that need not necessarily be dominated by imperialists & where the third world be continuously subjugated in the name of globalization.

To be able to work to bring together different organizations, networks, issues, people of diverse nationalities, cultures and give them an opportunity to be able to an exchange of ideas through conferences, seminars, workshops, open houses, cultural performances, movies and plays was always going to be difficult but ASF managed to pull it off.

More than 14,000 delegates and a floating population of at least 6,000 more people had ample opportunity to unite and find common ground even within the diverse fields and issues that they were advocating. So there were burqa clad women from Hyderabad attending the dalit events and relating to the feelings of suppression; there was the mother(Nora Cortinas) from a Latin country(Argentina) whose son had been taken into custody and than never seen again who saw the hands that wield power in Burma use rape as a means of suppression on the hapless citizens; there were the health-wallas from the Peoples Health Movement trying to remind everybody that this was the 25th anniversary of the Health For All call of WHO which has been conveniently forgotten by the governments in favor of the selective health care that the World Bank and the International Monetary Fund advocate& hence it was time to demand healthcare as a fundamental right; there were those who could still not understand why Gujarat could have exploded the way that it did; there were those who were dedicated to the cause of protecting our indigenous plant varieties and traditional folk-systems; there were also those who felt that they needed to attend because they wanted to prove that they had done their quota of social work for the year & happily went back home in their latest imported cars with soft drink cans in one hand and sleek mobile phones in the other.

Was there something achieved at the end of such a mammoth gathering- or was it a huge loss of resources? I have now come to realize after talking to my senior colleagues that the whole purpose of the meeting was just to be a platform- for everybody to be able to

stand up and have their say; there was no hierarchy and negligible security (though I guess the organizers lament that after the Hussain outburst) and so you had the activist celebrities mingling with the grassroots workers who were the real strength of the organizations. It was a great opportunity for people to meet old friends and make new ones.

The outlets serving Hyderabadi food, the dances, the continuos roll of drums in some part of the sprawling Nizam College grounds, the jostling around at the stalls that sold all kind of stuff from books, bags, handicrafts to short eats and ASF memorabilia just added to the 'mela' feeling and believe me at the end of each day, if you had not managed to gather enough dust to have to necessarily drag your tired body to have a pre-snooze bath, you had not entered into the true spirit of the ASF.

The mass of volunteers from all over Andhra who ran the whole show guiding delegates, making sure that you did not get fleeced by the autos and stayed on the grounds in the shamianas need to be appreciated. The efforts of NAZ foundation to provide safe drinking water to the thirsty masses went along way in ensuring that ASF did not become a public health nightmare that it so easily could have turned into.

From the opening plenary, when we began to the calls of the Telugu theme song 'AASIA SOCEL PHORUM' to the closing plenary when many joined in the chorus of the song, it was an experience that left of us enriched and convinced that Another World is Possible, Another Asia is Possible.

For a young medical graduate like me who had come from a biomedical background and had only attended medical conferences that were less of academic updates and more of marketing juggernauts of 'pharma' companies who sponsor everything from the delegate registration and travel to toilet paper in the rest rooms, ASF was a refreshing change. It offered a chance to remember a plethora of lost issues that the govt. and the media has conveniently forgotten. There was at the end of the event a deeper understanding in all of us of how the macroeconomic policies affect each and every corner of our country and continent. The interaction and time spent with people from diverse nationalities learning about their lives and the reasons for their convictions are memories that will last a lifetime. The discovery that arises from almost all the events at ASF is that health is inextricably linked to all the topics that were being debated whether it

be poverty, women's issues, malnutrition and the right to food, dalit marginalization or the problems of the landless, the agony of those affected by torture and communal disharmony. This is a learning process that cannot be conveyed through textbooks, lectures or seminars in our ivory towers of medical education but has to be explored through the sharing of experiences that ASF provided space for.

Sometimes, there was the feeling that the most of local populace of Hyderabad were not aware of the ASF and hence were conspicuously absent; also the fact that most events spent too much time on analysis and discussing much less of action was disappointing. There was also a feeling of mistrust in some sections about the funding and the involvement of the World Bank indirectly in the organization of ASF, which was unfortunately not clarified. This led to some groups deciding to organize an 'Alternative ASF' in Hyderabad which was purportedly free of the machinations of multinational funding agencies while others decided to protest- one of the most visible being the one led but Gadar, the revolutionary poet form Andhra. Their views have to be respected and thought upon, as there has to be room for dissent in the 'another world' that we are seeking. But these were minor hurdles which I guess, are to be expected in an event of the magnitude of ASF.

ASF as a meeting point was a success- a success that need not be quantified and critically reviewed too much in detail. It has been an experience that has left its mark on all those who participated in it. In this time of turmoil that the country is going through, I am sure we need more social forums to experience the feeling of togetherness which all of us felt during the ASF and while traveling to & fro to the events in trains and buses, singing, raising slogans and exploring new ideologies, new languages and new cultures etc.

I am sure we'll successfully organize World Social Forum in India next year as we have all learnt in ASF that national boundaries are not barriers to the basic problems that all of us face and the indomitable courage that some of us exhibit in the face of these problems to be an inspiration to mankind.

This reflection was published in the March 2003 issue of Health Action

Appendix 7

Action Towards a Tobacco Free World

A workshop at Asia Social Forum, Hyderabad

Date: 3rd January 2003

Time: 2:15 to 6:30 P.M.

Venue: Taj Mahal Hotel, Abids Road, Hyderabad

Facilitated by:

Community Health Cell, Bangalore on behalf of Jan Swasthya Abhiyan / People's Health Movement)

Partner Organizations

Consortium For Tobacco Free Karnataka
PATH-Canada, LIFE

A Report by Dr. Anant Bhan, Community Health Cell

The workshop began with registration of all participants. They were given files with background material about the purpose of the workshop. Around 40 people participated in the workshop.

The workshop began with an introduction to the purpose of conducting the workshop by Mr. S.J. Chander from the Community Health Cell who spoke about the global problem that Tobacco had become and the targeting of Asia and developing countries by Tobacco MNCs and hence the importance of a concerted effort to network for freedom from tobacco.

Dr. Ramesh S. Bilimagga, Radiation Oncologist and member, CFTFK (Consortium For Tobacco Free Karnataka, Bangalore, chaired the first session. He welcomed all the participants to the workshop and reiterated that tobacco was a major problem not just in India but also across the world. He stressed that a small step by everybody in the direction of a tobacco free world would make a big difference. He then invited Dr. Thelma Narayan from CHC to give an overview of the problem.

Dr. Thelma explained that the workshop was being held under the platform of Jan Swasthya Abhiyan (PHM) which was active in more than 92 countries ands was working towards making the govts. and WHO and international bodies accountable to their commitment for Health For All. She stressed that many coordinating and facilitating agencies had helped in organizing the workshop and also enumerated the other events at ASF being facilitated by CHC/JSA/PHM. She said that the workshop would help us understand the tobacco issue especially in regards to dealing with the tobacco industry. It was needed to share our solidarity in the ASF platform and to strategize and reflect. The effect of globalization on public health needed to be studied in depth. Opium had been used in the past by Britain to subjugate China and now the western powers through the tobacco MNCs were using tobacco to subjugate the Asian countries. The US was promoting the global consumption of tobacco and there had been a sharp increase in tobacco usage in many areas; the issue of tobacco

advertising was also an important issue. While tobacco use was reducing in the North America and Western Europe, the tobacco market was being relocated with increasing use in Asia and developing countries. Data from different Asian Countries was presented. The dynamics and intricacies influencing the negotiations of the Frame Work Convention For Tobacco Control (FCTC) led by the WHO (World Health Organization) needs to be more transparent in order to evolve a useful instrument.

A Magic Show and a talking doll show followed this. The magician stressed on the ill effects of tobacco and requested people to not let their lives go up in smoke and to avoid the bad habits. It was well appreciated by the audience. He also wished everybody present a very happy and tobacco free New Year.

Dr.Ramesh then invited Dr. Prakash C. Gupta, an epidemiologist and a public health consultant from Mumbai having 36 years of research experience in the field of tobacco. Dr.Prakash began by saying that tobacco is a public health problem even at the grassroots level. Understanding the problem was not enough and something needed to be done about the problem. There were various organizations working in the field of tobacco control in India-a loose coalition of which was the ICTC (the Indian Coalition for Tobacco Control). Each of the organizations was free to pursue their own agenda but it was an interactive forum for all participating organizations to pool their resources. He expressed hope that more organizations would join the fold. He also mentioned that a death clock had been installed in Delhi that would register the deaths being caused by tobacco usage in India.

After thanking Dr. Prakash, Dr. Ramesh introduced Mr. Sonam, a bureaucrat form the Ministry of Health and Education in Bhutan. Mr. Sonam said that Bhutan had initiated tobacco control regulations as early as 1729; the state religion (Buddhism) did not permit the usage of tobacco. He cautioned that in their experience regulation alone was not enough and there was he need to take undertake aggressive information dissemination and work for anti-tobacco legislation. The Hon'ble Minister of Health had ensured that the sale and consumption of tobacco had been banned in public places. The effort had come through a decentralized approach wherein 18 out of the 20 districts in the country had themselves taken up the initiative to work for local tobacco control. He said that a dilemma that faced the govt. was the continuing sale of tobacco in the duty free shops in the capital city, which could not be stopped because of diplomatic problems- he invited suggestions from the participants on how to deal with the problem. He said that one of the queens in Bhutan was committed to the cause of tobacco control and had been appointed as a goodwill ambassador by the UNFPA and she advocated the tobacco and health issues in various districts that she regularly visited. Appreciating the people of Bhutan, Dr. Ramesh said that it was important to remember that perseverance was the key.

Dr. Ramesh then called upon two members of the Bangladesh Anti Tobacco Alliance to speak about efforts at tobacco control in their country. One of them Mr. Ratan Deb said that sometime ago though there were many groups working in the field not many were working together ;only school level programs were being organized to raise awareness about the harmful effects of tobacco and these also not very effective as they were leading to rebellion in many cases. He felt that what would work is strict enforcement, high taxes, controlling of advertising, more elaborate warning in the packs. He said that BATA has little resources compared to other groups and tobacco companies. BATA had filed a case in the Bangladeshi courts and had managed to achieve a significant legal victory which led to decrease in the rampant advertisement of tobacco companies and had also proved that British American

Tobacco Company's antismoking campaign was a sham. BATA has been closely working with the Bangladeshi govt. and have been attempting to spread the message of harmful effects of tobacco even in the regional languages. A law for stricter tobacco control is now pending in the parliament. A second writ petition is now pending in the courts under the Right to Life campaign against the Imperial Tobacco company; the court has given a stay order on all relevant advertisements for two months. Many organizations and facilities in Bangladesh are now tobacco free due to the efforts of BATA. He ended stressing that working together was very important for tobacco control. Mr. Naveen Thomas expressed the view here that one major factor for the success of the campaign in Bhutan was the fact that the political, religious and local leadership had come together to fight the problem and were very much involved.

Dr. Ramesh appreciated the efforts of BATA and raised the fact that the various govts. had a dichotomous attitude towards tobacco wherein e.g. the Karnataka govt. had an anti tobacco cell in the Kidwai Memorial Institute of Oncology, it also had a research wing in the Tobacco Board to try to improve productivity and quality of tobacco crops. He said that in K'taka

- There were 8 million tobacco addicts.
- 6000 children under the age of 15 yrs of age and as many between the ages of 15-24 enter the pool of tobacco users.

There was a need to publicize the tobacco issue among the lay public as they had the right to information.

Mr. Jaggaiah, a security guard from Hyderabad who used to smoke around 48-50 beedis a day for over 40 years presented his medical problems directly related to his tobacco addiction. He used to get cough, dyspnoea and chest pain; he had to undergo surgery (pneumonectomy) for pathology arising from his tobacco usage; he said that he had now stopped smoking and was proud to be free from tobacco.

Ms. Lalitamma from Karnataka, an ex-cultivator then shared her experience .She said that she had been working in the tobacco fields for over 15 years; most of the workers used to be employed as daily wage workers by the rich cultivators and had work for only 3-4 months/yr. The workers had very hectic work in the fields everyday and at the end of each day they were so tired that they could not adopt any hygienic methods before consuming food or have a bath before sleeping. They also used to use a lot of pesticides in the tobacco nurseries in their homes and because of all this problems she felt that they used to inadvertently consume a lot of pesticides. During the course of her work, she developed health problems and approached a medical practitioner who advised admission – her treatment bills were in the range of about Rs 30,000. She said that she had resolved to never do that kind of work again and was hoping that other people also left that hazardous work.

Dr, Ramesh thanked all the speakers for giving an insight into the various issues related to tobacco that were affecting their lives and work. He then thanked the organizers for having given him the opportunity to chair the session and handed over the stage to the next chairperson, Ms. Devaki Jain.

Ms. Devaki then chaired the next session, which was distribution of certificates and mementoes of appreciation to

- The people of Bhutan for having shown great collective resolve for the fight against tobacco. This was received by Mr.Sonam Thunsho, secretary, government of Bhutan in charge of health education.
- The members of BATA for their work for tobacco control in their country and for dragging the guilty tobacco companies to court and make them accountable for their unlawful practices. This was received by Mr.Ratan and Mr. Biplob
- Dr. Prakash C. Gupta for his extensive work in research in the field of tobacco.

A short tea break was then announced which gave the opportunity for the audience to interact with the speakers and also for them to view the exhibition of anti tobacco posters that had been put up by Community Health Cell in the hall.

The tea break was followed by a panel discussion on various facets of the tobacco issue. The discussion was chaired by Ms. Devaki Jain. She said that the amount of money the govt. spent on treating diseases arising from the usage of tobacco was more than the money it received through excise. Tobacco related deaths were more than the number of deaths caused due to HIV, Malaria, and T.B. combined. There was a need for campaign mode activists, as knowledge about the ill effects of tobacco did not deter people from harmful habits. Death was a close phenomenon in India especially among the poor and hence morbidity and mortality due to tobacco could not be used as an effective deterrent in that sector. There was a need to work to change attitudes; also important was to fight the tobacco industry, which was targeting the young by using unfair advertising means. There was a need to talk about it in the background of globalization and macro-economic program. The relation between poverty in India and the addiction to tobacco, alcohol and the susceptibility to HIV in poor communities was well known and proven in studies such as one done by NIMHANS. Also, interestingly, the govt. had included Tobacco in the Foods and Beverages list.
Dr. Devaki then invited Dr. Prakash Gupta to give his presentation. Dr. Prakash's presentation had the following salient points:-

1. There were only two causes of death that were increasing worldwide- HIV and Tobacco.

2. Death was an objectively measured event; Tobacco usage was the single most preventable cause of death in the world.

3. Current WHO estimates of tobacco attributable premature deaths are in the range of4.9 million/yr. This is expected to rise to 10 million / yr by the year 2030; already in the 20th century approx. 100 million people had died due to health problems related to tobacco usage.

4. India was the second largest producer and consumer of tobacco in the world; ICMR estimate for the annual attributable mortality from tobacco was 8,00,000.

5. Tobacco causes a lot of medical problems and addiction is a key issue because of the nicotine content

6. Children are the mot severely affected and unfortunately they are powerless to fight against this evil.

7. There were many misconceptions related to tobacco e.g. that it was not a high-risk product and that tobacco users do not have any choice, once addicted.

8. The truth was that more than half of chronic tobacco users would die of health problems arising from that habit.

9. Tobacco smoke had a lot of toxic chemicals and carcinogens and had an effect even on passive smokers; hence there was a need for concerned people to fight for their right for clean air.

10. Tobacco and social justice was also an important issue- as its usage was more among the lower SE strata and the relative risks were also higher in this group; beedis, commonly used by this group were more harmful than cigarettes; also unfortunately, most of the interventions were aimed at the higher SE strata.

11. The rising usage of tobacco among the women was alarming- one study had shown that as many as 10% of college going women in Mumbai were using tobacco.

Dr. Devaki then invited Dr. Srinath Reddy to present his views and experience as the Indian govt. nominee and as a NGO health activist at the FCTC deliberations. FCTC was an attempt by WHO to exercise its treaty making power for tobacco control. The critical issues included stronger action required on the demand and supply sides. There were the issues of trade and public health involved; most country representatives participating in the deliberations were advocating a total ban on all forms of advtg.- direct and indirect. But there had been pressures from some quarters and in the ongoing round the talk was around restriction of advtg; unfortunately the issue of surrogate advtg had not been addressed. The WB and developed countries were of the view that there was a continued increasing demand for tobacco irrespective of control measures (more in the developing countries and lesser in the developed ones). Global resources were lacking for implementation unless a global fund was set up. Also, cross border advertising continued to be an issue and trade v/s public health was a battle that was still being fought out in the FCTC. The recent draft of the FCTC was disappointing. It has been prepared for the next round of negotiation in February 2003.

Ms. Devaki thanked Dr. Reddy and mentioned that the UN precincts and most eateries in the developed countries are smoke free. She then invited Ms. Shobha John of PATH Canada (Programme For Appropriate Technology for Health) based at Mumbai to make a presentation. Shobha spoke about the poor being affected the most by tobacco usage and she presented some data from her PATH studies which showed that the tobacco consumption among the pavement dwellers was 82% and among the street children was 76% - these people were spending less amount of money on food than tobacco. She also raised the issue of misplaced targeting by activists who were not addressing the tobacco problem that was afflicting the poor SE strata and the need to reach out to that group. In Bangladesh, a study had proven that many households were spending 18 times more on tobacco than health. The tobacco issue was causing a loss to the country as the estimated health costs were in the range of Rs 6.5 billion while the excise returns were only Rs.4.5 billion; hence the economic loss to the nation was immense. Also the tobacco industries were themselves promoting smuggling of their products and were using a lot of front groups for surrogate advertisements. The industry's argument that a lot of workers would lose their job had to be viewed with scepticism because the companies as they were getting mechanized were laying off a lot of workers; also experience had shown that the

industry was actually quite exploitative; Ms. Devaki mentioned that some traders in B'lore had been subletting the space outside their shops which was actually govt. property to vendors; she then invited Ms. Suvarna to share the findings of her study in Shimoga in Karnataka.

Suvarna mentioned that she had been working in the area for the last 12 yeras and she had noticed that tobacco cultivation had decreased by more than 50% - this had sparked an interest to initiate the study. They had discovered that the cultivators were actually the large farmers as the govt. Tobacco board regulations were that all tobacco cultivators should a possess a minimum of at least 3-4 acres of land .Tobacco cultivation was labour intensive. It also required a lot of wood for curing which had led the farmers to steal wood from the forests. Almost 80% of the forests had been depleted and now the local populace had sometimes to walk a distance of 10 kms to collect firewood. Good quality wood was required for curing wherein temperatures were maintained at 90-120 degrees Fahrenheit for 4 days. The alternative crops that some families had shifted to in the state were maize etc.; they had noticed that the land became more fertile if tobacco cultivation was decreased. As tobacco was a very labour intensive work, the people used to be busy from morning to evening in their work, which had affected families, as there was nobody to look after children and the elderly. This has been shown in falling attendance in school for the children of cultivators and agricultural laborers. The Sanghas and self-help groups discussed this and decided to utilize the govt. programs. Supporting each other, they started animal husbandry and were managing to get continuos money inflow. In tobacco cultivation, women were the most affected – they had occupational problems, were made to work hard and do menial jobs; there was gender insensitivity and the women were made to do the most difficult and strenuous work. This had affected the lives of many women and children adversely. Ms. Devaki appreciated the presentation and mentioned the need for linked narratives to help with advocacy issues.

This was followed by a group discussion involving all participants that was chaired by Dr. Srinath Reddy. The main points that were highlighted in the discussion by various participants were: -

- Coronary Artery Disease (CAD) caused by tobacco usage needs to be studied and publicized.
- FCTC needs to advocate strong regulations- local and national.
- Need to sensitize the politicians about the issue.
- Need for effective political lobbying and policy level interventions.
- Need to safeguard the interests of the involved people and to try to bring the larger forces to come together.
- Lesser emphasis to be laid on health and more on the fiscal and the environmental aspects.
- To try to attempt a linkage with the right to food campaign and the environmental issues.

- Promote the usage of the 73rd and the 74th amendments that promote local governance.
- Need for economists to study the long term effects of tobacco usage.
- Promote the ban of tobacco consumption in public places as it gives the right to people to protest tobacco usage.
- Alternate employment strategies to be promoted.
- Need to understand that there was no direct subsidy by the Govt. of India to the tobacco industry but indirect subsidy.
- Legislation against tobacco would be ineffective if people were not informed and convinced about the reasons for legislation.
- Need to approach and convince even the local and vernacular media to cover tobacco related issues.
- Need to convince the film producers and artists to not promote the usage of tobacco in the movies/serials; this was especially relevant as the theme of the World No Tobacco Day this year was '*Free Films from the influence of Tobacco*'.
- The information about tobacco to be integrated into existing health programs and through the educational system in school and colleges.

Mr. Niranjan from the People's Health Movement in Sri Lanka shared that the cost of one cigarette in Sri Lanka was 7-8 rupees and that was an effective deterrent also; it was discussed that Prof. Panchamukhi's study on Karnataka had proven that tobacco farmers were ready to diversify into vegetable cultivation but the market support was not in place. Whereas the tobacco industry was picking up its produce and taking it to the market, this support was not available for the farmers involved in vegetable farming to transport their produce to the distant markets.

The group then discussed the statement to be issued by the workshop participants- certain changes were suggested for incorporation in the statement before finalization and distribution to the ASF organizers and the media. The modified statement and the press release are attached.

Dr. Srinath thanked the participants for their active participation in the group discussion.

A formal vote of thanks was proposed and the workshop ended.

Appendix 8

NIMHANS- WHO Workshop on 'Suicide Prevention: Capacity Building Strategies' for Media Professionals
Venue:- NIMHANS Convention Centre, Bangalore
Date:- 1st February 2003

The Departments of Epidemiology and Psychiatry, NIMHANS have been organizing a series of workshops on the topic ' Suicide Prevention: Capacity Building Strategies' involving professionals such as doctors, teachers, police staff etc. to try to address the issue of increasing suicide rates in Bangalore. As a part of this series, a workshop was organized for media professionals to examine the role of media in the glamorization of suicide and to evolve parameters for ethical reporting of suicides.

As a part of this exercise, representatives from the various sections of media like radio, print, journalists, serial actors and directors along with a few NGOs and psychiatrists were invited to debate on this issue.

Prof. Mohan Issac, NIMHANS in his introduction said that suicide is becoming a public health problem throughout the country. Bangalore has the highest rate of suicide in the country and thus has got the dubious distinction of being called the *Suicide Capital* of the country. He explained that the suicide statistics in India, unlike other countries are sourced from the police and home departments using data of the National Crime Research Bureau. In the west, some studies had suggested that media portrayal of suicides did have an effect on the increasing suicide rates in the country but this effect needed to be studied in India. He said that the aim of the workshop series was to evolve a National Suicide Prevention Strategy.

Dr. Gururaj from the Dept. of Epidemiology spoke about the increasing reporting of suicides in the media. He said that the work on the present project had started with a seed grant from the Dept. of Science & Technology, GoK for work with the police in 12-15 hospitals. The Dept. had come out with two epidemiological reports regarding the same. There was a need to develop on the research as well as the intervention front and to translate research into practice. The current workshop was the seventh in a series of capacity building workshops to try to evolve culturally specific sustainable prevention programs. NIMHANS had begun a helpline in Bangalore along with the Medico-Pastoral Association and the Rotary Bangalore East. Suicide, which was a type of deliberate self-harm, was becoming a global problem. The WHO was trying to study violence as a public health problem. Violence linked to mental health was capable of leaving scars that would last for a long time.

Mr Ramesh Kumar, Former Speaker, Legislative Assembly, Karnataka who inaugurated the workshop said it would be better to revise the theme of the workshop to ' Has the media a role to play in the controlling of suicide rates'. Was suicide an act of bravery or one of cowardice? Age/Sex/Class was no bar to this problem and the factors that could be blamed would include discrimination, social/economic order, tension, anger, stigma,

political system etc. Suicide attempts not only affected the individual but also the family & community and the media needed to step in and try to address the general trends that were promoting suicides. A major reason could be the break up of the institution of marriage and evils accompanying marriage, which were leading to several suicides. A lot of vested interests were working to hush up theses issues- the media needed to realize that there was no need for sensationalizing but sensitive and courageous reporting was required to try to address the issue. Education of parents was also needed to make sure that they did not put unnecessary pressure on their children to perform in their exams. The race to be number one in all fields in Bangalore was perhaps by itself a mental health problem! The people who attempted suicide did not need compassion but support. The impact of cinema was significant and was working against the intentions of the seminar- in this context, the work of the people at the helm of affairs and the censor board had lost credibility. Suicide was an ailment and not a crime (which is how it is looked upon in the IPC) and directly or indirectly, we were all responsible for the suicides. Another important point was the role of teachers- parents left their wards in the care of teachers but some of them were behaving not as guides but as policemen without uniform. There was also a need for a commitment to tackle this problem by the medical profession.

Prof. D. Nagaraj, V-C and Director of NIMHANS in his presidential speech said that the suicide rate in Bangalore was three times more than the national average. Only 10% of the attempted suicides got reported to the police. In a way, suicide was a social (mis) behavior and society could promote a particular behavior. Frustration was common to everybody and there was a need to work to decrease it. He felt the best step for the media was to ignore the reporting of suicides. Sometimes the excessive glorification of toppers in various exams also caused a lot of depression in the not so successful candidates. The commonest association with suicide was family structure especially in relation to disturbed families – alcoholism/marital disharmony/mental health problems; media could help in promoting the strengthening of our family system.

Session 1

The First session dealt with an overview of the problem by Dr. Gururaj. He said that the global suicide rate had increased. The highest prevalence was in the states of Karnataka, Tamil Nadu , Kerala and West Bengal all of which had suicide rates in excess of 15/ lakh population. In Bangalore, the rate was the highest in the country (around 35/lakh population in 1999) followed by Indore. This increase had been marked in Bangalore which had seen the figure rise form 20/lakh in 1989 to 35/lakh population in 2000. The maximum numbers of suicides were reported in the age group of 15 to 34. 75% of the attempted suicides in the city involved usage of OP or carbamate compounds. Alcohol played a major role in suicides- directly or indirectly. The issues in causation were combined, cumulative, progressive, repetitive, unresolving in nature and inter-related to each other. The media sometimes indulged in irresponsible reporting and did not follow up the causes of suicides. There was also the sensationalizing of celebrity suicides on the front page of newspapers while the other stories usually appeared in small print in the innards of the paper. There was a need for a humane approach utilising our strengths.

Session 2

Prof. Mohan Issac in the next session examined the topic of whether media portrayal & reporting of suicidal behaviors influenced the society.

He raised two main queries

- Did media have the power to trigger suicides in some people?
- Did it also have the power to prevent suicide?

There was a variety of media including literature, press, music, broadcasting, theatre, films, television, electronic and internet (there were even a few sites that even helped in the planning of suicides).The person who was attempting to commit suicide could have displayed behavioral changes in the form of suicidal ideas/ gestures / threats /communications. The effect of the media portrayal could involve the following components:-

- Invitation- learning by modeling.
- Contagion effect- copycat suicides in the younger age group- teens/adolescents/ early 20s

The media effects could be examined with regards to the following issues:-

1. age and gender specific.
2. size of coverage.
3. audience /readership.
4. frequency and manner of presentation.
5. characteristics of the model of presentation.
6. personality of the viewer/reader-suggestibility of the individual and vulnerability.

Most of the research in the field of effect of media was from the developed countries and it would not be necessarily be applicable in the Indian context. Within the universality of rising suicides throughout the world, there were certain variables:-

- Suicides increased with age in the west while they decreased in India
- Suicides were more among the males in the west (global male: female ratio was 3.5: 1) while in India the ratio was in the range of 1.4 - 1.5: 1. In some age groups, the ratios was reversed (this phenomenon was also seen in China)
- The causation of suicides was multi factorial with a predominance of socio-cultural factors in India while in the west the developed countries, more than 90% of suicides were due to psychiatric disorders like depression
- The methodology in the west was suicide by firearms/motor exhaust/domestic gas/ CO poisoning while in India, it was OP and other insecticide poisoning, drowning and burning.

- It was important to not blindly ape the western findings but to do our own research.

Session 3

Mr. Prakash Belavadi, Kannada Serial & Movie Director did an analysis of the topic 'Suicide on the silver screen- Is there any silver lining'.

The main factors according to him were:-

- Morality and values
- Milieu
- Motivation.
- Methods and treatment (depiction in the media).
- Media- Cinema and television.

He also tried to analyze the treatment of the subject in various religions:-

- Islam- Suicide was forbidden by the Koran but there was a feeling that certain sections had been misconstrued and so there were the jehadis who were glorifying suicide attacks.
- Hinduism- it was rarely allowed but the practice of sati had been accorded social recognition.
- Christianity- it was tolerated in the early ear but had been declared a sin in the post 6th century.

Some authors had also dealt with suicide in their treatises like Shakespeare in *Antony & Cleopatra*- Act IV

Three main categories for the depiction of suicides in the media would include:-

- ✓ Martyrdom & Sacrifice- For God/community/country/cause/love e.g. the death of Jack in 'Titanic' movie.
- ✓ Honour & Dignity- Family/Gender/ Social Status/ Community Values.
- ✓ Expiation & Redemption- Sacrifice, Demonstration and Isolation.

The milieu exhibited in contemporary mainstream cinema predominantly had a feudal setting with the rich upper class where it was fine to have a glamorous lifestyle and divorces took place routinely while the lower classes were condemned to their lives. There was thus a lack of adequate representation of the middle class urban families.

The plot & setting of the suicides in movies/serials was-

- Family: monetary, premarital or marital discord.
- Community: Feudal setting in village, criminal mafia don in the city, political.
- Motivation: Lover, friend, poor father.
- Women: Bride or mother.
- Repentant Villain /Parent or mislead vamp.
- Suicide because of dishonor or for gallantry.
- Suicide out of shame.
- Suicide by the villain out of disillusionment or vengefully.

As the final aim was commercial success, the theme had to be visual & action oriented and had to be filmed in locations such as railway lines, cliffs, waterfall, factory godowns, home. The suicide was always of an identifiable character as it would be emotive. It was also assisted with special musical effects to reinforce the melodrama.

Television serials tended to be more realistic rather than movies unlike cinema that was intense. There was also more social censorship on TV than in films because of the advertising restrictions. Also, TV serials were primarily geared towards the middle class viewers.

Session 4

Mr. T.S. Nagabharana , Director, Films & TV in the next session said that there was a certain percentage of audience that received entertainment exclusively through the cinema. The main purpose of cinema was entertainment and very few ventures were meant for social reform. Violence, sex and thrill garnered the maximum amount of revenues for the producer and hence dominated the storyline.

Session 5

Ms. Aparna, film and serial artist and anchorperson spoke about the glorification of suicides in the media. Media could be used to prevent suicides and it could also work as an interventional tool. She recollected about the depiction of suicide in one of the famous Kannada movies that had stayed fresh in her memory because of the way it was conceptualized and shot. There were also increasing suicide rates related to job stress and the decline in the software sector. The ethos of the struggling city dwellers were such that they had all become apologetic about their lives and the belief that only if one could be a software professional working in the states was a person successful was causing a lot of depression. City life was impersonal and there was nobody to talk to (Gossip as a stress buster!). There was a need for an active outlook and to encourage everybody to respect their lives and the way they lead it (self esteem).

Session 6

Mr. Nagesh Hegde, Scientific writer, Deccan Herald explained that there were severe limitations in the way the media could deal with suicides; there was the necessity to stick to the truth. The print media depended on the police records and version and could not have a roaming reporter searching for suicides; also they could not have emotional coverage but had to strive for unbiased reporting. There was a lack of print space to reflect on causes and also the press could just be a mirror of the society. He also invited the health professionals to stop pointing fingers at the media but to start informing the media about how to intervene and how to teach parents/family members to pick up pre-suicidal hints in children.

Session 7

Mr. Krishnamurthy, Station Director, IGNOU Gyan Vani FM channel spoke about his three decade long association with AIR that included a stint as director. The policy was to seldom report suicides in the news along with murders and sexual assaults. The primary focus of AIR was education, information and entertainment and in its 75 yrs of broadcasting it had tried to convey news without sensation or speculation. Accurate and confirmed news were only broadcast According to him, mass media could only act as a catalyst but it was for the society to change.

The media could not be blamed for the increase in anti social activities when the society itself was denigrated

Session 8

The next session was a panel discussion that was moderated by Ms. Shailaja Santosh and involved artists, journalists and medical professionals. The main points that emerged included: -

- The public tended to remember those things that glorified violence/sex/problems rather than other parts of the movie.
- The increased expectations in the society – educational, financial etc. might be a root cause.
- There was also the issue of depiction of the women in media vis-à-vis helplessness, violence, gender disparity and sexual oppression.
- Emotional fulfillment was possible only in a relationship – this myth had been spread around in young women and so failure in relationships/love lead to devastating results.
- The print media usually buried the news relating to suicides in the middle pages in small font.
- The material aspects of life were being given prominence.
- Non-participation was the problem in our country and this was also reflected in the lack of concern in civil society to respond to the rising suicides.
- There was probably some indirect suggestibility of the suicide stories – it could mirror the fact that repeated viewership of advertisements could influence some viewers to buy that product.
- Genetic epidemiological studies had also shown some familiar predisposition towards attempting suicides.

Session 9

Dr. C.J. John, a leading psychiatrist then presented the experiment in Cochin that was among the very few cities that was witnessing a falling trend of suicides. A voluntary organization called *Mythri* had trained 42 volunteers to listen to the problems of those at risk of suicide. The organization had done a content analysis of the reporting of suicides – the unusual methods got prominence e.g. suicide pacts, celebrity suicides. However, there was under reporting of the preventable health problems such as depression and about people who had managed to deal positively with their suicidal thoughts and about early identification and

prevention in those at risk. A suicide affected the family members as well with stigma/discrimination/grief.

The issue of suicide was multifactorial and the media did definitely contribute. The same stimulus had different effect on different people and on the same person in different situations.

The media suicide stories with the potential of contagion effect were those that paid undue emphasis on the method, had repetition with prominence, involved celebrity status and had over simplified causes highlighted, those that were done with a touch of glorification.

The disinvestments in human values and relationships caused increased vulnerability and many ended up being emotionally isolated and depressed in economic hardships.

In Kerala, it was not poverty but the misconceptions about prosperity that were leading to the phenomenon of *neo-poverty* in the middle class families with the associated stress. State wise, Kerala had a higher suicide rate than Karnataka.

The decision to change the media coverage would have to address the need to attract and hold the audience, the freedom of expression and the desire to serve the public interest. Achieving a balance was difficult yet possible. Society also needed to debate whether the media was being provided with stories giving the message *that living worked.*

Mythri had especially tried to work on the *Sorrow of May* when the public exam results of X standard were declared. The stress here was the perception of failure – even 85% and not 90% and above marks in the exams was looked upon as failure. The interventions dealt with the facts that students in distress needed somebody to listen and to care and the understanding that they were not alone in that feeling because many were going through the same state. The Kerala govt. inspired by this initiative has decided to open intervention centers in all the districts of the state. There was now a movement 'Life calling: Suicide Prevention is Everybody's duty' which wanted to make the community aware that there would be feelings of depression in the midst of jubilation and celebration.

The health professionals need to consider meeting journalists as an opportunity and not a threat. Suicides were preventable in many cases if some simple things were remembered:-

- Learn to listen to the cry for help.
- Learn to share when depressed.
- When encountering severe depression, consult experts.

Some Suggestions that Dr. John gave form his experience included: -

- *Suicide stories could be perhaps published with the obituary columns.*
- *Counseling training could be given to the teachers of schools so that they could help during exams.*
- *Reorientation of GPs so that they could identify the depressed and counsel them at the earliest.*
- *Need to work at different levels with formal and informal leaders of the communities.*
- *Pre exam counseling in two batches – for the students and another for the teachers/parents.*

The media was playing a role in the moulding of unrealistic expectations in life.

Session 10
This involved an open house discussion in which the audience interacted with the speakers and gave their inputs about the topic.

Session 11
The final session was the framing of guidelines for the media, which was facilitated by Dr. Mohan Issac.
There was a need to strike a balance between freedom of expression, freedom of the media, the public health interest (minimizing the risks) and the commercial interests that influence media reporting and policy. The proceedings of the workshop would be framed into guidelines for the media and it would be a first step for a long term association with the media . There could be a dialogue with specific people in charge of sections in the media with innovative ways of reporting soliciting the help of NGOs. Work with the media required in depth investigation into the types of the media and how to address them. **The media needed to desensitize help seeking when in distress and highlight the succour centers and helplines for those depressed**. The media could also portray suicides differently, highlight the alternatives, focus on the positive roles and work for follow up.

The workshop ended on this note after a day of deliberations and discussions.

Dr. Anant Bhan
CHC
18th Feb 2003

(a synopsis of this report was published in the Issues in Medical Ethics Apr-Jun 2003)

Appendix 9

One-Day Seminar on the 'Pre Natal Diagnostic Techniques (Regulation and Prevention of Misuse Act)

Wednesday, 5th March 2003
Venue:- Institution of Engineers, Ambedkar Veedhi, Bangalore

Organized by

The Directorate of Health & Family Welfare Services, Govt. of Karnataka
Voluntary Health Association of Karnataka
Family Planning Association of India, Bangalore

Background:- In India, the female child population in the age group of 0-6 years has fallen from 945 per thousand males in the 1991 census to 927 in the 2001 census. In certain cases the fall is alarming with Punjab, which had a 0-6 yrs. female population of 875 per thousand males in the 1991 census having presently 793 per thousand male children. In the present scenario, female foeticide has become common while it was female infanticide earlier. The misuse of technological innovations like the ultrasound machine, Amniocentesis and Chorionic Villus Sampling (CVS) for the Sex Determination Tests has been a crucial factor in the rising number of abortions of female fetuses.

The PNDT Act was enacted in 1994 after a prolonged struggle by concerned members of society and various women's organizations. Despite this act having been in force for 9 years now, there has been not even a single conviction for female foeticide countrywide. With these facts in mind, this seminar was organized to raise awareness about the act not just among the doctors but also the members of the public especially the women.

Proceedings of the Seminar:

The seminar began with a Sharing of Experience by Dr. B.S. Ramamamurthy, renowned sonologist form Bangalore. Dr. Ramamurthy spoke about the pressures through which doctors are put through by the parents and the family to reveal the sex of the child. But the doctor has to be steadfast in refusing to divulge any such information especially now with the strict provisions of the Act. He revealed that many doctors while doing a chromosomal analysis also do not report on the types of sex chromosome but only whether they are normal or not.

The formal inauguration of the program followed this frank talk by the doctor. The key note address was delivered by Dr. Manorama Thomas, Emeritus Professor, St. John's Medical College. She said that the aim of the seminar was to raise awareness about the declining sex ratio and about the act. The purpose of the act was to prevent misuse of genetic techniques for the identification of the sex of a child for foeticide.

The problem was very acute in the states of Punjab, Haryana and Punjab and also in some parts of southern India like Salem district in Tamil Nadu. There had been some cases in families wherein 'draupadi' system was being followed with one bride for 2-3 brothers because of the lack of women in the community. Interestingly, the 'Charakha Samhita', the ancient Indian treatise on medicine also mentions technique for sex determination using the pregnant women's urine. The PNDT act was passed in 1994 and published in the Karnataka gazette in January 1996; the advisory committee was established in February 1996. The committee started registration of the 'antenatal genetic counseling & techniques' clinics. However it was soon realized that the advances in ultrasound made it possible for the sonologist to be able to predict the sex of the baby by scan after the 12th week of gestation and hence an amendment was brought in the Act to bring in ultrasound scan centers under the ambit of the Act- this move had met a lot of protest and in Karnataka, the professionals in Bangalore and Mangalore were very vociferous in their opposition to this amendment.

This was important as the sex ratio had fallen in the various districts in Karnataka except Hassan , Udupi and DK districts. Some of the doctors were not directly mentioning the sex of the baby but rather using terms like 'jalebi' for the female foetus and 'laddu' for the male foetus. As this was not a part of the records maintained at the centre, the committee could not do anything about it.

The need of the hour was to change the mentality of preference for males, but it had to be accepted that this was rather difficult.

Dr. Thimmaiah, Project Director, RCH, Karnataka then mentioned the responbilities of the state appropriate authority (Project Director, RCH). He said that each of the 27 districts of the state had a district appropriate authority. More than 1300 organizations had been registered, but only 31 implicated for practices against the provisions of the law.

Mr. Kogadu Thimappa, the Hon'ble Minister for H &FW and Information then formally inaugurated the seminar. He spoke about the dual personality that was persisting in the Indian psyche wherein we try to be scientific in our outlook but at the same time we are bound by our social beliefs. We cannot claim to have social and gender equality until we look upon a lady and a gent coming out of a room together in the same light as two men coming out together. There is a need for a consistent movement, campaign and debate. The practice of sex determination is more among the educated class who are aware about the relevant technology and in many cases also know the doctors who will oblige them – unfortunately, this seems to be catching up even among the rural folk with the mushrooming of mobile clinics. He said that the information dept. of the state govt. was very good at making posters and other educational material but a token 5000 posters would not change the mindset of a population in the state running into several lakhs. He expressed happiness that there were several young college girls in the audience who were the future mothers and would benefit the most from the seminar.

Mrs. Subhadra Venkatappa from the Family Planning Association of India (Bangalore branch) delivered the presidential address in which she highlighted the fact that as a

society, we need to be able to say an emphatic no to these abominable practices. She reiterated the fact that the misuse of the available technology was most by the educated class. Both women and men need to work together to address this social problem. Female or male, the child still belonged to the parents. Perhaps, a partnership between the civic society and the government would help.

Dr. S.V. Joga Rao, a famous health law consultant gave a detailed explanation of the Act. He began by saying that we were in the midst of pervasive technology, be it IT or BT. Any technology has a positive side and a negative side and this holds true for the medical technology also. At this point of time, the actual birth of the baby is not required to be able to know the sex of the baby but technology can do the same during the period of gestation only. The main aim of the technology was to diagnose and treat but the incidental finding was the sex of the fetus, a fact that could be misused. There was an ardent need for regulation of the technology. In India, the medical termination of pregnancy had been allowed in special conditions under law by the MTP act of 1972 and these provisions had been misused rampantly for female foeticide. All of society and not just the population in the reproductive age group is instrumental in the problem. By law, the Sex Determination Tests (SDTs) like amniocentesis can be used for the diagnosis in certain conditions like the woman's age being above 35 years, history of previous abortions, and family history of chromosomal disorders but adequate records mentioning the reasons need to be maintained. At present, the law is there, the structures are there, but the practices continue unabated. When the Supreme Court enquired about the fact that how many clinics had been registered across the country, 15 states feigned ignorance about the existence of the Act! SDTs were the cause of the victimization of the voiceless by a network, which could include the mother, father, in laws, the doctor and the brokers/touts. Already there were ads which proclaimed 'If you want a boy, contact Dr. X between 10 & 11' – maybe the day was not far when we would get promos saying 'If you want your child to be the next Sachin Tendulkar, contact at this time'. The need for regulation of the centers and proper documentation was needed but it was to be remembered that it was still possible to communicate the sex of the foetus in indirect ways. In India, we were experts in passing the buck. A few cardiologists, nephrologists using ultrasound machines had questioned their inclusion in the act but the court had clarified that any machine that is capable of picking up the sex of the foetus has to be registered. Three registerations have to be done- that of the place, the machine and the centre; this was to make sure that the relevant authorities knew who was doing the tests and where to address the issue of mobile clinics. At the end of the day, the PNDT Act was a simple Act but it had a lot of social ramifications. Records in all registered centers had to be kept for a period of two years unless a criminal case was ongoing wherein they had to be maintained beyond two years. Sometimes it was not the doctor conducting the test who was disclosing the sex of the foetus but some other accomplice and the new amendment in the Act had made this also illegal. The new amendments made it also illegal to indulge in techniques of pre conceptional sex determination (the infamous ad controversy regarding the ad of GenSelect in leading daily in Bangalore was mentioned) and the new title of the act was now the Pre natal/Pre conception Sex Determination Regulation and Prevention of Misuse Act.

Dr. Kamini Rao from the Bangalore Assisted Conception Centre spoke about the medical professionals and highlighted that it was for the health professionals and the activists to not be on opposite sides but to join hands to address the menace. The blacklisting of the medical profession due to the practices of a few was unjustified and unwarranted 'doctor bashing' needed to be stopped. The doctors could not go to the streets and do dharnas and morchas to present their case. The Dept. of Health & Family Welfare, which Dr. Kamini Rao had voluntarily approached for registration of her centre did not have any idea about the procedure involved for six years. Unfortunately, there was a lot of mistrust about doctors developing in the masses. FOGSI, which was the national body for Obstetricians and Gynecologists and consisted of 18000 professional members and more than 150 branches across the country had opposed the female foeticide and supported the empowerment of women. Education was not just teaching of the alphabet but the change needed to be in the heart of the person which would stop mothers from allowing their own daughters to be killed. Unless a multi pronged strategy was adopted to target the women who asked for the test, the family who was pressurizing her to do that and the doctor who agrees to do the test, it was difficult to make much progress. She stresses that doctors were ready to pledge at any forum their support for this campaign as they stood for the health of humanity –it was unfair to look upon them with jaundiced eyes.

Ms. Shantala, a senior correspondent with a local daily presented her thoughts about the role of the media, which comprised the fields of advertising, films, radio, television and newspapers. She reminded the audience about the controversy that had erupted when the soap 'Kyunki Saas Bhi Kabhi Bahu Thi' had shown pre natal sex determination in one of the episodes. While Article 19(1)a of the Constitution gave the freedom of speech, Art 19(2) also imposed reasonable restrictions and this was a clear violation of those. She had been offered a fellowship to study the PNDT act implementation in one district of Karnataka. Ms. Shantala had chosen Mandya as it happened to be the constituency of the Chief Minister. Mandya was a predominantly agricultural area and the feudal system still persisted. The first child in a family was expected to be a boy and there were cases wherein women who had two daughters had subsequently undergone five consecutive abortions (after SDTs) in the 'quest' of a son. The sex ratio in these areas was among the lowest in the state with Maddur registering 910 and Srirangapatna 890 in the age group 0-6 years. In a small locality called Ashoknagar in Mandya, there were around 15 nursing homes; most with scan centers attached, which were involved in the practice. Theses places preferred the uneducated who would have no knowledge of the law. The bait was the slogan '5000 spent now will save you 5 lacs later'. It was package deal wherein a middleman/ANM would help the patient get through the entire process of a SDT and an abortion, if needed for Rs. 5000 in a couple of days; the doctor would send the patient to a scan centre which would not give any report but only a chit of paper with + or – written on it which the referring doctor would interpret and act accordingly. The process was supposed to save the patient and her family the sum of Rs 5 lacs that they would have to spend on their daughter's marriage in the future should she be allowed to be born and raised up.

Dr. H. V. Ramprakash, a radiologist elaborated on the role of the voluntary organizations. He explained that a major reason for the increasing scan centers were because of

increased role of ultrasound in the fields of medicine- only 10/100 patients approaching sonologists were pregnant antenatal women. He hastened to add that however there were 122 female children dying for every 100 male children dying in the 0-4 years age group. The number of dowry deaths had also been showing an upward trend. The NGOs had an important role to play. Female literacy and health awareness was a major component and the high literacy levels in Kerala and the healthy sex ratio there was an indicator of the importance of this step. Some TBAs had a belief that they needed to kill the 3rd born girl child as it was supposed to bring harm to the attendant. There was also the problem of neglect of the girl child and the battered baby syndrome- in these cases the mid day meal schemes like the Akshayapatra service of ISKCON could help. We as a nation had quite a high MMR (490 per 1 lakh live births which was the highest in the world); only 30% of the deliveries taking place were being handled by the trained staff. In the productive age group of 15-48 years, there were only 906 women per thousand males. There were more than 7 lakh abortions a year in the country while the govt. claimed that it was only around 60,000(because only these many got registered). Identification of mobile clinics that conducted SDTs and closing them was also something the NGOs needed to take up with the govt.

The discussion was then thrown open to the audience. Dr. Manorama opined that if the falling sex ratio continued, then the practice of dowry would stop and that of bride money would start. Another lady said that it was important to treat every child as a human being – not as a male or a female; society needed to accord respect to a woman, whether she decided to get married or remain unmarried, whether she was having a child or was childless. A doctor in the audience said that the dowry deaths were being encouraged by women themselves- including mothers-in –law or sisters-in-law. A young college girl responded to this very frankly and **asked that this might be true, but what was the husband doing at that time**? If the husband was supportive, then no other relative could cause harm to the woman. Another doctor ventured to say that there were a lot of educated young people who were coming forward to undergo permanent sterilization even if they had a single child. We needed to respect ourselves and other human beings irrespective of sex. The purpose of the seminar was not to encourage the hatred of men but to develop a feeling of mutual regard. A case wherein a junior engineer had asked the doctor to kill his 3rd girl child was narrated – the doctor asked the person to donate the child but the person refused saying that he did not want his wife to know that the child had survived so that she could get pregnant a fourth time. Interestingly, this couple had not gone in for a SDT because some local deity they had prayed to had purportedly told them that they would get a son this time. The condition was so abysmal in some places like the Erode Hospital that ayahs had to be posted to wards having recently born female babies to prevent any killing. Dr. Manorama mentioned that some of the ultrasound scan centers were telling the patient about the sex of the foetus as early as the 10/11th week of gestation when the test could only predict with some degree of accuracy only after the 12th week of gestation- this accuracy was limited to 85% in the case of scans and 90% in the case of Chorionic Villus Sampling. This was clearly just a ploy to cash in unethically on the craze of Sex Determination.

Ms. S. Venkatappa spoke about the concerted efforts to implement the act. She said that the purpose of such seminar was to sensitize people about the PNDT act. All the speakers had expressed their commitment to the cause. And even the participants had been convinced about the need to sensitize others; the need of the hour was the right environment to empower people especially the women.

H.E. the Governor of Karnataka, Sri. T.N. Chaturvedi in his valedictory address highlighted the need of establishing partnerships for removing social ills. He narrated personal experiences of getting to know about cases of infanticide when he was serving in Rajasthan. While the govt. was making efforts, support towards awareness and consciousness was need. The problem was widespread and deep rooted and hence, the society needed to be vigilant about the problem and continuously work towards helping the message percolate to every part of the state – perhaps such seminars/workshops could be organized in other pats of the state and the country. The declining sex ratio in Punjab due to foeticide was surprising because one of the Sikh Gurus was emphatic in his teachings about the women's empowerment. It was not just the quacks and half-baked physicians but also respected professionals with loads of degrees who were making the Hippocratic oath hypocritical. It was unfortunate that the legislature had not enacted the law but it was on the direction of the Supreme Court on the basis of a PIL filed by an individual. The practice of SDT was an affront to the constitutional rights of the 'would be' citizens of the country and violation of the dignity of the individual (the importance of dignity has been enshrined in the Preamble to the constitution). Karnataka could perhaps take the lead in encouraging a govt.- public interface for the purpose. The seminar was a summing up and a call for concerted action in the future.

Sex Ratio(in the age group of 0-6 years; girls per thousand boys

- National (1991): 945
- National (2001): 927

- Karnataka (1991): 960
- Karnataka (2001): 949

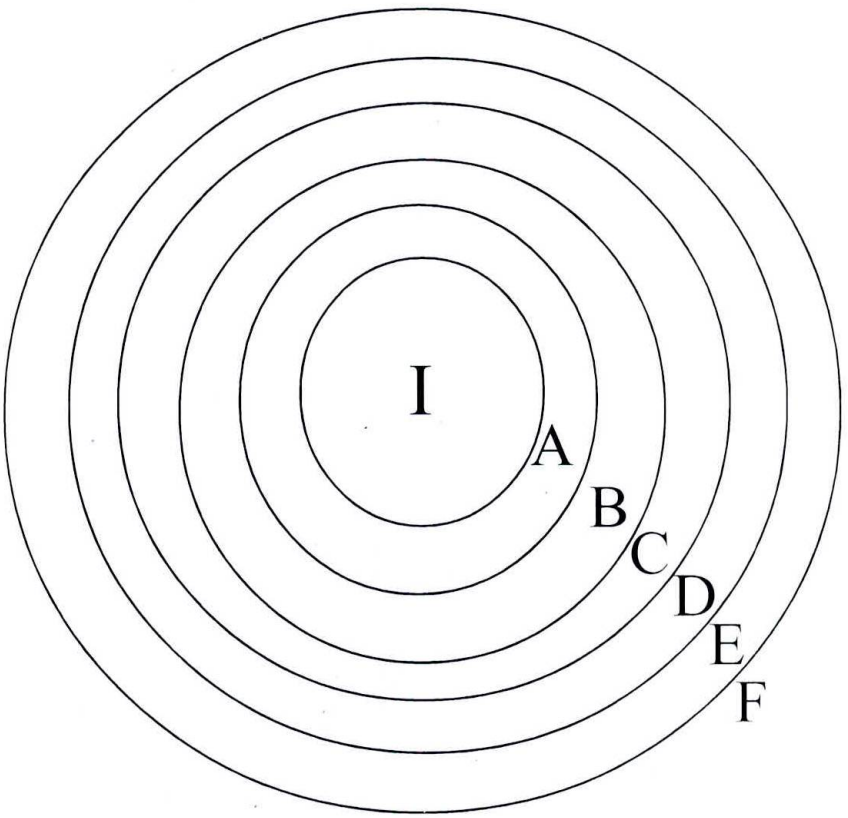
Dr. Anant Bhan

Appendix 10

COMMUNICATION STRATEGIES

As a part of the Life Skills Training Program for trainers organized by CHC on 18,19 and 20th March 2003, Mr. Maggimai Prakaṣam conducted a session on Communication Strategies.

He began by highlighting the fact that life is based on relationships, which are developed through communication. Many times, we are not able to relate to others because of fear. Human communication is a complex and difficult process.



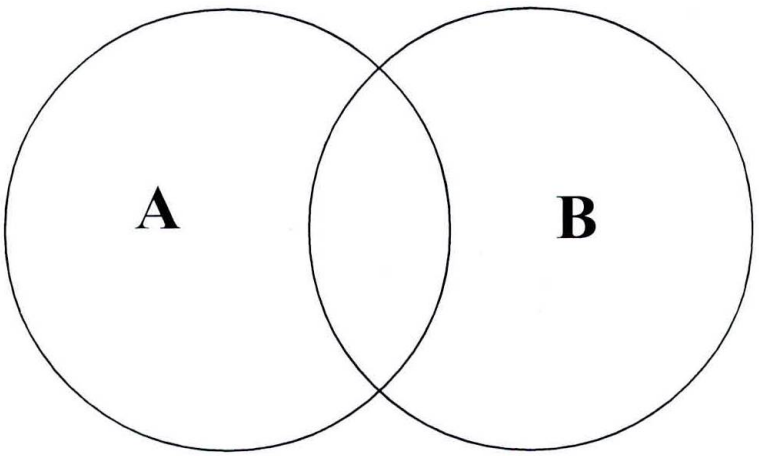
In society, we live in various **circles of closeness**.

1st circle: Closest family (A)
2nd Circle: Friends, relatives (B)
3rd Circle: Colleagues (C)
4th Circle: Community (D)
5th Circle: Others (E)
6th Circle: World (F)

Appendix 10

Our emotions are continuously dynamic and the ambient environment, light; touch etc. can keep changing our emotions on a continuous basis. It is only that emotion which we are feeling inside us, that we can share with others.

At the time we are born, we create a world around us, and relate to the people around us. To have better communication with others, we need to overlap our circles to influence each other. Also, we need to work together to pool our resources and identify our Strengths, Weaknesses, Opportunities and Threats (SWOT).



There are a few major stumbling blocks in this process: -

(1) What is going on (WIGO): IF we tend to assume that what is going on in our mind is the same as what is going on in somebody else's mind, then there is 'Conflict' as all of us, even identical twins differ in our thinking to various degrees.

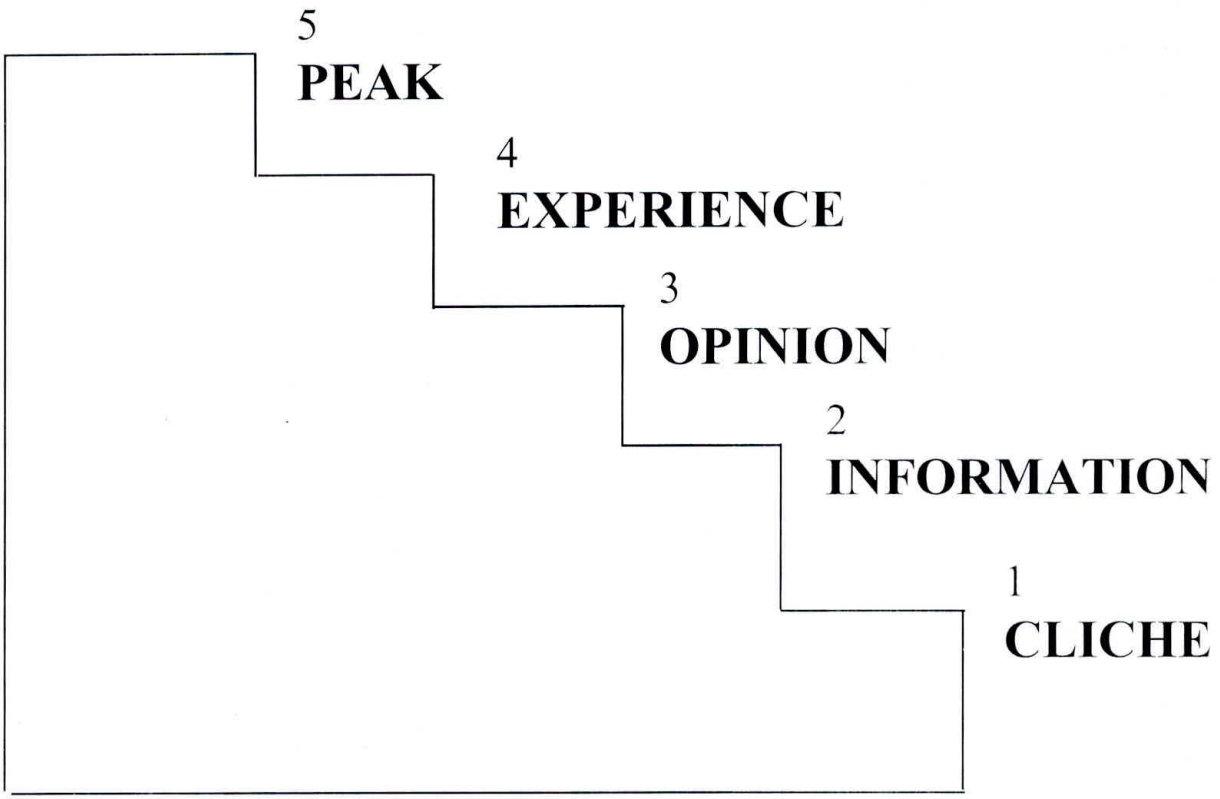
(2) What is Selected (WIS): Humans are selective by nature and so also in their relationships and communications. We usually select what we want from the conversation; we need to improve our selection process.

(3) What is means to you & me (WIMTU): This relates to how we interpret the message- properly or not; meanings lie in people and not things.

Appendix 10

We all differ in our upbringing and hence we also interpret new things based on our past experiences. There are at many times differences like cultural ones between various people; the way we talk, sit and behave sends out messages and signals to other people based on their past experiences. Only solution for better communication is to attempt to overlap the circles of closeness. A lot of overlapping is especially needed in the first 3-4 circles, as we have to walk with theses people for a long distance in our personal and professional lives.

We often forget that every other person is equally intelligent. However, the other person can sense this very quickly and she/he modifies his/her behavior accordingly.



Levels of Relationship

Appendix 10

Levels of Relationship

(A) Cliché- *French; it is there, at the same time, it is not there* 'formalities'. We cannot remain in this level for too long as it causes problems in relationships. Here, the interaction of two individuals is limited to exchanging pleasantries like good morning, good evening, Hi etc.

(B) Information- 'facts'; when we share info, we are in the second level of relationships; if we stagnate here, the relationship will not grow.

(C) Opinion- according to us, what we feel; To apply 'I' in any situation, we need stronger ties; when we express opinion, we have to take the responsibility for the same because we might be quoted in the future; this is an important stage because, here trust is built and we come to know how assertive we are.

(D) Experiences- we need to share experiences; 'SWOT' is needed to bring the two worlds of individuals together and increase the space in the common third world.

(E) Peak- we should aspire to achieve; in the least, in most of our relationships, we should reach the fourth stage.

- The more we identify with others, the more we relate to them. We cannot put on a show for a long time.

- 'Your non verbal gestures are more important that your verbal gestures' Sigmund Freud

Listening- 80% of our problems related to interpersonal relations & skills are due to lack of listening properly; if we listen properly, we accord respect to the person.

Appendix 10

WIGO- Hearing

WIS & WIMTU- listening; it is a process of selecting, organizing and interpreting. Human brain is capable of doing this process at a speed of 400-words/ minute at the maximum.

Causes: Poor Listening

(1) Physiologically tired- it is better to tell this to the other per son than to fake talk.
(2) Emotionally preoccupied.
(3) Language- not known, speech too fast or incomprehensibly.
(4) Pre conceived notions- judging people prematurely based on assumptions.

Good listening skills required: UPISE

Understand the other person.

Patience is necessary

Interest- head nod, eye contact, face to face.

Support

Empathy- put oneself into the other person's condition.

Dr. Anant Bhan
March 2003.

Appendix 11

Report of the Training Program at FRLHT between 14-16 April 2003

A three-day residential Trainers' Training Program on Documentation and Rapid Assessment of Local Heath Traditions (LHTs) was organized by FRLHT at their sprawling new campus in Yelahanka, Bangalore from the 14th to the 16th April 2003, the aim of the program being to orient the participants towards the richness of the cultural heritage in the community health practices that our country possesses and to give hands on training on rapid assessment and documentation of the same using classroom lectures, discussions and field visits.

The total numbers of participants were ten, most of them with no prior experience in this field. Mr. S.D. Rajendran and Dr. Anant Bhan represented CHC in the training. The participants were picked up from Anand Rao circle on 14th morning and were taken to the FRLHT premises.

After the participants had freshened up (as many of them had come from outside Bangalore) , the sessions began with the traditional lighting of the lamp and then an introduction was given to Local Health Traditions and it was explained how they were different from the codified systems of medicine (e.g. Unani, Tibetan , Ayurveda etc.). The contemporary relevance of the LHTs was discussed in the next session and the fact that these could help in better health care to the populace was highlighted especially with regards to the key components of accessibility, affordability and compatibility. The neglect and the causes for the downfall of the LHTs and the need to revitalize them was explained.

A brief introduction to the Participatory Research Methods was given and the steps involved elucidated. The ethics and the IPR (Intellectual Property Rights) issues were discussed, the facilitator being Mr. Ghate, a researcher on the subject at FRLHT. This was followed by the explanations of various documentation methods, the methodology involved, and the need for care during the process. A preliminary plan was evolved for the field visit scheduled for the next day.

On the 15th April, a visit was organized to a Natti Vaidya Shri Thirumalaiah in Urdigere near Tumkur. The participants spent around three hours with him and interacted with him on various aspects of his practice, using the opportunity to do a documentation exercise. The Vaidya also took the team to his medicinal garden and explained the uses of some of the plants grown there. This was followed by a visit to a Natti Vaidya Sangha consisting of around 15 women in Aladamaradapalya, a village nearby where groups were made and the LHTs related to Post Natal Care were discussed and documented. The team then left for Namadachillume where a MPCA (Medicinal Plant Conservation Area) has been established in conjunction with the forest department. The team then returned to FRLHT.

The third day (16th April) started with analysis of the documentation done the previous day and reporting of the same. An introduction to digitalization and the in-house software designed by FRLHT for documentation of LHTs was the next session. Mr. Murthy, administrator and Snr. Program Officer explained various promotional strategies w.r.t LHTs and the experience of FRLHT in the same especially the work done in the field of KHGs (Kitchen Herbal Gardens).

A visit to the Herbarium at FRLHT was organized where 2500 species of plant specimens have been preserved on 25000 sheets of handmade paper of which 1500 species have medicinal value. Many wet specimens have also been kept. All these have also been digitally stored in a database making it easy for exchange of specimen information between researchers without actually transporting the specimens.

An introduction to the methods for Participatory Rapid Assessment of LHTs was done. Dr. Unnikrishnan from the Traditional Systems of Medicine (TSM) dept. then summarized the proceedings of the three days and encouraged all the participating organizations to initiate work on this important area. A formal vote of thanks was proposed and the program drew to a cose.

Dr. Anant Bhan
17th April 2003

Appendix 12 (Preliminary draft)

Gender in Medical Education: Why the need

'Its Friday night in the undergraduate boys' hostel of the medical college and this is the day when one finds the maximum hostelites in the mess room. This is because this is the day of the week where almost on a religious basis; a fest of pornographic movies is held starting from Hollywood skin flicks and then graduating through soft porn into hard porn. The catcalls and the sexist comments reach a crescendo as the night progresses'.

'September brings with it the fresh batch of students into the hostel and soon, it is time for the annual freshers night. The juniors are made to 'perform' for their seniors. The most popular performances with the seniors are the ones in which there are simulations of the sexual act, jokes with sexual innuendoes, and usage of locker room banter. The juniors who have not used these 'creative' ideas have to bear the brunt of more ragging that their 'wiser' counterparts'.

'It is noisy in the labour ward as many women are about to deliver. As they cry out in pain, the interns on duty are busy playing cards, not at all concerned about the apparent distress that the women are in; the ayah on duty keeps cursing the women periodically and asks them to hurry up'.

The issue of the importance of bringing in gender issues in the field of medical education is being widely debated with CEHAT and the AMCHSS having taken up the mantle of also devising a short course in the subject. The young medical professionals who graduate en mass form the Indian medical colleges have most of the time no clue about. how to relate to a female patient & to address her special health needs. This is especially true of many male graduates who sometimes just blank out when they have a young lady coming in with specific complaints.

The dehumanizing way in which the practice of Obstetrics and Gynecology is carried out in many teaching institutions and the scanty respect given to the patients in the wards/delivery rooms/ operation rooms gives no opportunity for a student to learn the art of making a lady patient comfortable before a pelvic/gynecological examination which is almost an intrusion of the privacy of the individual, especially so in the Indian context. The way the women are herded for the D&Cs, MTPs, IUD insertions in almost a factory production line manner with a rare word of encouragement, succour or empathy only serves to build up a stereotype in the impressionable mind of the student.

The lack of choice that the patient has in matters relating to her own health is frequently reflected in the way she is asked to eat this tablet, get that test done, and many times in the way the contraceptive choices are thrust on women without explaining the pros and cons and the side effects of each choice. This is an example of the typical top-down approach that ails our beleaguered health care system.

Many students when they join medical college come from backgrounds of having studied in same sex institutions and it takes a long time for many to adjust to the atmosphere in the co-ed medical institutions. When this is the time when a feeling of camaraderie

between the students should be developed, either the freshers are being ragged or are being thrust into dissection halls and asked to cut up cadavers reeking of formalin without any time given for adjustment.

There is also the issue of the paramedical workers being looked down upon by the doctors and hence the students also imbibe the art of unfair treatment to them especially the nurses (most of who are female) who are expected to be following each order to the hilt and are almost never thought as team mates. Unfortunately, even the women physicians fall prey to this mindset, thanks to the well-entrenched system & the trap of the male hierarchy.

The focus in women's healthcare is on the obstetric and childbearing aspects in the reproductive age group of 15 to 45 years and many times not on the pre menarchal girl child and the postmenopausal women. Many times, the elderly women who come to the outpatient departments and wait in long queues to be examined for their age related medical problems such as osteoporosis are just blatantly prescribed analgesics such as 'Nimesulide' and shooed off without even a proper examination and explanation about the reason for the symptoms.

Young women interns and residents are sometimes bogged down by the excessive work pressures in the clinical wards (as they work harder to garner the same respect as their male contemporaries) and at the same time, they can expect no sensitivity form their colleagues or seniors about their personal conflicts like family/societal pressures to get married or if already married, to bear children.

Sometimes women present with vague and psychogenic complaints that are dismissed by the 'busy' doctor without even realizing that this could be a pointer to the trauma (physical, mental, sexual or otherwise) that the woman might be going through and is expressing indirectly. This is not only restricted to the poor women only but affects the women from all strata of society. Violence against women has many forms- rape, assault, burning, incest, and sexual harassment at the workplace etc. Young medical graduates who are predominantly uncomfortable examining female patients many times are unable to pick up the non verbal cues form these women as they are unable to establish the feeling of trust that is the foundation of a ideal doctor-patient relationship.

Perhaps the only encouraging trend has been the increasing ratio of female students joining medical colleges over the years and the foray of female residents for post graduation into 'unconventional' subjects like Surgery, Orthopedics etc. which were earlier considered to be male bastions.

These are just a few of the reasons why the component of 'Gender in Medical Education' has to be considered to be a priority issue by the academia.

Suggested Reading

Gender & Medical Education; CEHAT & AMCHSS; June 2002

Appendix 13

Community Health Awareness Program for the Jyotisadan Scholasticates
Brief Report based on the evaluation feedback

- Dr. Anant Bhan

First Phase: 16th to 21st Dec 2002
Second Phase: 20th to 24th Jan 2003.

A training program was conduced for the scholasticates of JyotiSadan in a phased manner on the dates mentioned above. The aim of the exercise was to give an introduction into the fields of community health to the participants and raise awareness about social issues and health.

The team members of CHC and various associates conducted the sessions and a field visit to a voluntary organization was organized on one of the days of the session.. At the end of the program, an evaluation form was given to each participant and they were asked to rate each session as

- Useful/ not useful
- Adequate/ not adequate
- Additional comments/suggestions.

The participant was not required to reveal his name.

The training program was appreciated by the Scholasticate and they felt the session would be very useful for them in their vocation of providing spiritual guidance and support; the course and helped them in understanding a lot of issues related to health and also the importance of life skills especially with regards to adolescents.

Some of the responses include:-

- The course is very relevant in our future ministry; when we are working in remote villages, this course is going to help us a lot. My sincere thanks to every member of CHC for this wonderful experience for each one of us...

- Personally, I gained a lot of knowledge from this course especially in the field of sex education, HIV/AIDS, Tobacco, personality development etc. These are essential for a healthy society and I hope you continue with these kinds of programs to make better citizens in our country.

- It was wonderful and I liked it because the things that were taught were very useful and practical- these things are connected with our day-to-day lives and not like other intellectual subjects. The course does not need much intellect and is suited even for ordinary people. As a whole- the course was very good and useful, it was well arranged and the resource persons did a great job; probably it would

have been better if certain topics like Managing emotions, Self Awareness, Alternative Systems, Mental & Family Health would be given a little bit more time.

- Personally, I am happy to thank you for the valuable contribution to our life- it is more precious than money. Indeed, we are grateful to all of you personally. Please take this message to the uneducated and neglected. Enlighten them in all the fields. We do pray for you and hope you will be able to carry out the task that you have begun. May God bless al your endeavors.It was a new experience for me because I got to know the situation of the Indian people who are very poor – I hope to do something for the people with the knowledge that I got from this program.

- I suggest that you conduct this course for all the poor people of India; I hope CHC will reach every nook and corner of India within a few years.

- All the sessions were very good but they should not go until late in the evening. This course should be given to all the religious congregations. The faculty members spoke simple English and it was very understandable.

- Wish you all the best and may God bless you.

- I like it because I am going to be involved in the community activity of people and so I can impart all this knowledge to them. The course should be for more number of days and sessions should not last beyond 4:00 P.M.

- We got a lot of knowledge about CHC and health- it will be useful in the future for us; thanks a lot and wish you the best.

- The course was new to me and I am very much inspired and enlightened by the course. Personally speaking, it was a break through in my life- my whole perspective in life has changed after attending these classes. The faculty has done a wonderful and spectacular work over the past two weeks. You are really motivating the people to lead a good and moral life. Excellent, please do keep it up.

- May you be able to continue the good works you are doing for humanity. May the almighty give all of you a long life to serve the people and may all your dreams come true. Don't look back and travel on the same track – wish you all the best & may God bless you.

Dr. Anant Bhan
29 March 2003.

Appendix 14

I am writing to u today about two recent cultural experience Vasantahabba- the annual festival of the dance village Nrityagram which has become a sort of cultural Haj for a lot of people not just from Bangalore but from around the world and Eka Aneka- art for integration on the occasion of Shivratri.

Vasantahabba

Started 12 yrs ago by the inimitable Protima Gauri Bedi as a small dream on a few acres of land given by the Karnataka govt. on the outskirts of Bangalore , Nrityagram today is the only dance village in the world , set up for the preservation and popularization of the seven Indian classical dance styles and the two martial arts. It is also the base of the world famous Nrityagram dance ensemble that has won many accolades for its dance theatre performances.

Vasantahabba has grow as an event over the years – it started off with 1500 spectators and this year the numbers attending reached the 40,000 mark- this included the lucky few who managed to come early and squeeze themselves into the amphitheatre and watch the performances live holding on with dear life to the cramped space they had and to their bladders and the rest who had to be content to watch on the giant screens on the outside.

Held from dusk to dawn every year, Vasantahabba is held in the spirit of festivals such as SPIC MACAY. Entry is free and the sooner u arrive, the better vantage point you get. As is the practise every year, the first performance is by the Beliappa and party with their Dollu Kunita – the tribal drums of Karnataka. The high energy drumming and accompanying acrobatic dances were a treat for music lovers and kicked off the festival on a high note.

This was followed by the village ensemble of Nrityagram presenting Odissi, Bhartayam and Kathak- this included the kids from the surrounding villageds who are given free dance lssons over the weekend. Dancing with grace and beauty, they won a lot of hearts in the audience with their skillful depiction of dance theatre.

Next on stage was Ms. Mandakini Trivedi, a senior Mohiniattam dancer from Mumbai who presented excerpts form her woks where she had tried to expand the range of Mohiniattam creating powerful visual impact.

Guru Jayarama Rao and Vanashree Rao, the famous Kuchipudi dance couple who have been dancing together since 1978 brought to life the intricacies of this unique dance form on to the stage and enthralled the audience.

The B'lore based Stem Dance theatre presented Contemporary Dance interspersed with World Fusion Music by the Amit Heri Group. Creating an amalgam of various dance forms and arts like Kalariyapattu and exploring the range of movement and athleticism that the human body can exhibit, the Stem Dance theatre mesmerized the audience dancing to an original music score. The interludes wherein the Amit Heri group presented

the fusion of Indian & western music incorporating various forms like Latin, Indian, Contemporary, Jazz, Funk, Blues & European Music ensured that the audiences were wide-awake as the time approached midnight.

With the end of the dance performances started the musical ones. Malini Rajurkar from the Gwalior Gharana of Hndustani music exhibited the versatilkity and wide range of her voice- unfortunately, a section of the audience, obviously never having been exposed to Hindustani classical but instead fed on the techno-pop-trance genre of the likes of Britney Spears and Eminem created a bit of the ruckus that spolit the atmosphere for some time,

A young Carnatic flutist Shashank with his team was a revealation- having maturity beyond his age in the music that he played and the zing and youthful vivaciousness, he was very popular with the crowd.

The famous Grammy Award winner Pt. VishwaMohan Bhatt with his son Salil Bhatt brought to life the Mohan Veena, essentially a modification of the Hawaiian guitar; they played various notations including a few from the Grammy award winner album.. Pt. Bhatt had to do an encore at the end of the performance when the audience pleaded.

Four o'clock in the morning and if somebody had manged to doze off, they were all awakened by the high spirited response that marked the Qawwali of Nazeer and Naseer Warsi from the Old Delh Gharana who presented the works of Sufi great slike Amir Khusro and Bhakti saints like Kabir carrying the messages of unity and communal harmony. Almost the whole audience provided the chorus when they sang the eternal favorite Dum Mast Kalandar.

It was always going to be tough to be the last act but Taufiq Qureshi and friends including Niladri Kumar (Sitar), Sridhar(Mridangam), Karl Peters(Bass Guitar), Nishad (Keyboard), Geetika Varde (vocals) gave an enthralling demonstration of the a range of musical styles with a vruety of international percusson insruments that /Taufiq, younger brother of Zakir hussain efoortleslly palyed.

The performances were peppered with the compering of Arundhati Nag(Aru akka as she is fondly called) and the honoring of the artists by Nrtiyagram trustees including Lillette Dubey, Lynn Fernandez, Pooja Bedi , Kabir Bedi etc.

Stalls outside the venue sold everything from food , nicotine, alcohol to guide maps. As people started trickling out with the first rays of sunrise, one could see the contented smiles that everybody carried having experienced a spiritual crescendo of dance and music carrying the red earth of the ground on their bodies and clothes as testimony to their attendance.

P.S. Nrityagram conducts a summer workshop from July 15 to Aug 15 of every year to give students training in Odissi or Kathak. The daily work schedule includes body conditioning exercises , jogging, yoga, Pranayama, and informal discussions on the theoretical aspects of dance forms. The residential program also requires involvement in

gardening, cleaning the gurukul and working in the kitchen. Besides being a basic training program in classical Indian dance, the summer workshop is also a great experience in community living and working in perfect harmony with nature.

You can also take guided tours of the campus throughout the year.

Nrityagram can be contacted at
Nrityagram, Hesaraghatta Vilaage, Bangalore-88
Tel:- 91 80 8466 313/314
Fax:- 91 80 8466 312
E-mail:- nrityagram@vsnl.com

Eka Aneka- Art for Integration

This program is held every year on the occasion of ShivRatri and is also an overnight affair. It is organized by the Bangalore based Prasiddha Foundation that works for the promotion of the performing arts. It is an attempt to bring together artistes from around India on a common platform.

This year even though it was the evening (1st Feb) of the India-Pak match, a fair amount of people turned up at the venue of the performances which was the Chitrakala Parishat to appreciate the artistes.

The program started with a Yakshagana recital, which is a folk art form of Karnataka especially in the coastal belt and involves depiction of stories from the Hindu mythology. It set the mood for a pleasant night in the open-air amphitheater.

Next on stage were the Carnatic violin brother duo of Ganesh and Kumaresh who had been the youngest violin players to be accorded recognition by the AIR. They played the some lilting classical tunes with the effective support of their percussionists.

Pratibha Prahlad, a celebrated Bharatnatyam exponent and the main person behind the Prasiddha Foundation then enacted beautifully excerpts form various dance dramas.

Mahendra D. Tokay , an accomplished Hindustani vocal exponent chose some eloquent Ragas to herald the onset of midnight.

But Rajendra Gangani, a young Kathak dancer from the Jaipur Gharana made sure everybody was wide awake and paid riveted attention to the jugalbandi he performed with the Table player and the portrayal of the mischief of Krishna and the anger of Shiva- truly a treat for the eyes.

T R Srinath, incidentally a gold medallist in Food Nutrition then gave a Carnatic Flute recital and regaled the audience with his melodious instrument.

Odissi is a dance form that is captivating with the associated grace of the dancer and the costume- doing full justice to this was Sujatha Mishra , a famous dance teacher from Puri.

The last on stage was Biswajit Sarkar with the Sitar and he did pull a lot of strings- quiet tunefully though.

The festival ended on this high note in the wee hours if the morning with many invoking the blessings of Lord Shiva – probably for the good fortune of the Indian Cricket team.

Anant Bhan
March 2003

Appendix 15

Reflections in Community Health

Dr. Anant Bhan, CHC

Community health at a field level has been in a sense radically different from what is taught at medical schools. Medical students and interns think of the department of community medicine as a department that does not arise any interest because they are not encouraged to think, to reflect as to how they could use the theory and clinical skills that they learn at the tertiary level institutions they study at to affect the lives of people not just at the out-patient and inpatient level in hospitals but also in the community and in their homes.

When I tell my classmates, juniors and seniors about my interest in community medicine, they wonder how I could be attracted to a subject that only deals with 'mosquitoes', 'toilets' or the lack of them and how to make sure you are correctly chlorinating a well. I guess I cannot fault them because they just have been taught theory in a textbook fashion without bothering to take them to the field and making them understand how mosquito borne diseases like malaria and Japanese Encephalitis has wreaked havoc in so many areas of our country, how more than 70% of the diseases that the poor have can be prevented by ensuring sanitation and safe drinking water. Their 'field visits' are restricted to doing school health check-ups where they dole out Albendazole tablets by the dozen, at camps organized by philanthropic organizations where impersonal medical advice and a couple of near expiry tablets are doled out to hundreds of poor unsuspecting villagers who have been rounded up especially for the purpose usually at the behest of some local leader or Swamiji- I have been to camps where more time was spent in inaugurating the camp, garlanding 'dignitaries' than in actually interacting with patients. With the help of glucometers that a pharmaceutical company would have gladly provided in the hope of increasing their patient base, blood samples are taken and people are branded as 'diabetics'- no care is taken to ensure that the person receives health education and understands the origin and the progress of the disease; the latest drug form the pharma major's arsenal is prescribed- the young attending doctor feels happy that he/she has done social service, the drug industry increases its profit margin, the organizing organization makes a splash in the local media but the person who is labeled is soon conveniently forgotten until the next cycle of camps start.

Is community medicine only practised by people who venture into field practice areas in adivasi settings and return enriched with the knowledge of life and the vibrancy of the people who unlike us do not feel that they are living their life fighting the odds but are content and happy in their environment. Do those among us who decide to work with voluntary organizations only practise it? Or can all those who are working in the field of health practise it. Would an orthopaedician or a neurosurgeon who is getting concerned by the increasing injury cases he/she is treating and makes an effort to network with the governmental agencies and other concerned citizens to try to decrease the factors causing road traffic accidents not be doing community health? Would a cardiologist who does not keep adding medications for his refractory patient but tries to talk to him and analyzes that lifestyle modification in the patient's household with curbing smoking and changing dietary patterns is required not be practicing public health. Would an emergency room resident who tries to take time off and just listen to a young adolescent admitted repeatedly with attempts at suicide and gives psychological support not be trying to practise holistic medicine.

The lack of linkages between medical academia and the voluntary health agencies results in the prospective health practitioners never being able to fully explore the community part of community medicine. There is also the problem of the approaches to medical education which are still stifling and do not encourage the student to think creatively and to be able to question- he or she just learns to believe what is printed in the textbooks and what his peers and his faculty practise. So when he sees his professor shuttling from ward rounds to his private practice in the latest imported car and spending more time speaking on the trendy cell that he possesses than to the students and patients combined, the student imbibes that as being the *art & practice* of medicine. Some institutions have tries to break free of this by encouraging their students to think and to be comfortable working even in a community setting but these institutions are far too few and have their own idiosyncrasies.

How many departments of P & SM have had the courage to question the govt's prioritization of RCH and FP neglecting the other health programs? There are not many also which have ensured the provision of comprehensive health care in the PHC areas allotted to them. Encouraging students to interact with social scientists and paramedical staff to understand the socio-economic dimensions of any disease prevalent has never been the forte of community medicine teaching.

And so we have graduates emerging from the hallowed portals of medical institutions with their degree certs in their hands and the Hippocratic oath on their lips armed with biomedical understanding of disease but ignorant of the social, economical, political and cultural reality of Bharat.

Appendix 16

Report on visit to Hakki Pikki (HP) colony

Date: 4th December 2002
CHC team members: Prahlad and Anant Bhan
Facilitated by: Vimochana, Bangalore.

As a follow up to the previous visit by CHC team member (Refer to Prahlad's earlier visit report) another visit was carried out on 4th December 2002. *Objective of the visit was to find out more details about health situation, health problems and local practices community follow about health. Along with this socio economic factors affecting their health were also ascertained.*

After the community was initially met, few leaders were requested to organize meeting. Before the community could gather, CHC team members, along with field worker from Vimochana went around the habitation to find out about the environmental hygiene situation in the area. This revealed that Iruliga living area (there is very clear demarcation of living areas of these two tribes) is much more cleaner than Hakki Pikki tribal living area. There are 150 households in the area- 110 houses belong to Hakki Pikki and 40 households belong to Iruliga tribe. Iruliga live in more Pucca houses, while Hakki Pikki tribe live more in Semi Pucca and thatched houses. Iruliga household have bathroom, but without drainage facilities, while all the members in the area go for open-air defecation. A few families live in houses that have been recently built by the government and have drainage facilities. Discussions with Vimochana team members also revealed that Iruligas are more organized than hakki Pikkis and this has also might have led to shabby surrounding in which Hakki Pikki population live.

Water supply is through bore well, which is connected to Mini Water Tanks(at the time of visit ,a rainwater drain was being constructed in the settlement).Government has relocated them in this habitat from 1962. Government at the time of relocation also gave 3 acres of land per family. But land is rocky and is not conducive for agriculture. Very few families' practice agriculture (its carried out only in the seasons when adequate rainfall is there and mainly Ragi and Jowar is sown. Most of the families are into petty business.

Most marriages are stable and couples have between 3 to 5 children. Hakki Pikki group told that Iruligas are not very religious, the HPs worship Kabalamma(the main temple is in Satanur)- a silver image of the goddess is kept in al the houses.

The HPs have peculiar names like *High Court, British etc.* and use the Vaagri language that does not have a script and a mixture of various languages.

Overall, both the tribes are quiet healthy and have many elderly members- this might be related to their exercise habits (walking around quiet a lot). The staple food in the Hakki-Pikki group is Ragi balls and Sambhar. On Sundays and Tuesdays, the communities usually eat meat (chicken/goat/pig). They used to hunt earlier but now it is very rare because of stringent laws and the security in the area of the Bannerghatta Park.

There is a government school in the area that has classes from standard 1 to 5. There are 2 teachers here, who stay nearby and have been identified by Vimochana.

At the time of the visit, members of many households (of both sexes) were busy in making artificial decoration material using raw material that they had brought from K.R. Market- the final product is usually directly sold by them only as they travel from place to place. Also, television and radio has made an inroad into few houses and some houses had FM music blaring away this later turned out to be also a source of discontent as some felt that the younger generation was not working adequately and instead whiling away its time watching television leaving their work behind.

There are almost no visible petty shops in the settlement but there is a govt. arrack shop that sells packets for Rs. 10 each. The habit of consuming alcohol is almost a socio- cultural phenomenon here and both men and women drink on an almost daily basis (this increased consumption has occurred over the last 15 years).

Discussions with 15 to 20 community members (only very few members could come as Ramzan time is best time for them to make some business) revealed about health situation and practices prevailing in the area. This meeting was the best testimony for the equitable gender equations prevalent in the community (as both of them playing pranks and teasing each other was evident). People told during the meeting that major health problems include body pain, back pain, joint pains, giddiness, headache, skin infections, chronic cough, heartburn, chest pain etc. The children usually suffer from water borne diseases and pneumonias (ARIs) . Some community members said that there were a few cases of typhoid, malaria and ?cholera in the last one year. As the Alcoholism and Tobacco consumption found to be rampant, causes for

many of the health problems could be attributed to these two phenomena besides the lack of hygiene an indoor smoke due to chulhas.

Some of the older community members said that all these problems were because the HPs were now being prevented from hunting foxes and other wild animals for food (the HPs believe that fox blood is almost like an elixir for all ills)

Community was told that they should prepare few volunteers from the area who could be trained as health contacts. They should concentrate more on the prevention, than depending upon outsiders for their health. Community appreciated this idea and they promised the team that volunteers would be identified.

Later they were asked to assemble in school for little checkup and advice. Even during this period, most of the problems treated and advised are from the range of the problems mentioned above. Drugs were prescribed and some health education was carried out.

The nearest PHCs are in Bannerughatta and Kaggalipura but the HPs did not seem to be happy with their functioning and instead prefer to go to the private practitioners in Bannerughatta.

The team then assembled and left for Bannerughatta. While the Vimochana team went to the local Grama Panchayati office, the CHC team members visited the FOSA (Friends Of the Sick Association) hospital at Bannerghatta. Interestingly, the HPs had not mentioned about the FOSA hospital as a nearby medical center.

At the FOSA hospital, the CHC team met Dr. Basavaraj who is the RMO there who explained about the hospital and took the team around on a tour of the facilities. The FOSA hospital has been built by Mr. Ravi Melwani, reputed businessman from Bangalore with the motto 'Free Service for the Poorest of the Poor'. There are 4 full time doctors, who include a dentist and an ophthalmologist (all of them are salaried). A couple of doctors visit on a voluntary basis once a week (e.g. a dermatologist visits on Tuesday between 1000 and 1300 Hrs.

There are 2 outpatient examination rooms, 2 wards for inpatients with 30 beds totally, a dialysis machine, laboratory and X-Ray room, Minor O.T. and Dental Surgery rooms. The hospital also has a well-equipped O.T. for conducting cataract operations. There is a Dialysis machine and also a Humanitarian Hands Coronary Care Unit with Tele Medicine facility connected to Narayana Hrudayalaya and the Asian Heart Foundation.

The paramedical staff includes 3 nurses, 2 dialysis technicians, 1 X-ray cum Laboratory technician, 3 ayahs, 1 ward boy, 1 cook and 3 security personnel.

At the time of the visit, a dental surgery was being carried out. There were 26 inpatients in the hospital and these included patients with stroke/ asthma/ recuperating from burns etc.

Near the gate there are 2 isolated rooms that house a HIV +ve lady and A Hepatitis-B +ve lady.

Dr. Basavaraj said that the needy patients could approach the hospital directly and he said that the hospital gets around 20-25 patients from the HP settlement everyday. He said that the HP patients usually come with complaints like asthma, dysentery, injuries, geriatric problems like arthritis and a few have mental problems that have been initially treated at NIMHANS.

He said that the HP patients, if admitted usually disturb other inpatients because of their habit of consuming alcohol in the evening. Also, their follow-up is quiet poor.

He said that FOSA hospital would co-operate in any health intervention being planned for the HP settlement.

Suggestions:

1. To find out causes for lesser utilization of FOSA hospital by HP population.
2. To discuss with Dr. Sudarshan about selling arrack in Tribal area. Government bans selling of arrack in Tribal area.
3. Government Ayurvedic hospital needs to be observed during the subsequent visits.
4. Ideally 3-5 volunteers from each group should be identified with equal proportion coming from both genders.
5. Vimochana can try contacting few philanthropists and corporate groups, which can support this kind of initiatives.

Appendix 17

MEETING AT 'EQUATIONS'
Topic:- GATS and various sectors
12th November 2002

A meeting was organized at Equations, a NGO working for equitable tourism options. This was one of a series of such meetings that have been taking place to try to develop a framework for a workshop on GATS and various service sectors including tourism, health etc. and also its effect on citizens. Mr. Naveen Thomas has been regularly attending these meetings and on his invitation Dr. Anant Bhan(on behalf of CHC) attended a meeting held at Equations on 12th November 2002 from 3: 45 P.M. onwards. Mr. Benny (Equations Team member) and Mr. Rana Ghose, a volunteer initially shared their work. The formal meeting started at 4:15 P.M. involving Mr. Suresh, a policy expert and Benny from Equations, Naveen and Anant. Mr. Vinay Baindur from CIVIC, Bangalore (a citizens initiative NGO) later joined the deliberations.

The discussions in the meeting initially revolved around the Asian Social Forum and the various workshops that Equations would be involved in/ co-coordinating. Benny spoke briefly about GATS as a WTO Services agreement and the need to involve all the various organizations representing the sectors that would come under the purview of the agreement. Mr. Vinay spoke about the 73rd and the 74th amendment and how CIVIC was involved in the evolution of these. He also spoke about the emerging changes in the functioning of the Municipality and other government services in Bangalore and the increasing transparency that is being adopted after the Transparency in Public Procurement Act was brought about in Karnataka. He also shared the plan of CIVIC to hold a 2-day workshop on the 74th amendment in second part of December 2002.

Since ASF was coming up and both Equations and CHC would be actively involved in preparations and conduct of the forum, it was decided to hold the workshop on GATS after ASF in late January 2002. However, since CIVIC was already conducting a workshop in December, Mr. Vinay was requested to explore the possibility of granting a 1-hour session to Equations and CHC for them to shore their experiences with the participants and to build up the momentum for the proposed workshop in January. Equations would explore the possible effects of GATS on the various service sectors and CHC would give an input about the effect in the domain of public health and environment (74th amendment and Public Health; Municipalities and public health).

The meeting was then concluded. Mr. Vinay was requested to discuss with his organization and intimate to CHC and Equations about the decision as soon as possible fo further action.

Appendix 18

Corruption in the Medical Examinations: can the students do anything about it?

The fact that corruption has by now been firmly embedded in the medical profession is a well-known fact. But when it is practiced in the examinations, it is bound to great despair as the sanctity of the 'guru-shishya' tradition and the exam system is affected. Especially if money exchanging hands during the course of exams takes place during final year MBBS exams when the clinical skills are tested and is the final obstacle before the candidate is allowed to legally practice the science if medicine and hence influence the health of the community, it raises a lot of question marks about the quality if doctors that are being trained.

The corrupt examiners use a variety of ingenious means to collect the 'bribes'. Some prefer the broker system (the same professionals probably employ these brokers to collect money from hapless patients and their relatives in the wards) while others prefer to do the honor themselves; there have been instances where HoDs of some departments have sent out unofficial notices declaring the amount of money to be paid for the subject for that year.

Even the students who are prepared well are so terrified at the prospect of failing because they did not pay, that they spend the days preceding the practical exams not studying but rather trying to find out whom to pay and how much to pay.

The incident I am describing took place a couple of years ago in a government medical college before the final year exams. For the preceding decade or so, money had been changing hands every year and it was almost becoming a tradition. As the exams approached, there was a lot of curiosity about *the prevailing rates of various subjects*. This was the time when a small group of students decided to make a difference- while they decided not to pay, they also thought they would try and make an attempt to break the unholy nexus that existed in the exams. So a few reporters in local leading dailies were contacted discreetly and the issue was explained to them along with the need for maintaining confidentiality. A series of news reports then appeared on the front pages of these papers for the next few days about the rampant corruption in the examination system. Exams were a month away and the sensationalizing of the media led to the college administration getting suddenly activated. The fact that a concerned parent sent a copy of the reports to the Medical Council of India, which immediately faxed a letter to the principal urging her to take action and the malpractice section of the university deciding to converge on the college, was contributory. A meeting was hastily arranged and some of the faculty members and the principal spoke to the students asking them not to pay; this situation was almost funny as some of these 'teachers' had been taking money with impunity in the previous exams and here they were talking about the ethics of the profession. After the theory exams, the college appointed examiners with credible credentials under the strict supervision of the university and for the first time in years, a 'clean' exam was conducted. The results were not affected in any way and the overall performance of the batch was quiet good.

This incident just goes on to prove that sometimes all it requires for an unethical practice to be broken is for somebody to stand up and refuse to be a part of a system gone rotten. It does not always need to be by making a big hue and cry but even a small stone thrown in the darkness can sometimes find its target.

The examination continues to be free of corruption in that college to this day.

This is another incident that portrays the methodology used by the corrupt faculty members to collect money. The exam was for the third year dental students of a college who were giving their internal medicine clinicals. The students were approached through a broker by the external examiner who happened from a neighboring medical college.

The students were asked to get a fixed amount of money in envelopes to a busy street near a temple. The examiner was waiting there with the broker and he had parked his car at a safe distance with the windows adjoining the back seat conveneintly rolled down. Making sure that there was no direct contact with them, the students were asked to place the money- laden envelopes in the backseat of the parked car and to disperse. This modus operandi gave the examiner a chance to identify the students who had paid and at the same time he tried to play safe by not receiving any money directly.

The following day the students who had paid were passed while most of those who had not were flunked. The way our examination system is structured, perhaps it offered no opportunity to the students who had not paid to protest as they did not have any proof and because their classmates who had paid had kept them in the dark about the bribing process. Nobody lodged a complaint and the examiner made easy money.

These true incidents show two different situations and different responses from the affected i.e. the students.

I guess that while it is important that the relevant authorities take utmost precautions to prevent corruption in exams, it is also important that the students have a resolve to not be sucked into the vortex of corruption in medical examinations, which encourages the practice.

Dr. Anant Bhan
March 2003

A brief version of this write up was published in ***'Issues in Medical Ethics Apr- Jun 2003'*** *issue*

Appendix 19

Human Organ Transplantation Act 1994: A Discussion

An interesting exchange of ideas took place in a recent session of the Medical Law and Ethics Course at National Law School of India University regarding the Human Organ Transplantation Act 1994.

When the act was formulated, the main objectives of the act were

- Regulation of the removal, storage & transplantation of human organs for therapeutic purposes.
- Prevention of the commercial dealings in human organs.

The human organ has been defined by the act as 'Any part of the human body consisting of a structured arrangement of tissues which, if wholly removed, cannot be replicated by the body'.

Transplantation has been defined as 'The grafting of any human organ from any living person or deceased person to some other living person for any therapeutic purpose'.

In the present circumstances, any patient of End Stage Renal Disease (ESRD) who has to go in for kidney transplant has only two choices- either a compatible kidney is donated to him/her or the patient 'purchases' (*acquired donation*) a kidney.

The donation of an organ can be from near relatives or from unrelated donors. Research has shown that in India, only 10% of transplants involved donation from the relatives while the remaining 90% were from non-related donors.

- The near relatives mentioned in the act include son, daughter, mother, brother, sister, father and spouse; an interesting factor here is the inclusion of the spouse who is in most cases, not related genetically directly to the patient. This has also encouraged the practice of a lot of **Kidney Marriages** wherein poor young women are being married to patients requiring kidney donations so that the organ donation acquires the sanctity of law.
- The non-related donation of the organ can be from a living person (out of affection /attachment) or from a cadaver. Sec (9), Clause 3 of the act mentions that 'If any person willingly come forward to donate an organ not influenced by money but by attachment or affection, then donation can be allowed'. To prevent misuse of this provision, there has to be an application submitted by the donor and recipient to an authorization committee constituted by the state govt. who is supposed to look into the level of their 'attachment' and 'affection' and its genuineness. In many cases, the patient's brother's servant, driver or gardeners have had 'affection' for the patient but not the patient's own relatives who perhaps were more 'attached' to their own kidneys.

In Karnataka, in Mandya district, there is a village where the kidney trade is so flourishing that it is called 'the single kidney village'.

The Karnataka state authorization committee has only rejected four out of the more than two thousand applications it has received. In the neighboring state of Tamil Nadu, a Frontline expose in July 2002 revealed that the authorization committee had not kept a record of the applications received and had only rejected one application among the scores received in the previous year. Surprisingly, the act mentions that there is no need to keep a record if the application is accepted but a detailed record has to be maintained with reasons if the application has been rejected.

The act does not put any emphasis on the follow up of the donor's health by the operating doctor or the nursing home and so in many cases, the poor donors are now suffering from complications arising from the surgery. While the donor usually did not have any problem in the first two years post donation, later on, the donor suffered more financial losses on his/her own treatment than the amount of money he/she received for donating the kidney.

Though the Centre has promulgated this law, it is applicable only in seven or eight states, which have ratified it (health being a state subject).

Interestingly, Brain Stem Death has also been defined under the act-' It is that stage at which all the functions of the brain stem have irreversibly and permanently seized and certified so by an authorized person (professional); the decision has to be ratified by a board of medical experts which consists of four members – the doctor in charge of the patient, the doctor in charge of the hospital, an independent professional and a neurologist who have to certify the brain death on a prescribed form'. If the patient had indicated his/her willingness to donate his/her organs or if the near relatives are willing, then an organ donation(s) procedure can be carried out. However, the relatives also have the right to refuse donation even if the patient had been willing.

The procedure involved in organ donation in the case of unclaimed bodies has also been enunciated in the act.

Some glaring lacunae in the act include: -

- Advertising for receiving organ donation is prohibited but advertising by a person wanting to donate an organ is not.
- No adequate provision to prevent misuse of the term 'affection/attachment'.
- No provision for the post retrieval care of the donor.
- The inclusion of spouse as a 'near' relative who can donate a kidney.

Interestingly, out of a thousand donations analyzed, 815 were from females and the remaining by males.

A case where a lady from Kashmir received a kidney donation form an unemployed youth from Assam in a hospital in Mumbai, the operating doctor being from South

India exemplifies the degree of national integration we have achieved in the kidney racket.

Its almost as if the 'Organ thugs are now operating with the sanction of the law'.

Dr. Anant Bhan
March 2003

An excerpt from this discussion was published in the 'Issues in Medical Ethics' Apr-Jun 2003 issue.

Appendix 20

IMA meetings: down in the dumps

The Indian Medical Association, Academy of Medical Specialities (Karnataka Chapter) recently organized a South Zone Conference on the topic 'Multi Specialities: Current Scenario' on 8th February 2003. The venue was the picturesque Nandi Hills resort, the famous summer resort of Tippu Sultan on the outskirts of Bangalore.

Delegates started arriving at the venue from the wee hours of the morning in chartered buses or in their own vehicles. The morning and afternoon were spent in the scientific sessions dealing with various topics like Trauma Care, Imaging technology etc. and then a guided tour of the venue was arranged.

A banquet was arranged at the venue from 7:00 P.M. onwards. Various branch leaders were felicitated and then an orchestra started belting out various film songs, as most of the doctors were busy downing their shots of alcohol. Around an hour and a half into the show, came the real shocker- suddenly on stage appeared four 'bar girls' suggestively dressed and started gyrating to the music which also picked up tempo. That there were a lot of families and in many cases, their own wives present at the venue did not deter many of the medical profession from shamelessly herding around the stage half drunk and trying to get nearer to the dancers and trying to shove money into their hands. This continued for almost two hours with a few squabbles also breaking out regarding proximity to the stage. Finally the orchestra called it quits and the dancers were escorted away to their lodgings for the night.

It is incomprehensible why a prestigious organization like the IMA would resort to such a cheap sort of entertainment for its annual meet, which was not just degrading to the dancers but also to the women in the audience.

If this is the kind of entertainment that IMA meets come up with, one has to definitely wonder about the falling standards and morality of the profession.

Dr. Anant Bhan
March 2003

Published in Issues in Medical Ethics Apr-Jun 2003 issue.

Appendix 21

PUBLIC HEALTH ASPECTS OF ACUTE RESPIRATORY INFECTIONS

Dr. Anant Bhan

Community Health Cell,
Society for Community Health Awareness, Research and Action
367, Srinivasa Nilaya, Jakkasandra 1st Main,
Koramangala 1st Block, Bangalore - 560 034
Phone- 5531518 / 5525372
E-mail:- drbhan@sify.com

PUBLIC HEALTH ASPECTS OF ACUTE RESPIRATORY INFECTIONS

Abstract for the Presentation

Infections of the respiratory tract are the most common human ailment. While they are a source of discomfort, disability and loss of time for adults, they are a substantial cause of morbidity and mortality in young children and the elderly. In India, ARIs are one of the major causes of death in states and districts with high infant and child mortality rate.

The poster will attempt to examine the public health aspects of Acute Respiratory Infections and the various factors involved such as environment (including housing, industrialization), nutrition (including breast feeding), low birth weight, Vitamin A deficiency and other host factors, poverty, overcrowding, poor ventilation, unclean surroundings, occupational factors and lack of awareness etc. The SEPC (Social, Economic, Political and Cultural) Analysis of the causative factors will help in understanding the associated problems.

The importance of locating action for prevention and control of Acute Respiratory Infections in a comprehensive health care context by strengthening primary health care services to provide better Maternal & Child Health facilities, universal immunization, improved nutrition and decreasing indoor smoke pollution will be highlighted.

Introduction

- Infections of the respiratory tract are the most common human ailment.
- ARIs are the leading cause of death in children under 5 years killing an estimated of 4 million children annually.
- 40% of the Global mortality due to ARIs is accounted by India, Nepal, Indonesia & Bangladesh.
- A report by the DGHS, Govt. of India indicates that ARIs contribute towards about one fourth to one third of all under five deaths in India. (Mar 1991)
- Most young children worldwide have 4-8 episodes of respiratory infections per year.
- The risk of an Indian child dying of ARIs is 30-75 times higher than his / her counterpart in the developed countries.
- Upto 40% of children seen in health clinics are suffering from ARIs.
- ARIs are responsible for about 20-40% of admission to hospitals.
- Measles has an annual toll of around 30 million cases & 9 lakh deaths, (2500 deaths daily) predominantly in children. Measles thus kills more than half of the 1.6 million children who die annually from Vaccine Preventable Diseases. [WHO Bulletin, 2001, 79(6)]
- Measles global vaccine coverage is currently only 74% - it needs to be at least 90% for its eradication to be possible.
- Upto 10% of survivors of Measles may suffer disabilities, such as blindness, deafness and irreversible brain damage [WHO Bulletin, 2001, 79(6)]
- The pandemic of HIV/AIDS with increasing number of people affected & their susceptibility to ARIs is an important focus area

Major causative organisms of ARIs

Bacteria	Viruses	Other Agents
◆ H.influenzae	● Adenoviruses	● M.pneumoniae
◆ S.pneumoniae	● Rhinoviruses	● C.burnetti
◆ B.pertussis	● Influenza viruses A,B,C.	● Chlamydia type B
◆ C. diphtheriae	● RSV	
	● Enteroviruses	

Anatomical Classification: ARIs

- **Upper Respiratory Tract Infections**
  - Pharyngitis
  - Tonsillitis
  - Sinusitis
  - Otitis Media

- **Mid Respiratory Tract Infections**
  - Laryngotracheobronchitis
  - Epiglottitis

- **Acute Lower Respiratory Tract Infections**
  - Bronchiolitis
  - Pneumonia

* Lankinen, K., et al. Health & Disease in the Developing Countries
London: Macmillan Education Ltd.

Treatment decisions in children with cough or difficulty in breathing-the WHO case management strategy

Signs & Symptoms	Classification	Therapy	Where to treat
Cough or cold, no fast breathing; no chest indrawing	No pneumonia	Home remedies • Inhalation • Herbal/others	Home by parent (mother)
Respiratory Rate RR Age 60 or > < 2mths 50 or > 2-12mths 40 or > 12-60mths	Pneumonia	Cotrimaxozole orally for 5 days**	Home by trained Community Health Volunteer (CHV)
Chest indrawing	Severe pneumonia	IV/IM penicillin	Hospital
< 2 mths infant with cyanosis, severe chest indrawing, inability to feed, grunting, convulsions, etc.	Very severe pneumonia	Chloramphenicol	Hospital

**The major disadvantage of using Cotrimaxozole however is the increasing rates of resistance of the two major pathogens that cause bacterial pneumonia – S. pneumoniae and H. infleunzae. Recent studies in some parts of Asia and Africa have shown resistance rates between 30 to 60 percent. The alternate antibiotic, amoxycillin, is about twice as expensive as cotrimaxozole, which deters its use by the national programs. Furthermore, the standard dosage recommendation is three times a day. The compliance with three times a day dosing drops to 60 percent or lesser. Both these factors work to the disadvantage of amoxycillin use.

Proximate Factors

➢ Poor Housing & High Population Density

Poor housing with overcrowding is a very important risk factor for the development of ARIs especially in the developing countries. The incidence of ARIs has been especially found to be high in families that live in 'kutccha' houses rather than 'pucca' houses- this is related to the presence of more dampness in the former. Agarwal DK and Katyar GP, (1981) and Gupta S and Krishnamurthy K A (1970) found that the morbidity incidence was significantly higher in those children who lived in 'kutccha' or mixed houses as compared to those living in 'pucca' houses. In many instances in rural areas, the practice of keeping the child on the floor (which is made of mud) increases the chance of exposure to the dampness and thereby increases the risk of respiratory infections. Parental education in this aspect is thus very important.

In a study in Bangladesh, it was found that the risk of acquiring ARIs was 3.33 times higher in low socio- economic index, 3 times in no access to piped water, 2.39 times in low housing index, 1.9 times in mother's age below 20 years. (Rahman MM, Shahidullah M, 2001)

The presence of dampness within houses as seen in certain western countries like the U.K. is also conducive to the spread of ARIs. Large families (with more than three children) that live in close proximity e.g. in slums lead to the most susceptible population- the children and the elderly being vulnerable to ARIs. The lack of adequate ventilation in these crowded settlements is also an important factor-'good ventilation is not just the replacement of vitiated air by a supply of fresh outdoor air but also control of quality of incoming air with regard to its temperature, humidity so as to provide a thermal environment that is comfortable and free from the risk of infection'. (*Park's T.B. of P & SM; 16th Edn.; Pg 509)*

Kumar V et al (1982) in India showed that there is a greater likelihood of ARI in large families than those with fewer families.

It is important to remember that these poor families also have a poor intake if calories and proteins that leads to increased Protein Energy Malnutrition.

Also, high population density in urban areas with poor quality of air due to high degree of industrial and vehicular pollution leads to frequent irritation of airways, making the person susceptible to respiratory infections. The risk of RSV infections is doubled in infants living in industrial populations, probably due to overcrowding. (Clarke et al, 1978). Children living in areas with high air pollution have more respiratory diseases (Douglas & Warren, 1966) and measures to control environmental pollution appear to be beneficial (Lunn et al 1970). Especially during the winter season, smoke combines with fog to produce smog that makes breathing very difficult.

➢ Poverty

Poverty is an issue that is related to the person's housing status, educational status and also the degree of environmental sanitation s/he maintains. It is also inextricably linked to the purchasing power of nutrients- a well balanced diet is immuno-protective and can keep the person healthy. It also helps in quick recovery during convalescence.

Poor people might look upon disease as a burden and hence they wait till the disease progression has reached a late stage and is not resolving. They at many times may not be able to afford the travel and treatment involved in managing the complications at the referral level.

➢ Lack of Hygiene/ Environmental Sanitation

Poor personal hygiene makes the entry of pathogens easier and increases susceptibility to infections- it also promotes repeated infections. Inadequate environmental sanitation makes the spread of infections easier at the community level. The need for education about the importance of hygiene at the individual and collective level is imperative to control the spread of infections esp. ARIs.

➢ Malnutrition & Vitamin A deficiency

Biswas et al (1999) found ARI incidence to be significantly higher in undernourished children of poor socio economic status. Malnutrition causes increased susceptibility to infection and decreased local & systemic immunity; there is also inability to fight infections; the respiratory muscle drive and the cough reflex is weakened making the entry of pathogens into the respiratory tract through aspiration easier. These factors together with the impaired regeneration of the respiraotory epithelium increase the susceptibility to, and the persistence of ARIs.

Undernutrition and respiratory infections make each other worse- this can lead to malnutrition & death (it is thus a vicious cycle). Pneumonias are 20 times more common in malnourished than well-nourished children. In malnourishment, the IgA is also generally reduced which results in delayed recovery from infections and also, infections tend to be severe in malnourished subjects. There is decreased food intake and increased metabolic requirements during ARIs. There is also a fair amount of intestinal loss especially in measles.

Vit. A deficiency makes a child more vulnerable to respiratory and other infections esp. measles; similarly, respiratory infections can change mild Vit. A deficiency into severe deficiency (that can lead to xerophthalmia and blindness)

Vit. A also has an effect on the maintenance & regrowth of epithelial cells that line the respiratory tract.

➢ Management of ARIs with regard to Nutritional care

- ✱ Ensure adequate hydration
- ✱ Reduce fever (as appetite will accordingly ↑)
- ✱ Mouth care
- ✱ Frequent foods
- ✱ Extra foods during convalescence
- ✱ Special supplements (Vit. A, Iron, Zinc etc.)

-ARI NEWS, 1988

➢ Indoor Air Pollution

✱ Coal & Biomass Fuel

Globally, around 50% of people, almost all in the developing countries rely on biomass fuels for domestic energy. Exposure to indoor air pollution esp. to particulate matter from the combustion of biofuels (wood, charcoal, agricultural residues and dung) has been associated with respiratory disease. These materials are burnt in simple stoves with very incomplete combustion and consequently, women and young children are exposed to the high levels of indoor air pollution everyday (Bruce N etal, 2000). Hence, it is important to advocate the use of innovations like smokeless chulhas that will reduce the quantum of indoor air pollution. There is the added gender factor also related to this as the women who are the caretakers of the sick especially the children are also constantly exposed to the indoor air pollution and may in many cases have respiratory problems themselves. A more systematic approach to the development and evaluation of interventions is desirable, with clearer recognition of the interrelationships between poverty and dependence on polluting fuels.

✱ Tobacco Smoke

The smoker inhales only 15% of smoke from a cigarette but 85% is released to the environment as ETS (Environmental Tobacco Smoke) - this smoke is a well-known causative factor for respiratory disease. Maternal Smoking influences incidence of respiratory illness in children mainly through an antenatal effect.

➢ Maternal Literacy; Health Education & Awareness

Education is a decisive factor in health improvement, and moreover, basic education is the foundation of health education, a major component of health promotion. Education is decisive in improving health, and reducing mortality, particularly infant mortality; several studies have shown that educating the male parent alone does not have a significant positive impact on infant and child mortality if the mother is illiterate. Other studies confirm that the wide differentiation in child survival is closely related to the differences in the educational level of the mothers. Evidence also points to a close relationship between educational levels and a prepared acceptance of family planning, birth spacing, improving the health of mothers and better care & health for children. It is important to remember that education has been emphasized as a principal means of improving a woman's health status and that of her children and family- lack of education acts as a major contributing factor to the feminization of poverty. Nearly 2/3rds of the world's illiterate adults are women; most of them living in the developing countries of Africa, Asia and Latin America. A quarter of the world's girls are estimated to be out of school, compared to about $1/6^{th}$ of the world's boys. (TILEM, NLSIU, 2002).

In the present context, education is related to the lack of awareness about ARIs- causes, signs and symptoms, when to report and management. Health education of families and community involvement in childcare practices related to ARIs is very important. In particular, strengthening the ability of mothers to recognize early the severe forms of ARIs to provide supportive care for sick children can make a lot of difference in reducing the mortality associated. There is also a need for promotion of breast-feeding and also the promotion of healthy and clean environment through community education.

It is essential that parents who are at the forefront of clinical management of children with ARIs need to understand the difference between the child with a minor self-limiting illness and a more serious one that needs treatment.

➢ Inappropriate feeding and weaning practices

Infants inadequately breasts fed and weaned early and improperly are susceptible to under nutrition and infection. Breast milk also contains adequate Vit. A for the first 4-6 months of life, to help protect against ARIs.

Artificially fed babies even if adequately nourished suffer from more episodes of serious ARIs (pneumonia & bronchiolitis) than breast-fed babies. Nasopharynx is the entry point for respiratory viruses and bacteria; breast milk coats the

nasopharynx during the feeding process and makes entry of these pathogens less likely while formula foods have been proven to make the entry easier.

Human milk contains antibodies and other factors like secretory IgA, lysozymes, specific inhibitory substances for viral infection and anti staphylococcal factor that prevent microbial attachment to the respiratory epithelium. These humoral antibodies and other host resistance factors play a crucial role against both viral and bacterial agents. (Ghai OP, 1990)

Young mothers should be told that breast-feeding should be continued during the child's illness and convalescence.

➢ Preterm and Low Birth Weight Babies

They are more susceptible to various infections especially ARIs primarily because of their low immunity status. The protective maternal antibodies are transmitted to the fetus during the last ten weeks of gestation.

Low Birth Weight is indirectly a reflection of the health and the nutritional status of the mother and the care she receives during the pregnancy; hence better antenatal care would decrease low birth weight incidence and ARI morbidity.

In studies Bhakoo ON (1987) reported that lower the birth weight of babies, higher are his chances to develop infection. The same author in a rural cohort study in 1985 had showed that the ARI deaths among LBW babies were significantly higher (7.1%) as compared to their normal counterparts.

➢ Access to Primary Health Care Services

* Distance from the nearest Primary Health Center is important as this influences the decision of the sick to report early or late.
* Regularity of visits of the Primary Health Centre staff- this can help in picking up the cases early and prompt initiation of treatment.
* Availability of adequate staff at the health centers to be able to attend to patients judiciously.
* Provision of essential drugs which may be life saving.
* Transport and referral mechanism in case of serious cases has to be effective.
* Training of Community Health Workers / Volunteers (CHWs / CHVs) or Trained Birth Attendants to identify the types of ARI, start treatment and refer when required- this has been shown to work and has been found to drastically reduce the morbidity and mortality associated with ARIs when combined with indigenously developed implements like a breath counter for effective diagnosis.

-SEARCH, Gadchiroli experiment; Bulletin of the WHO, 1994, 72(6):897-905

✱ Strategies that could help here could be: -

- Improved and standardized case management at both the PHC & referral levels, which includes early discrimination of the mild and severe ARIs by families, local community representatives and PHC workers, supportive measures and anti microbial treatment.
- Health education to the community about ARIs
- Improved Primary Health Care through ARI case management.
- Encouragement of the community involvement.
- Improved child care practices.
- Proper referral systems

➢ Health Care System

In the present healthcare system, there is excessive stress on curative aspects. Health education is not given adequate emphasis, though it is vital for preventing the occurrence and spread of ARIs. Also, there is a need for continued effective teaching and training programs for the paramedical staff for ARI management. The paramedical staffs esp. the Ante Natal Midwives (ANMs), being understaffed are usually overworked also.

Availability of appropriate and effective drugs especially antibiotics at all the levels of the healthcare system is vital.

Surveillance of the ARI mortality at the level of Anganwaadis and the subcentres can help in evaluation and development of adequate facilities at the primary and community health centers.

Broader Factors

➢ Immunization Programs

In the past couple of years, there has been an increased incidence of Vaccine Preventable Diseases except Polio (WHO SEARO, 1998-2000) because of selective focus on the Pulse Polio program. This needs to be addressed. Coverage is still an issue with a part of the population not having access to immunization. Strengthening of existing immunization programs is needed. Also, research is vital for the production of cheap & effective vaccines for the primary prevention of ARIs.

➢ Disasters – Natural / Manmade

There is a lack of system of emergency medical response in our country, which suffers form disasters- natural or manmade on a regular basis. Refugee camps, public shelters have conditions (abysmal sanitation and over crowding) conducive to spread of ARIs. There is an urgent need to evolve a system to address the needs of emergency medical care in the country. This holds true also at the global level wherever disasters occur or conflict is ongoing.

In areas with famine, measles, ARIs and diarrhea with dehydration may bring about an increase in infant mortality. When people migrate and settle down on the outskirts of famine-hit areas, poor hygiene and overcrowding may facilitate the spread of endemic communicable diseases (WHO, 1989).

➢ Migration, Displacement, Occupation

Economic hardship and drought leads to migration to urban areas where the families stay in crowded slums with limited space; these migrant populations also carry the diseases endemic in their areas with them. This is a situation wherein ARIs can occur easily.

Occupation- certain vocations promote an environment favorable to respiratory infections, some of them being: -

(1) Agarbathi workers- work in one-room tenements with little or no cross ventilation.
(2) Beedi Workers
(3) Vegetable cultivators - they usually spray large amounts of pesticides without even the minimum precautions.
(4) Brick Kilns.
(5) Cement Industry
(6) Manufacture of plastic bangles/glassware.
(7) Sericulture- child labour intensive; long hours; exposure to 'Sericin', a protein that may have a relation to respiratory disease.

➢ Lack of intersectoral coordination

* At the village level, there are various departments working that are directly involved in the health of the people. Its very common to find coordination between these various departments missing.

  - Dept. of Women & Child Development – responsible for Anganwaadis and nutrition supplementation
  - Dept. of Education department- school health
  - Dept. of Rural Development & Panchayati Raj - Water supply and Sanitation
  - Dept. of Health & Family Welfare- all the national health programs.

* ARI control strategies have to be integrated with other programs such as control of Diarrhoeal Diseases, Immunization and Family Planning, Maternal & Child Health.

* Public Health Engineering is sometime found to be dismal like in the case of 'Junta Houses' which were built by the govt. –they are small tenements with two windows and a door; the animals sleep, chulhas, washing areas and sleeping quarters are all within this area only.

➢ Economic Policies (Liberalization, Privatization and Globalization)

These are promoting disinvestments in health and selective health care leading to economic devastation in some areas; the worst affected are the poorest of the poor. There is also promotion of huge projects that cause displacement and migration- e.g. the Bagalkot Upper Krishna dam that displaced the local populace to small dwellings with zinc sheets that are virtual ovens during the day.

Cost of all drugs including the essential ones is expected to rise after 2005 with the WTO regulations coming into effect.

➢ Role of the Medical Profession

There is a lack of standard treatment guidelines for ARIs in the medical community. There is also the problem of indiscriminate and unethical usage of the antibiotics, whether indicated or not leading to increased antibiotic resistance. The ARIs have been considered as the 'bread and butter' of general practice. In many cases the natural history of the mild disease also is not allowed to progress because the treating physician is 'trigger happy' in prescribing antibiotics thus not allowing the body's immunity to respond and fight back. However, caution needs to be taken in this regard in the cases of malnourished and the immuno-depressed who might need antibiotic cover because of their status. The process of treatment has become over-medicalized with inadequate time given to health education for patients/families. There is a tendency to prescribe antibiotics in almost all cases of ARIs without realizing that most of the cases are caused by viruses and would not respond to antibiotics (unless there is a secondary superadded bacterial infection). In this aspect, the WHO case management also is defective as it stresses the use of antibiotics. In the Indian context there is also the problem of self-medication without any formal training- also, most patients do not complete the whole course of antibiotics facilitating the development of antibiotic resistance. There is also misinformation about drug usage and hence there is usage of antibiotics like Ciprofloxacin in the pediatric age group in ARIs when it is specifically contraindicated in that age group.

In 1991, the Indian Medical Association carried out a survey on the prescribing practices of 1,000 of its members. They were asked to indicate how they treated

viral respiratory infections like colds and coughs. The results are of concern in that over half treated all cases with antibiotics, and a further quarter gave antibiotics to 50 percent of their patients. (ARI News, 1992)

Appropriate usage of antibiotics is not only a public health priority- it constitutes the best care for the patient. Avoiding antibiotics when not necessary can also prevent antibiotic associated complications & is in accordance with the physician dictum 'Primum Non Nocere' (First Do No Harm).

Most children with cough and cold need no drugs at all. The illness resolves usually in four to fourteen days. Supportive care is all that is needed, and can help relieve symptoms. Rest, continued feeding and herbal medicine or local health traditions will be enough. It is important to remember that in ARIs, usually there is no role for:

- Antihistaminics & nasal decongestants.
- Antiseptic & anesthetic lozenges, sprays and gargles.
- Cough medicines.
- Irrational combinations of cough suppressants with expectorants and mucolytics.

➢ Promotion of research work

According to an estimate, only 0.2% of pharmaceutical research is devoted to acute respiratory infections, TB, Diarrhea, while 18% of deaths are attributable to these diseases. So this is a priority area that needs to be taken up.

- www.tacd.org

➢ HIV & ARIs – a public health concern

ARIs are likely to be more common and more severe in HIV positive individuals, and episodes are likely to be more prolonged and to become recurrent. Pneumonia has featured prominently as the cause of death of people with HIV; hence they have to be very careful to avoid getting ARIs.

In the early stages of HIV, especially in children the causes of pneumonia are the same as that for general childhood pneumonia. Recognition and management should follow the ARI standard case management guidelines. Response to treatment is generally good. In the later stages of infection, when the children might have developed AIDS, a much wider range of pathogens cause pneumonia. Treatment should start as for very severe pneumonia; however, it may need to be changed to cover unusual organisms. At this stage, the response to treatment and the prognosis is generally poor.

➢ IMCI approach

Integrated Management of Childhood Illness (IMCI) – an approach developed by the WHO and UNICEF is now the principal strategy for reducing ARI mortality. It does so by promoting:-

* Prevention through reduced air pollution, improved nutrition- including breastfeeding and immunization.
* Early recognition of disease by caretakers and improved home management.
* Prompt recognition of symptoms and signs of pneumonia by health workers.
* Rapid treatment with antibiotics in accordance with national treatment policy.
* Rapid referral of the most serious cases.

However, the IMCI approach needs to be adapted to the larger issues, as it does not address many of the determinants in the causation of ARIs (some of which have been discussed above) comprehensively.

➢ Emerging concerns

* Tobacco marketing change- younger customers and women are being targeted by the tobacco transnational corporations.
* Hitchhiking microbes
* New viruses- this is exemplified by the recent spread of the SARS virus around the world.
* Drug resistance
* Dumping of ineffective drugs in developing countries by the big pharmaceutical houses.

  (See also Veronica Bailey et al, online resource)

* The inadequate focus on ARIs in the geriatric age group, which all around the world is expanding with the increasing life expectancy, needs to be addressed.

[NOTE

Insert Appendix 1 and Appendix 2]

References

1. A.T. Bang and R.A. Bang; Breath Counter: A new device for household diagnosis of Childhood pneumonia; Indian J Pediatr 1992: 59: 79-84

2. A.T. Bang and R.A. Bang, P.G. Sontakke et al; Management of childhood pneumonia by traditional birth attendants; Bulletin of the WHO; 1994; 72(6); 897-905

3. Abhay T Bang, Rani A Bang et al; Reduction in Pneumonia mortality and total childhood mortality by means of community based intervention trial in Gadchiroli, India; Lancet; 1990; 336; 201-206.

4. Acute Respiratory Infections and its control (in under five children); Directorate General of Heaalth Services, National Institute of Communicable Diseases,; India; Mar 1991.

5. Agarwal D K and Katiyar G P; 'Influence of Environmental factors on Under 5 morbidity'; Indian Pediatrics'; 18(8) ; 545; 1981.

6. ARI News, Issue 12, December 1988, Pg 3, produced by AHRTAG, London

7. ARI News, Issue 23, August 1992, Pg 7, produces by AHRTAG, London.

8. Biswas A, Biswas R, Manna B, Dutta K, Indian J Public Health 1999 Apr-Jun; 43(2); 73-5

9. Bhakoo ON; 'Pneumonia in the newborn' Indian Journal of Pediatrics; 54; 199-204; 1987.

10. Bruce N, Perez-Padilla R, Albalak R, Bull World Helath Organization 2000; 78(9); 1078-92

11. Clarke SJR, Gardner PS, Poole PM, Simpson H, Tobin JO; 1978; RSV Infection: admission to hospital in industrial, urban and rural areas.

12. Douglas JWB, Waller RE 1966; Air Pollution & Respiratory functions in children, British Journal of Preventive & Social Medicine 20; 1-8

13. Ghai OP; 'Textbook of Pediatrics', 1990.

14. Gupta S and Krishnamurthy K A; 'Morbidity and Mortality in Children'; Indian Paediatrics; 7; 563; 1970.

15. Health Situation in the SE Asia Region, 1998-200, WHO SEARO publication.

16. Health Law & Ethics: An Introduction; TILEM, The National Law School of India University; 2002; 49,50,60

17. Kumar V et al; 'Infant Mortality in a Rural Community Development Block in Haryana'; Indian J Pediatrics; 49; 795-802, 1982.

18. Lankinen, K., et al. Health & Disease in the Developing Countries; London: Macmillan Education Ltd.

19. Lunn JE, Knowelder J, Roe J W 1970 Patterns of Respiratory Illness in Sheffield Junior School Children; British Journal of Preventive & Social Medicine 24; 223-228.

20. Park's T.B. of P & SM; 16th Edn. ;Pg 509

21. Rahman MM, Shahidullah M., Risk Factors for Acute Respiratory Infections among the slum infants of Dhaka city; Bangladesh Med Res Counc Bull 2001; 27(2); 55-62

22. WHO (1989), Coping with natural Disasters: The role of the health personnel and the community

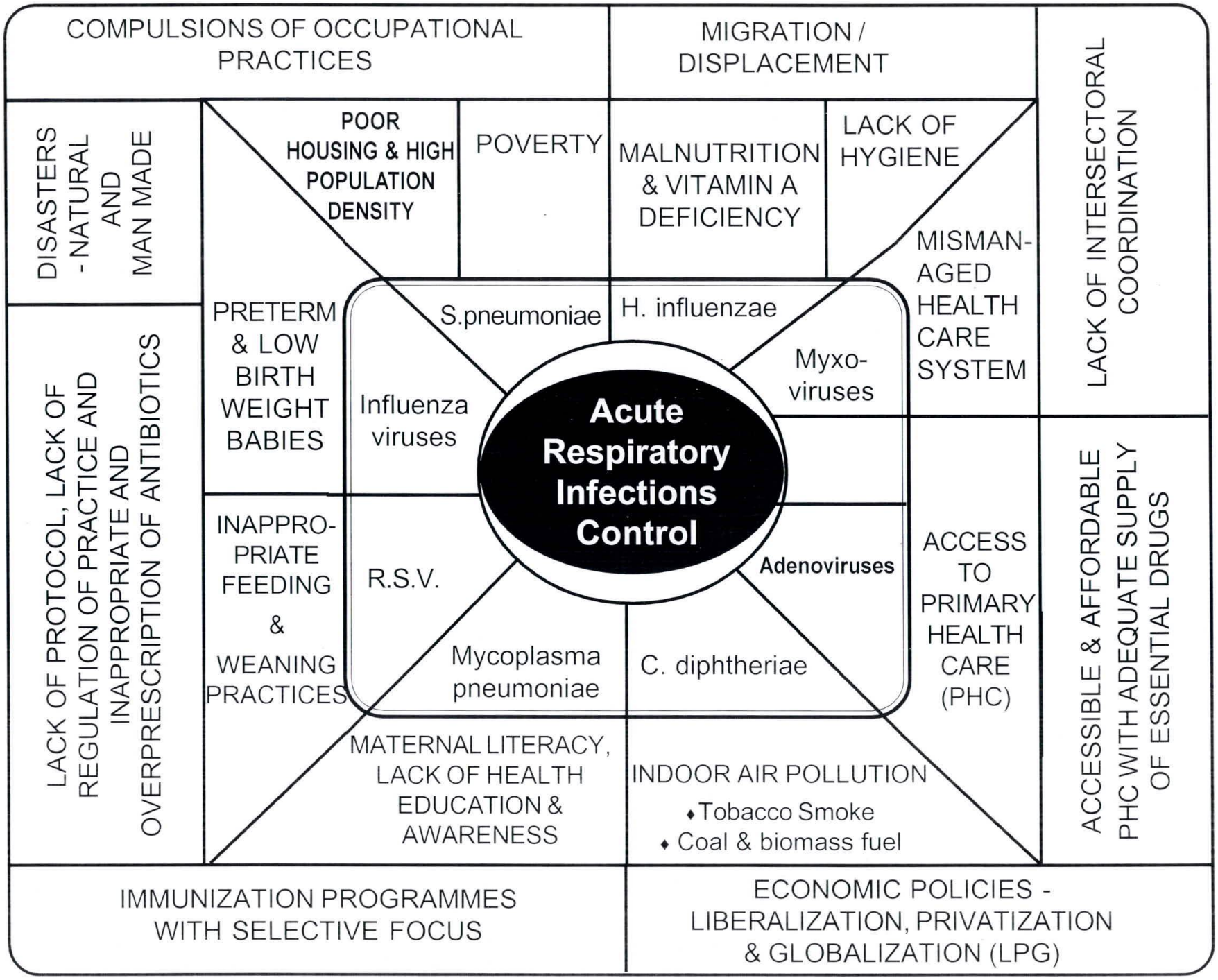
23. www.tacd.org

24. Veronica Bailey, Karen Boatman; Acute Respiratory Infections; www.who.int/aboutwho/en/preventing/acute.htm

THE PARADIGM SHIFT FOR DEEPER UNDERSTANDING & PREVENTION OF ACUTE RESPIRATORY INFECTIONS

PARAMETER	BIOMEDICAL APPROACH		SOCIAL / COMMUNITY APPROACH
FOCUS DIMENSIONS	INDIVIDUAL	⟷	COMMUNITY
	PHYSICAL (ARI PATHOLOGY)	⟷	SOCIAL, ECONOMIC, POLITICAL, CULTURAL AND ECOLOGICAL
TECHNOLOGY	DRUGS / VACCINES	⟷	EDUCATION, AWARENESS & SOCIAL UPLIFTMENT
TYPE OF SERVICE	PROVIDING / DEPENDENCE CREATING	⟷	ENABLING / EMPOWERING AUTONOMY BUILDING
PATIENT	PASSIVE BENEFICIARY	→	ACTIVE PARTICIPANT
RESEARCH	MOLECULAR BIOLOGY	⟷	SOCIO EPIDEMIOLOGY
	PHARMACO THERAPEUTICS	⟷	BEHAVIOURAL SCIENCES
	CLINICAL EPIDEMIOLOGY	⟷	SOCIAL POLICY AND POLITICAL COMMITMENTS

Adapted from CHC (1989)



Adapted from : Narayan R., SDTC, 2002