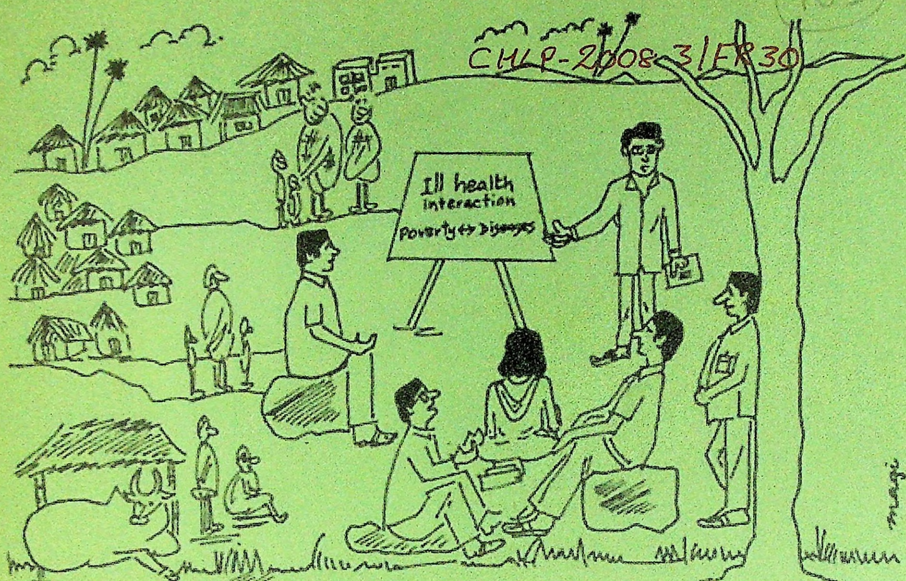
Community Health Learning Programme 2008

CHLP-2008.3/FR30 (103)



Source: Community Health Cell

A Report on the Community Health Learning Experience

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COMMUNITY HEALTH CELL

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CHLP-2008.3/FR30

Community Health Learning Programme

June 2008 to February 2009

REPORT

Varsha Gaikwad

Intern, Community Health Cell

Acknowledgment

This programme has given me a special opportunity to know about my self thru the special care and guidance of Dr Sukanya, my mentor in this course. Without her valuable guidance I would have not come across the vast world of knowledge and esteem which was under cover due to my personnal family problems. She was the guiding lighthouse to change my view to live independently and take my own decisions through various means. I am also grateful to Mr Premdas who always encouraged me to go for the new avenues in life without taking care of other worldly things on my own even with sacrificing my own personal family life. Dr Rakhal who also was a inspirational lamp and his valuable guidance was very much practical from time to time. All the friends', interns, who were with me through out the programme at the various points taking care of each other and shared the views at various point in their happy moments.

I am very much grateful to the whole staff of CHC for their ready to help attitude and kind nature without which it would have been not possible for me to achieve this small drop of knowledge from the ocean.

This learning programme would not have been possible without Dr Ravi Narayan and Dr Thelma Narayan whose vision gave rise to the idea of CHC where there is fusion of knowledge and values from various fields which provides a platform to an individual to groom up his/her knowledge and change the view of life.

Introduction

I am Varsha, President of Positive Womens Network, Maharashtra, and Vice-President of Positive Womens Network at the national level. I had completed my Master's in social work. We started the state level Positive Women Network of Maharashtra (MPWN+) in the year 2007 and are working in the field of HIV/AIDS and are affiliated to the Positive Women Network (PWN+), Chennai, a national body of women living with HIV in India. The members of MPWN+ are also offering their services through counseling and treatment adherence programme of the Government Medical College, at the ART centre in Nagpur. Besides, there is our counseling centre close to the Government Medical College where the PLHAs are counseled with regards to the nutrition.

MPWN+'s purpose is to change the existing situation of all women living with HIV/AIDS and infected/affected children in the State of Maharashtra. We build women's capacities to increase their access to rights, develop partnerships and advocate for programmes and policy changes to address concerns of women living with HIV/ AIDS.

As a leader, I was not capable to handle all responsibilities of leadership. I was completely unaware about the national health policies, health movements and the related NGO's who were working in this field. I got a great opportunity to learn the various aspects relating to the policy making in respect to health and the NGOs who are pioneers in the respective fields, I honed my skills for efficient leadership to lead my Organization, The Positive Women's Network of Maharashtra in Nagpur.
From childhood I am very ambitious, always to ready to learn new things, to meet new friends and different thoughts of people, When I opened website SOCHARA, on seeing the contents I was puzzled. My first question for myself was that what is community health? I gathered the related information on the matter to understand that this fellowship will be of help to me to show a new path in future.

Reflections of the fellowship programme

There were many questions in my mind before joining CHC. What and which type of learning can I acquire? In CHC, I came across a very unique way of learning, which was the active participatory method of the volunteers, by self learning groups, critical thinking and adult learning process. I acquired more knowledge by observation and group discussions. When I had earlier read the WHO definition of health, I merely understood the meaning, but from the CHLP I came to know the real sense of health, it is not only related to disease and illness but it is also affected by social determinants like class, caste and gender.

Dr. Ravi had given us space to express our feelings, experiences and facilitated self awareness for the first time I had asked myself what will I learn, what I like and don't like. I recalled some pleasant and unpleasant memories in my life. We learnt skills and values required as community health worker. I learnt that participatory skill, communication, nonjudgmental attitudes are important for leadership. The sessions on the epidemiological triad and primary secondary and tertiary prevention of Tuberculosis;

Alma Atta Declaration - Health for All concept; the Public health system, policies and programmes. Implementation of services, regulation and monitoring were very useful. Now I am aware about what is primary and public health care , structure of PHC , duties and responsibilities of ANM.

Through stories, I deeply understood the concept of then People's Health Movement. The life journey of Dr. Ravi and Dr. Thelma, in the community health movement is an inspiration for me.

Through the group work assignment on structure of public health system in respective states, I learnt more about how geographical position and population affects community health.

In group discussions I got a clear idea about positive and negative impact of globalization and how globalization, liberalization and privatization has eventually increased the gap between rich and poor.

All the interns from different background, shared their experience on issues from grass root level to global participation these discussions have been instrumental in increasing my confidence.

Exposure visits were really an interesting learning experience for me. In Hannur, the Holy Cross Comprehensive Rural Health Project (HCCRHP) are taking initiative to protect the children from child labour and provide platform to enjoy their childhood and education through day care bridge schools and residential and join them to the main stream. The bridge school Satvidya, bridge school, is a great example of the first I have seen. When we saw vast areas in Arbgare covered under water shed project, I really felt happy that with help of organizations and fund's acres of wasteland has been cultivated. I visited a PHC for the first time in my life. We observed what health facilities were provided, the health workers attitude and also their limitations due to the limited facilities available in PHC. Then I concluded that every PHC must be having similar problems. Meeting with Jaddejamma a health worker trained by a Holy Cross project was unforgettable moment in my life. We learnt lot of things (use of herbal medicines) when she had shared her experiences with us.

In Hospet, we met Dr. Bhagya of SAKHI. This organization is running a hostel for SC/ST girls and provides scholarship for higher studies. Here I came to know the real meaning of globalization or capitalization. Due to the increasing illegal mining projects, life of people had been changed, as they had lost their land. Agricultural land has become infertile. Unemployment has increased leading to addiction of drugs and alcohol. There were also cases of sexual abuse and rape, and Sakhi also fights for justice for the victim.

We also had a chance to visit Hampi, it was a memorable trip, cannot be described in words. We all fully enjoyed the scenery and even forgot the tension, worries and regained our energy.

The visit to Jagrutha Mahila Sanghatan (JMS) in Raichur was a very interesting experience. JMS is working for empowering the Dalit women and organizing the women to fight for their rights. Their continuous effort of 8 years, got them the success, that women have come forward and have made 42 SHG groups and are running a school for poor, orphan and helping working children to get back to schooling. Women groups are running many income generating programmes like making terracotta jewelry, herbal medicine and neem fertilizers.

We stayed for four days with these children, sang songs, danced and played games with them. I was surprised to see the way they maintain discipline throughout the day .Early morning they did yoga, exercise, homework, got ready for school and all the daily chores. Jeyapaul had taught them many songs with actions. We all had seen simple hardworking village life. We also learnt how to make terracotta jewellery and preparation of herbal medicines from medicinal plants and which disease it can be used. Chinamma shared her experiences of successfully treating many people.

The field visits which were carried out were personally very interesting for me as I came across many situations where the community had found solutions to their problems and I was also able to help them with some.

Our CHC mentors are like friends and guides for each fellow. When I came to CHC, I was very upset and unhappy due to my family problems but when I met with all the staff of CHC , then I forgot all my problems due to the lovely behavior of all. Dr.Sukanya always provided me help in my personal problems. Due to my health problems I was worried about traveling. Through email and phone we were always in touch. My Mentor always showed me the way whenever I needed.

Learning objectives

1. Improve my leadership skills to be an efficient leader for the movement.
2. Learn National level HIVAIDS policies and NACP III in relation to women and children.
3. Understand different health and women related movements and network for collective advocacy.
4. Understand and learn more on alternative medicines that help in improving the health of an individual
5. Development of personality skills.
6. Improve writing and documentation skills.

Plan of action

1 a) Visit and talk with various leaders in movements.

2. b) Collect and read the NACP III document and the related programmes.

c) Visit MSACS and collect state's action plans on HIV and women & children.

d) To visit MASUM, CEHAT and other women movements and network within the state

3. a) To visit and document activities of PHM and its structure.

b) Visit PWN+ Chennai and strengthen Maharashtra PWN+.

c) Participate in training programmes related to reproductive health, HIV AIDS and advocacy.

4. a) To collect literatures on alternative medicines for women's health.

b) Compile a booklet for HIV positive women on alternative medicines to maintain good health.

c) Participate in future in the related trainings, to work towards the betterment of the community.

Time line of activities:-

Time Period	Activity	Organisation
13th to 18th July	National workshop for planning for strengthening national and state level Networks	PWN+Chennai
From 22nd to 30th July	Advocacy training on reproductive Health and Rights at Naukuchiatal in Uttarakhand	SAHAYOG ,CHSJ,PLP
On 1st to 3rd Aug	meeting for advocacy programme	DPWN+
4th to 8th Aug.	Orientation course on prevention of micronutrient malnutrition	NIPCCED Delhi
22nd to 26th August 2008	1st National Consultation Workshop	New Delhi DPWN+
From 1st to 7th September	Mid term review of CHLP	CHC Bangalore.
16th and 17th September	meeting with D. G.	NACO New Delhi
21st September TO 7th November	Field work and attending public hearing in 4 district	SATHI CEHAT Pune.
1st to 8th October 2008	2nd National consultation workshop	New Delhi
29th to 2nd Nov	Revised training for trainer	PWN+Chennai
15 th Nov	Signature and quilt campaign	MPWN
1st to 4th Dec 2008	3rd National Consultataion Workshop	PWN+ New Delhi
5th to 6th Dec 2008	Alumni workshop	• CHC Bangalore
Jan and Feb	Project work	• MPWN

Presentation of work with respect to Learning Objectives

* National **workshop** for planning for strengthening national and state level Networks

We were 22 women leaders from nine different states who participates in the 3 days workshop.

On day one, we interacted with each other, shared our state wise concerns and strength's and weakness of the National secretariat office.

On day two, Ms. Geetha from engender health took a session on understanding the situation of women's movements in India. The state level network's shared their work. We reinstated the PWN+ vision (see Anexure V) and came up with ideas and solutions to strengthen our network.

On day 3 we went to Mahabalipuram where a three days National conference of project directors on HIV/AIDS was going. We, all the 22 WLHIV state leader's met Dr.Sujata Rao Director General of NACO .We gave her the memorandum on why, Drop in Center's exclusively for women are required.

* I gave a **short note** in AIDS INDIA about Railway concession for PLHIV which is available only in the general class which created interest and a long discussion was needed on this issue.

* On 21st July I went to ICRW (International Counsel for Research Welfare) office and met the project director, to **seek technical support** for documenting the research undertaken on the current landscape of involvement of WLHA and the results of training workshops and a national consultation on involvement of PLHA. The ICRW was also given the responsibility of documenting (print and film), the history of PWN+ to commemorate its tenth anniversary.

* I attended a ten days **training programme** on advocacy for Reproductive Health and Sexual rights in Nainitaal which was organized by SAHAYOG ,CHSJ, and population Leadership programme from July 22 - July 30, 2008.

<u>**Objectives of the Training Programme**</u>

Build conceptual clarity on rights-based approach to sexual and reproductive health (including maternal health and safe abortion) within an overall human rights perspective

1. Develop an in-depth understanding of the present scenario in sexual and reproductive health and rights: policies, evidence and debates - globally and locally
2. Understand the role of rights based advocacy in the context of social change, what factors/actors are involved to change opinions, practices, policies
3. Develop understanding of the components of essential advocacy
    - analysis of the political, economic, social context
    - identification of problems/advocacy issues/rights violations
    - stake-holder analysis
    - mobilization, organization-building, networking, alliance building
    - communication, negotiation, conflict-resolution
    - campaign planning, influencing specific groups of opinion makers, working with media
    - using and building evidence, developing information and advocacy materials

4. Apply the above in developing strategic advocacy plans including identifying process indicators and intermediate outcomes

Modules and Contents

1. Sexual and Reproductive Health and Rights (Two and half days)
   - Gender, Power and Reproductive and Sexual Health
   - What are Rights? Introduction to Human Rights.
   - Reproductive and Sexual Rights - Tehran, CEDAW, ICPD, Beijing, MDG
   - Health and Human Rights - UN system and India, AAAQ framework
   - SRHR and Population Facts and Myths
   - Rights based approach
   - Introduction to NRHM and RCH2

2. Understanding Advocacy (3 days)
   i. What is advocacy – advocacy and social change
   ii. Rights based and evidence based advocacy
   iii. Identifying key advocacy issues - Using evidence
   iv. Identifying actors and factors - stakeholder analysis
   v. Advocacy Experiences - community based advocacy, policy advocacy, legislative advocacy, legal advocacy, media advocacy
3. Planning for Advocacy (One and half days)
4. Developing an advocacy plan

I met the Facilitators Dr. Abhijit, Ms.Jashodhara and Ms.Renu Khanna.
I shared my views and got them refined by Ms Renu, who was very cooperative and explained each and every point that was raised in a very easy to understand way. Total 25 participants came from different NGO,s all over the country.

In this training I came across some technical points related to advocacy. I was able to distinguish between advocacy and activism. I came to know that many women suffered from genital T.B. and it has an affect on their fertility which is a cause of social stigma. I also learnt full forms of abbreviations like:
CEDAW- Conventional Elimination of all forms Discrimination Against Women
UDHR- Universal Declaration of Human Rights.

The training helped me significantly in my work. I learnt about the analysis of stake holders networking of the NGOs, the media power and how to utilize it best for the advocacy of a cause.

* I stayed four days in the Delhi Positive Women Network state level office.
Here we had a meeting and fixed an agenda for a one day advocacy programme to be held on 6th August in Delhi to raise issue on widow pension scheme.

* I met with Ms. Freya who was providing her voluntary services from VSO (Voluntary Service Organization). She gave training on improvement of computer skills, how to access internet and many other things to our WLHIV in DPWN+ office. I had a

discussion with her about the VSO strategies and capacity building programmes for state level network.

* I attended the **orientation course** on prevention of micronutrients, malnutrition at NIPCCED New Delhi from 4 - 8 Aug, 2008.
The National Institute of Public Cooperation and Child Development designed this course especially for executive and middle level functionaries associated with health and nutrition programmes for women and children. The main objective of this programme was to sensitize the participants about the magnitude of the problem of micro-nutrients, create a awareness about policies and programmes for control of micronutrient deficiencies, highlight causes and consequences of micronutrient malnutrition, and evolve the strategies for prevention of malnutrition of micronutitient.

The contents of the programme had been covered through a combination of training method including lecture cum discussions, group discussions, case study analysis, group exercise, films, with emphasis on participatory approach to learning. Besides faculty of the institute, programme faculty comprised of experts from technical institutions, government and non govt organizations working in the field of nutrition and health. I learnt that MM is a serious problem in adolescents and the programmes that are run by the govt to reduce micronutrient malnutrition. I enjoyed participating in group discussion and exercises.

* A three day **workshop** on introduction to GIPA, its structure and functions and the role of gender was held from 22nd to 26th August 2008. The sessions were as follows:

Workshop One Day 1 - Understanding GIPA	Day 2 - Structures and Functions	Day 3 - Gender and GIPA
Introduction and background to GIPA	Structure of NACO, SACS, district units and their programs on prevention, treatment, care and support	Gender and HIV
Benefits of GIPA for PLHA, NGOs and government.	Understanding the role of networks and NGOs	Gender and GIPA
	Involvement and meaningful involvement - case studies	Why women should be involved
		Overcoming barriers to involvement

During the workshop I was introduced to GIPA, explored its structure and functions and developed an understanding of the role of gender in GIPA.

* Another three day **workshop** was held for exploring national policies and the role of GIPA. The sessions are listed below:

Day 1 - GIPA at national level	Day 2 – Policies	Day 3 – GIPA Draft Policy and training for own research
GIPA revisited	NACP-III	Exploring GIPA draft policy
Structure and functions of national level stakeholders	UNAIDS "Three Ones" principles	Training on participant's own field observation on the prevalence and quality of women's involvement at the state level
	Global Fund Country Coordinating Mechanisms	

This workshop developed my knowledge on national and international level policies including NACP-III, UNAIDS "Three Ones" principles and the Global Fund Country Coordinating Mechanisms.
One the final day of the workshop, 15 participants were trained on how to undertake their own research on the prevalence and quality of women's involvement in their own states.
I got the GIPA draft Policy translated in the local language and in our MPWN+ I took a complete session on GIPA and NACP-III for our members.

* National **consultation** was organized with the support and involvement of Global Coalition on Women and AIDS (GCWA), NACO, UNAIDS, UNIFEM, UNICEF, UNDP, VSO and other national and international organizations working on women and HIV and AIDS in December 2008 at Delhi.
The 110 women attending the consultation were divided into three groups, focusing on national, state and district level functioning of government bodies and NGOs. During the consultation participants who undertook research, had discussions on the results of their field observation on levels of involvement of WLHA and barriers to involvement. The groups began to develop recommendations to improve involvement of women living with HIV with input from stakeholders. UNAIDS "Three Ones" principles and the draft GIPA policy was analyzed and further recommendations developed. WLHA had been given the opportunity to share their thoughts and experiences with stakeholders and discuss the barriers to involvement that they have experienced and the ways that these can be overcome. The recommendations for improving involvement presented followed by a panel discussion. Feedback was obtained from stakeholders through an open discussion.

The National Consultation had given the, supporters and stakeholders an opportunity to commemorate the tenth anniversary of Positive Women Network. And to present the achievements of PWN+ over the last ten years, the challenges we faced and the challenges we have to overcome in the future. We had launched our ten year commemoration document, screened the accompanying documentary film and honored our supporters and network members.

The 30 women who attended the training workshops travelled from their states. 15-20 women attended a the preparatory training workshop two days prior to the consultation to develop skills to enable them to facilitate sessions and share knowledge during the consultation. The first two days of the consultation involved discussion and development of recommendations with stakeholders. Stakeholders and supporters invited to attend PWN+ 10 year commemoration event on the final day of the consultation.

National Consultation Sessions are as follows

Two day preparatory workshop	Day 1	Day 2	Day 3
	Presentation from 15 participants who undertook own research on the prevalence and quality of women's involvement at the state level and barriers encountered	- Analysis of draft GIPA policy and "Three Ones" principles. - Further development of recommendations.	Commemoration of PWN+ tenth year anniversary
	- Discussion on the functioning of government bodies and NGOs at district, state and national level and the barriers to involvement - Development of recommendations	- Presentation of testimonies of WLHA and recommendations to stakeholders. - Forum for discussion and Q&A.	- Launch of booklet and video documentary commemorating PWN+ anniversary - Launch of research report on women's involvement

	as to how women can become involved.		
			Honoring of PWN+ partners and supporters
			Celebration of past ten years and looking forward to future of PWN+

* My fieldwork was in **SATHI** (Support for Advocacy and Training to Health Initiatives) SATHI is the action centre of Anusandhan Trust evolved from CEHAT. SATHI envisages a society, which has realized its right to health and health care-

- A society which has eliminated health inequities, by removing the structural barriers which today prevent the majority from accessing healthy living conditions and quality health care;
- A society which instead of the current pathological model of development, has adopted a developmental path which fosters health of both the people and their environment;
- A society where people, are not appendages of the health care system but; are its prime movers and have universal access to appropriate health care as a human right.

To realize this long term goal, SATHI's strategy is to contribute as a team of pro-people health professionals, to the movement and initiatives towards such a society, by focusing on the aim of realization of health and health care as fundamental human rights.

SATHI's origin is traced to a small action-team in CEHAT, which since 1998, pioneered a collaborative Primary Health Care project with three People's Organi-zations. During the last 10 years this work has developed considerably and, has moved beyond it's initial focus and now consists of many components.

A. Collaborative health initiatives with four people's organizations in Maharashtra and Madhya Pradesh.

B. Advocacy at broader level for Primary Health Care and Health Rights

C. Training on Health Rights and in Community Health Initiatives

D. Action-research related to Health Advocacy
During the field placement of two months with SATHI, I attended 4 district level Jansunwai and one state level Jansunwai (Public Hearing). In this process I encountered the positive angles of Community Based Monitoring of Health Services.

Under the NRHM programme, nine states were selected to be part of the first phase of CBM Maharashtra wss one of the state. In Maharashtra this community based monitoring process started in 5 districts, i) Amravati ii) Nandurbar iii) Osmanabad iv) Pune v) Thane. Three Talukas were selected in each of the above districts, and three PHCs in each taluka and 5 villages under each PHC were undertaken. As a State nodal organization SATHI CEHAT Pune, undertook the above said programme for the period of April 2007 to January 2008. [see Annexure IV]

My observation

- People were very actively involved with greater enthusiasm in the process.
- The people were getting aware of the health services which are available at PHC, sub center, and about the rights to avail them.
- People at grass root level were coming to know about the amount of funds which was made available to their village/taluka/district/state. Awareness was seen on ascending trend for the services provided on paper and in physical state.
- Provision of health services improved at sub center PHC and RH level after the public hearings.
- The mothers were getting there dues under the Jannani Suraksha Yojana without any delay from the concerned authorities.
- Various vacant posts at different levels were filled in due course and fresh appointments and tenders were issued for future programmes.
- The people's health rights charter was displayed in each PHC and RH prominently and was given wide publicity.
- All the essential medicines will be provided across the counter on a cashless basis and with the provision of local purchase if not available on hand at the time of requirement.
- Free transportation will be provided to and from the referral services if it is not available
- arrangement will be made through the IPH funds

- **Signature and quilt campaign on 15th November 2008: Women Voices & Positive Thinking!**

MPWN+ organized a signature and quilt campaign (Quilt made by the belongings of people living with HIV and few those no more with us) to enlighten the masses and to bring greater awareness about the SHGs, and NGOs working in the field of HIV/AIDS or those voicing the various issues pertaining to women.

The Objectives of the Campaign were -

- To impart knowledge to the general public on how to reduce Infection rate among women.

- To help the community to be aware of how they can help the positive women. (Both Emotionally as well as by Economic Support)

* In December 2008, with the experiences of women living with HIV AIDS in areas of sexual and reproductive health, I developed a proposal for MPWN+ with the following goals and activities and submitted to ITPC. The goal of the project was Empowering women living with HIV as peer educators and activists in responding to women's specific opportunistic infections in three districts of Maharashtra

1. Developing 30 master trainers / educators in three districts of Nagpur, Gondia and Gadchiroli as prevention ambassadors for women specific opportunistic infections
    - 1.1 Selection of 10 WLHA master trainers from each district based on prior experiences and background knowledge on HIV and ART
    - 1.2 Developing a Flip Book on prevention and treatment referrals on cervical and breast cancers among WLHA
    - 1.3 Three day training for master trainers in Nagpur and training on how to use the Flip Book in community
    - 1.4 Organising and sharing information through support group meetings of WLHA in respective districts
    - 1.5 Mobilising 300 women living with HIV in three districts and encouraging them for screening tests on cervical and breast examinations

2. Networking with health care providers in public and private sector to improve referral services on women specific illnesses like cervical and breast cancers among WLHA
    - 2.1 Individual one to one meetings with public and private health centers that provide treatment on breast and cervical cancers
    - 2.2 Organising quarterly meetings among heath care service providers to strengthen the referral systems
    - 2.3 Recording information and encouraging WLHA to access cervical and breast cancer tests
    - 2.4 Documenting the results and preparing status paper towards treatment advocacy for women specific illnesses

3. Advocating with SACS and other service providers to include prevention of specific OI among WLHA
    - 3.1 Develop advocacy IEC materials (Poster and an information Brochure) on prevention and treatment of Women specific Opportunistic infections
    - 3.2 Organise one day advocacy event involving district and state level HIV AIDS stakeholders in highlighting the need and further action on needs in women specific Opportunistic infections in the state.

Though we submitted with the detailed list of activities and plan, unfortunately our proposal was not accepted. Hence the same concept I am using with CHLP support to implement some components of this proposal.

*** One day health training programme on 14th February 2009**

The main objective of this health training programme was to empower women living with HIV as peer educators and activists in responding to women specific opportunistic infections.

This programme started at 12 pm in the premises of the Positive Women Network of Maharastra office. Near about 30to 35 participant had registered.

In introduction session every one gave their introduction and why they participated in this training programme and their expectations.

A small questionnaire was given to them for pre evaluation.

Mr. Riyaz Quazi, project co-ordinator of HIV+T.B. cordination project, gave information on causes, etiology , signs and symptoms and treatment of Tuberculosis.

After tea snacks break I took a session on Opportunistic infections and how to manage them. Availablity of treatment In the session on I focused on women specific O.Is like breast cancer and cervical cancer ,available screening test like paps smear .

Mr. Sanjay, counseller of Ashirwad Kanti, gave information about government schemes like Sanjay Gandhi Niradhar yojana , children hostel and day care school by their organistion .Health check up camp and health facilities was available free of cost.

Dr. Amabade, of A.R.T center, made a short visit from his busy schedule.

He provided valuable knowledge about ART and management of its side effects and also on the importance of adherence.

Looking Inward - What did I learn about myself?

I was very narrow and fixed minded, and also short tempered. After attending the orientation in CHC , a total change has occurred in my behavior as observed by friends, colleagues and family members. As I attend programmes , training and various workshops, I am finding it very easy to make present, with a high level of confidence which I was unable to do earlier

Looking Outward - What did I learn about the community?

- During the programme I came across many NGOs and social workers who are pioneers in there own fields or have attained a place of respect in the community. It was a great opportunity to meet them and learn about their way of working and the process they followed. This gave me vision to carry out my new ventures in future.
- In the advocacy programme I experienced discrimination. When my room partner came to know my HIV status, she felt uncomfortable and left the room. This incidence taught me a good lesson not to disclose my HIV status before

unsensitised people. During counseling I always tell my clients to disclose their status to sensitized medical health care providers.

- During field placement in SATHI CEHAT I learnt about coordination, networking and team work which are the essential ingredients to carryout a successful project.
- I met Dr. Satish Gogulwar who started a project called -Aamhi Amachaya Arogyasathi which motivates women in the villages to come together and form 'bachat gat'. They have become confident and having dairy decoration and herbal medicine. Aamhi Amachaya Arogyasathi whose vision statement is to build healthy capable and equity based global society. Believe in initially several concept and get them implemented from local people after their empowerment.
- I went to Nandurbar district with the sathi-cehat team. Personally it was a great experience for me. We stayed in Dr. Dhananjay's native. I met his parents his mother was so kind and active .She shared her experiences with me and I gained a lot of knowledge from her .
- After attending the three workshops national consultation of the Positive Women Network, I learned the gender policy, GIPA (Greater Involvement of People Living wit HIVAIDS) and NACP III (National AIDS Control Programme).
- During the workshop in New Delhi of PWN, I got the opportunity to visit NACO head office and meet the director general Ms Sujata Rao, I also visited the UNODC, the UNICEF and UNIFEM offices which gave me a golden opportunity to gain knowledge about big structure of ournational and international health policy.
- I have learn the meaning of community health which is a process of improving physical, mental and social well being of the community and all component members. Health services must be available, and equally shared with the whole community, It is not merely the absence of illness, sickness and disease but related with the social determinants geographically, economically, and class, caste, gender. Practically what I saw was that common people do not get access to treatment according to their needs .Government has made many health policies but due to corruption, lack of awareness, gap between health care provider and common people, lack of coordination between public health system and Panchayati Raj and political leader health programme, it is not successfully implemented. Any public service can be improved only with active participation of the local people. Social action can improve health. Community health can be improved by participation of people in decision making, for example for the GIPA policy, there was PLHIV at decision making committees with gender balance
- The people need to enable themeslves to maintain their health, exercise their responsibilities collectively and also demand health as their right.
- Due to community monitoring process in the pilot project districts people were aware about their health rights through display of health charter. People got platform to solve their problems in public hearing at PHC, district and state level.
- As a counselor I am trying to implement all these principle in my work. In the ART center I counsel every new client with information about HIV/AIDS, respective tests, treatment and their health rights.

Looking Ahead - Where do I go from here?

With all the learning's I received I will be able to work with a stronger position and the weapon of skills achieved from the programme to strive for the betterment of the community at the grass root level and also take the grievances of the community to appropriate position to solve them.

Annexure

Annexure I

NATIONAL AIDS CONTROL POLICY -PHASE III

Excerpt from NACP III document
To halt and reverse the epidemic in India over the next five years
Specifically reducing new infections by

- 60% in High Prevalence States
- 40% in Vulnerable States

Objectives:

- Prevention of new infections (saturation of HRG coverage and scale up of interventions for General population)
- Increased proportion of PLHA receiving care, support and treatment
- Strengthening capacities at district, state and national levels
- Building Strategic information management systems
- Three Ones
- Equity
- Respect for the rights of the PLHA
- Civil society representation and participation
- Creation of enabling environment
- Improved access to services
- Effective HRD strategy
- Evidence based and result oriented programme implementation
- Prevention
    - Saturation of HRG
    - Targeting of Bridge Population
    - Focusing on Women, Youth and Children
    - Blood Safety
    - Access to STD Care
    - Condom Promotion
    - Comprehensive Communication Package
        - Advocacy
        - IEC (Mass Media & IPC)
        - Social Mobilization

IIa Care and Support

- Community Care Centers
    - OI Management
    - Drug Adherence

IIb Treatment

- ART
    - Adult
    - Paediatric

IIc Impact Mitigation and Stigma Reduction

- Implementation Strategies

- Shift of focus from states to district based on evidence
- Decentralization
- Capacity Building - Infrastructure and Training
- Setting up procurement systems
- Convergence with health systems
- Mainstreaming
- Partnership with Civil Society and Private Sector

Annexure-II

The meaning of 'Greater involvement of PLHIV'

In December 1994, at the Paris Summit, 42 nations declared their support for the greater involvement of people living with HIV/AIDS (PLHIVs)1 in prevention and care, policy formulation, and service delivery. Signatory governments to the Paris Declaration undertook to "support a greater involvement of people living with HIV/AIDS through an initiative to strengthen the capacity and coordination of networks of people living with HIV/AIDS and community-based organizations. By ensuring their full involvement in our common response to the pandemic at all national, regional and global-levels, this initiative will, in particular, stimulate the creation of supportive, political, legal and social environments (Paris Declaration, 1994)."
Since the Paris Summit, GIPA has been endorsed in numerous international statements, most recently by the UNGASS Declaration of Commitment on HIV/AIDS, which acknowledges "the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects and recognizing that their full involvement and participation in design, planning, implementation and evaluation of programs is crucial to the development of effective responses to the HIV/AIDS epidemic (United Nations, 2001, paragraph 33)."

The PLHIV movement in India

From a handful of selectively open PLHIV in the mid 90's, the PLHIV movement has steadily grown in size, visibility and capacity. In the late 90's the first National network of PLHIV was formed which has since grown to have many state level networks and district level networks. New leadership has emerged; women living with HIV have increasingly become part of this growing group of articulate and informed advocates.
Alongside, collectives of men who have sex with men, sex workers and Intravenous drug users have also benefited from the experience of those among them who live with the virus. These collectives have specifically contributed to the advocacy on creating enabling legislative environment, reduction of stigma and challenging discrimination.
Consistently, they have represented their concerns at international, national, state and district levels. They have been at the forefront of treatment advocacy in India, played the important role of being the eyes and ears of the national AIDS programme, ensuring that quality services are provided. Many PLHIV have stood shoulder to shoulder with Presidents and Prime Ministers of India, ministers and legislators at

different levels, sensitizing them about the key HIV issues. Their fearless presence on print and electronic media has contributed significantly to reduction in stigma.
However, the involvement of PLHIV and those directly affected can become more meaningful, consistent and systemic, thereby benefiting the national HIV response by accelerating its impact.

Purpose/objectives of the policy

The National AIDS Programme of India defines the involvement of PLHIV and affected communities as a specific expression of the right to active, free and meaningful participation in all aspects of the HIV/AIDS response.
The application of the principle of GIPA is an organic and ongoing process that demands different levels of readiness. This policy aims to effectively harness the meaningful involvement of PLHIV in order to reduce the spread of HIV and mitigate the impact of the virus in India.

Guiding Principles of the GIPA Policy for HIV Programmes

The national AIDS programme of India recognizes that involving PLHIV and affected communities in the HIV response makes a powerful contribution to the pandemic by enabling individuals and communities to draw on their lived experiences; thus contributing to reducing stigma and discrimination and to increasing the effectiveness and appropriateness of the HIV/AIDS response.
The advantages of GIPA at the policy level flow beyond the immediate concerns of prevention, care, and treatment issues and can improve the capacity of various sectors, such as education and employment, to respond to HIV/AIDS.
To effectively ensure that PLHIV and affected communities are actively involved in responding to the pandemic it is essential that PLHIV fulfill a diverse range of roles that include policymakers, activists, healthcare workers, educators, scientists, community leaders and public servants, as may be applicable in a given situation and setting.
Meaningful inclusion of voices of PLHIV who are marginalized because of gender, sexuality, age and behaviors in the HIV response is key to the success of the programme.
PLHIV leadership is also central to establishing a voice in the policy process. PLHIV leaders generally have to accept the heavy burdens imposed by the physical and social experience of living with HIV & AIDS. Leaders often emerge because they are among the first people in their country to speak openly about living with HIV. The limited number of openly positive people creates huge demands on those who have taken the step to be public about their status. A critical element in sustaining such public leadership remains the provision of ARVs and OIs treatment and diagnostics including second line for those who lack sustainable access.
To ensure that PLHIV and affected communities are meaningfully involved in all aspects of the HIV/AIDS response it is essential that we all work together to advocate for and with PLHIV. Effective advocacy requires that:

- The voice of PLHIV is heard
- PLHIV obtain their rights
- The interests of PLHIV are represented
- PLHIV have access to necessary services and support in an enabling and conducive environment

Policy Guidelines

PLHIV will be recognized as important providers of information, knowledge and skills; their participation will be on the same level as professionals in the design, adaptation and evaluation of interventions.

PLHIV will be facilitated to carry out real and meaningful roles in HIV interventions such as acting as caretakers, peer educators and/or outreach workers.

PLHIV will be active spokespersons in campaigns to change behaviors and will be meaningfully involved in sharing their views at meetings and conferences.

PLHIV will be meaningfully involved in contributing to public awareness raising activities and act as role models in the HIV response.

PLHIV will be actively involved in the development of HIV information, education and communication (IEC) resources, and provide important feedback that will influence the ongoing development of IEC initiatives

NACO, SACS and all partner agencies will promote the active and meaningful involvement of PLHIV and affected communities within the organisation—in partnership with organizations and networks of PLHIV and affected communities; this is essential for implementing the GIPA Principles.

NACO, SACS and all partner agencies will have an organizational environment that fosters non-discrimination, and values the contribution of PLHIV and affected communities.

The national AIDS programme will recognize and encourage the involvement of a diverse range of PLHIV and affected communities in all HIV work.

All implementing partners of NACP3 will define the roles of PLHIV in our organisation and their associated responsibilities, including supporting the capacity of individuals to fulfill those roles, and provide the necessary organizational and financial support to those people.

All implementing partners of NACP3 will ensure that organisational policies and practices provide timely access to information so PLHIV and people from affected communities work in an environment that fosters non-discrimination, and values their specialized contributions.

All implementing partners of NACP3 will ensure that workplace policies and practices recognise the health and related needs of PLHIV, and create an enabling environment that supports their involvement in our organisation.

All implementing partners of NACP3 will ensure that PLHIV and affected community organization/network representatives that work with organisations are supported to be accountable to their members, and we assist them to establish processes that enable them to represent the views of their membership.

All implementing partners of NACP3 will give resources and support to capacity building within PLHIV and affected community organisations and networks.

All implementing partners of NACP3 will fund and/or advocate for funding for PLHIV and affected community organisations to ensure they have the resources to build their capacity and empower others within their own networks.

TO include:

- include the perspective of PLHIV
- involve PLHIV to feed into the programs on prevention and care programs on HIV

- all implementation agencies of NACP3 to involve PLHIV as watchdogs to evaluate and monitor the program progress
- involvement of PLHIV towards bridging the gap between service providers and community
- PLHIV are the best advocates for the issues
- Involve PLHIV to reduce stigma and discrimination and impact mitigation efforts
- Preferences to be given to PLHIV during recruitment of staff and as and when required PLHIV experiences be replaced with educational qualification
- At least one PLHIV be recruited in each intervention sites supported by NACO/SACS. This will help reduce stigma
- Promoting GIPA at the management level- involvement of PLHIV at decision making committees with gender balance

Investment in GIPA (capacity building, network formation and strengthening, sustaining networks)

Annexure-III

Positive Women Network

Positive Women Network (PWN+) is the only national self-help organization focusing entirely on issues of women living with HIV. PWN+ was initiated in 1998 to address the need for a support mechanism for women and children living with HIV. With the organizational goal of improving quality of life by providing an enabling environment, PWN+ envisions a better life for women living with HIV. Positive Women Network seeks to empower women and children living with HIV/AIDS to access their rights and live a life of dignity, free from stigma and discrimination.

PWN+ functions as an information centre, organising workshops and sensitising groups on positive living and issues of women living with HIV/AIDS. Its activities include networking, advocating for issues affecting women living with HIV, counselling, training and the initiation of self-help groups of WLHA.

For the last ten years, PWN+ has been committed to building the capacities of women living with HIV and campaigning for equality and justice. It has conducted numerous capacity building workshops for WLHA, including gender training and visioning sessions and legal literacy workshops designed to create awareness among WLHA of their rights and the existing laws and policies which can protect them. We have also conducted advocacy training to empower WLHA to advocate for women's rights in HIV-related policies and programs put forward by government and other stakeholders. PWN+ has also campaigned tirelessly against stigma and discrimination and for the recognition of the rights of WLHA.

In 2002, PWN+, with the support of UNIFEM, UN agencies and NACO, organized a national consultation, Positive Faces and Voices of Women, the first of its kind in India. The consultation was the outcome of a felt need for a platform to address the special needs, concerns and issues of women living with HIV/AIDS in order to bring about tangible improvements in the quality of their lives.

In 2003, PWN+ alongside the National Commission for Women organized public hearings in Karnataka, Kerala and Tamil Nadu to address concerns of women living with HIV. The public hearings were organized in response to 'Positive Speaking', a study undertaken by PWN+ and the Centre for Advocacy and Research (CFAR) which indicated high levels of stigma and discrimination against people living with HIV/AIDS in the three states.

Organized in 2004 with support from UNIFEM, UN agencies and NACO, Shaping a New Reality: for Women Living With HIV/AIDS, which promoted a gender-sensitive multi-sectoral approach to HIV/AIDS was the second national consultation organized by PWN+. The consultation was preceded by training-workshops undertaken over a six-month period which addressed mainstreaming concerns of WLHA in existing schemes of the Government. Following the training, women were able to develop local goals and strategies to access government programs, which they advocated during the National Consultation. During the consultation, recommendations were developed for Government ministries including the Ministry of Social Justice and Empowerment, Ministry of Rural Development and Ministry of Youth Affairs and Sports on how various government schemes could be extended or adapted to better involve WLHA. Out of the consultation came a declaration by members of the Positive Women Network to shape a new reality.

In 2006, PWN+, in partnership with UNICEF organized The National Consultation for Children Affected by HIV/AIDS in India. The consultation brought together children affected by HIV/AIDS and created a platform for their voices to be heard by high-level policymakers in the Indian government and NGO community. Through this forum, children from all over India articulated many concerns - being orphaned, being denied services, lacking access to education - and offered suggestions to improve the quality of their lives.

Significance

Improving involvement of people living with HIV/AIDS is recognized as 'critical to halting and reversing the epidemic'[1]. However, despite being officially on the agenda in the response to HIV/AIDS since the Paris AIDS Summit of 1994, it is widely recognized that the principles of involvement are rarely fulfilled.

At the 2001 UN General Assembly Special Session on HIV/AIDS it was agreed by over 180 countries that gender equality and women's empowerment are fundamental to reducing girls' and women's vulnerability to HIV/AIDS. India's National AIDS Control Organization (NACO) has renewed its commitment to improving involvement of people living with HIV/AIDS in its NACP-III guidelines in recognition of the failure of NACP-II to adequately address the issue. UNAIDS also supports the principles, calling for 'all actors to ensure that people living with HIV have the space and the practical support for their greater and more meaningful involvement'[2]. Similarly, the

[1] UNAIDS Policy Brief (GIPA)

Global Coalition on Women and AIDS have made improving involvement of women living with HIV a priority in its Agenda for Action of Women and AIDS.
PWN+ wishes to be at the centre of the renewed commitment to involving people living with HIV/AIDS to represent the voices of women and children living with HIV.

Annexure IV

Key issues emerging from various District level Jan Sunwais Related to Community monitoring of Health services in Maharashtra

This note briefly lists the key issues that were presented in various District level Jan Sunwais in five districts, as part of the Community monitoring process under NRHM. Not all the issues and cases of denial of health care have been listed here, however major issues, especially those requiring district level or state level intervention, have been outlined.
It should be noted that Community monitoring has led to a number of improvements in all of these districts, and this process has led to increased dialogue between people and public health providers. However these improvements have not been covered in this note.

District Nandurbar

Key issues:

Availability of medicines

Representatives of the Block Nodal NGO in Akkalkuwa and Dhadgaon have shown that most of the PHCs do not have adequate medicine availability (especially ASV, TT inj, and disposable syringes).
Specific issues observed-

a. Participants in the Jan Sunwai have unequivocally said that many times syringes that are used in the PHC are autoclaved, although these are disposable syringes.
b. Mechanism of local procurement of medicine was not revealed to community monitoring agencies inspite of repeated requests.

A. Ambulance availability-

Out of the nine PHCs monitored, only four PHCs have a functional ambulance.
Issues observed-

a. It has been claimed time and again that wherever ambulance is not available people can hire a private vehicle for which reimbursement would be given. However in practice it is rarely done citing various rules.
b. Though the untied fund is supposed to be used for hiring private vehicle wherever ambulance is not available, many people have reported that for one or the other reason this service has been denied. Hence patients are often denied ambulance facility.

B. Vacant Posts-

It has been pointed out that there are large number of Health posts which are lying vacant for last few years, mainly posts of ANMs and MOs.
Issues observed-

a. One interesting phenomenon that has been observed in Nandurbar is simultaneous appointment of single doctor at two places, e.g. Kusumvada PHC doctor also happens to be ADHO. Because of this arrangement though on paper PHC MO post in Kusumvada appears filled, in practice the MO is never present in the PHC. It should be noted that arrangement like this also hides real number of vacancies in the District.
b. ANM posts have been vacant for last many years; even the monitoring agencies are convinced that the present ANMs are simply overburdened.

C. Construction of new PHCs and location of the present ones-

a. One of the issues which has been repeatedly stressed by community level activists is the poor location of certain PHCs. In Dhadgaon block most of the PHCs become inaccessible during monsoon, including the one which is designated as 24x7. Similarly in Akkalkuwa, location of some PHCs is inconvenient to the people residing in the PHC area.
b. In some areas though the new PHCs have been sanctioned, due to non cooperation of Panchayats and also because of the vested political interests these PHCs could not be constructed.

D. Incentive based schemes- (Janani Suarksha Yojana and Matrutva Anudan Yojana)-

Delay in the payment, partial payment, asking for number of documents which are difficult to arrange are some of the general problems that are observed in Nandurbar.

Issues Observed-

a. In some cases payment was delayed for more than three months. According to the DHO, at the District level itself there was delay in receiving the money.
b. The range of paperwork that a potential beneficiary of JSY or Matrutva Anudan Yojana (Maharashtra specific maternal benefit scheme) has to perform is simply overwhelming for the ordinary Adivasi person. This leads to lapse of benefits.
c. Incentives are provided only at the service points like PHC and RH. There were instances where woman who has delivered at home, with a newborn baby has to go to these service points within 10 days of her delivery for seeking benefits of the mentioned scheme.

District Pune

Key issues:
Taluka Khed
PHCs

- PHC Wada and Kadus do not have drinking water leading to lower utilization by people
- The planned new PHC should be operationalised at Vashere (which is more centrally located) instead of Vetale (less convenient location for most villages)

- PHC Khed does not have proper quarters for doctors, hence doctors and staff are not staying at PHC. Similar problem of quarters for PHC Kadus

RH Chandoli - Serious issue of demand being made by doctors in the range of Rs. 5000 to Rs. 7000 for performing operations, including cesarean operations

Taluka Velhe
PHCs

- Sub-unit at Panshet is insufficient to provide full range of health services to surrounding villages. This must be upgraded to PHC at the earliest
- Quarters for staff inadequate, leading to non-residence of PHC staff
- Vacant posts of ANMs and MPWs
- Almost all of the PHCs do not have functioning laboratories, lack of lab technicians
- Most of the PHCs do not have functional ambulances or patient transport vehicles

RH Velhe

Not a single specialist doctor. Entirely run by general MOs. No cesareans or operations performed.

Serious problem of electricity supply leading to some deliveries being performed in near-darkness. Inadequate water supply.

Ambulance exists but no proper driver. Peon is driving vehicle but charge of Rs. 5 per Km. taken from all patients.

Inadequate number of indoor beds.

Taluka Purandar
PHCs

- Belsar PHC does not have its own building, lack of proper space leading to serious deficiency in provision of services. Adequate building needs to be arranged at earliest
- Till recently doctor at PHC Malshiras was frequently prescribing medicines for purchase from medical store
- Quarters for staff inadequate, leading to non-residence of PHC staff
- Vacant posts of ANMs and MPWs
- Almost all of the PHCs do not have functioning laboratories, lack of lab technicians
- Most of the PHCs do not have functional ambulances or patient transport vehicles

RH Saswad

- Expired drugs have been found in the pharmacy, which were kept for being dispensed
- Pharmacist is on leave (period not known) leading to problems in dispensing of medicines
- Pregnant women are asked to have Ultrasound performed from a private facility, have to make payment for this
- Patients required to have HIV and Widal tests performed from private labs
- Inadequate specialist doctors and staff

Cases of denial of Health care at various Rural Hospitals -

- Serious complaints were voiced by certain women patients concerning RH Chandoli (Tal. Khed), who accused the surgeon of having demanded large amounts of money for performing cesarean operation. It was alleged by two women that Cesarean operation was denied when they refused to pay the illegal bribe of Rs. 5000 that was demanded.
- Similarly another woman who had undergone sterilization in RH Chandoli one and half years back, became pregnant (a clear case of sterilisation failure) yet when she approached the same RH for D&C (abortion), Rs. 1500 were demanded by the doctor. It was only after the intervention of a local journalist and the threat of media exposure that this demand was withdrawn and the abortion was performed.
- Complaint was voiced by a woman who approached RH Saswad (Tal. Purandar) during labour, and was asked to get Ultrasound performed from a private clinic as a precondition for the delivery being done in the RH. This was despite an earlier, normal U/S report for the woman being presented when she approached the RH. Ultimately delivery care was denied and she had to undergo delivery in a private hospital

Some cross cutting issues noted by the panel:

- Lack of availability of medicines is significant and in some cases medicines are being prescribed for purchase – this must stop and all essential medicines must be made available from the PHC stock itself.
- Certain commonly required medicines found deficient include Inj. Methergin, Syp. Paracetamol and Syp. Co-trimoxazole
- Large number of PHCs do not have functioning laboratories; serious shortage of lab technicians needs to be addressed
- Charter of Citizen's health rights needs to be displayed in all PHCs with name and mobile numbers of Medial officers

District Amaravati

<u>Key issues:</u>

A. Inadequate infrastructure and humanpower at PHCs –

<u>Issues observed-</u>

a. Vacant Posts of ANMs and MOs for last many years in certain PHCs.
b. Unavailability of certain essential medicines.
   Upon checking the indent register in some of the PHCs it has been observed that there is inconsistency in medicine supply, most of the medicines that are supplied are less than what has been demanded.
c. In one PHC upon checking the medicine stock it has been observed that lot of medicines are still stocked though their expiry date has already passed.

B. **Referrals of delivery cases-**
   a. It has been observed that in many PHCs the tendency of referring women in labour without even examining the patient is growing. There were at least

three instances where a woman was referred to the Rural Hospital or the private hospital citing complications. However all these woman had normal delivery after reaching the referral hospitals. (In every PHC there should be clear guidelines about referral, in case it is observed that the referral was unwarranted an enquiry should be conducted)

b. Another significant problem that has been noticed is access to ambulance services in Rural Hospital. It has been observed that in some of the PHCs ambulance services are available, however these services are available only till the rural hospital; for subsequent transfer from RH to the sub district or district hospital people have to approach the Civil surgeon. This arrangement is creating lot of problem for patients who need ambulance services in RH.
c. Almost all PHCs do not have stretcher or wheel chair facility, upon enquiry it was told that there is no provision of budget to buy these essential commodities. However if needed PHC officials were told to buy it from untied fund.

C. **Anganwadi Services-**

a. In Melghat it has been observed that there are some Anganwadis which are giving services to as many as seventy children, with limited man power and resources. There has been consistent follow up of this issue by the district nodal NGO however no action has been taken on it.
b. Though there is a guideline by the state Government that whenever a grade III and IV child is admitted in the hospital, the mother accompanying a child should also be given adequate food and also monetary incentive to take care of loss of daily wages. However this rule is not at all followed by the Public Health Department.

D. **Arbitrary transfer of PHC MO at Dhamangaon Gadhi -**

In spite of large scale community protest, the DHO and other officials at the district level are adamant on transferring a PHC MO, Dr. Mrs. Miraj Ali, in Dhamangaon Gadhi. This is despite the fact that she has significant community support since she has been regularly providing services while being based at the PHC. (separate letter has been sent by panellists to MD, NRHM in this regard).

E. There has been a long standing demand by many activists working in this area that every PHC and RH should have a counsellor, who knows local dialect, who would facilitate communication between local Adivasis and Public Health functionaries. This would lead to better access to health services and better awareness amongst Adivasis about various Government schemes.

District Osmanabad

Rural Hospitals

There were two main issues that need follow up at higher level-

I) **Availability of Essential Medicines -**

Gross shortage - for example, out of minimum eight commonly required antibiotics that should be available, five were totally missing in Ter and six were totally missing in Tuljapur RH respectively. Out of 14 medicines examined, 9 were missing in Ter and 10 were missing in Tuljapur RH respectively.

II) Vacant posts-

In Tuljapur and Kalamb RH -

- Only one or two of the four posts of specialist doctors have been filled.
- The post of Medical Superintendent was vacant in both RHs.

Primary Health Centres

Because of Community Monitoring, number of visits of the staff to villages has improved but home visits have not improved.

As regards supply of essential medicines, out of 8 PHCs surveyed, the situation was as follows:

Good - 3 (37%)
Fair - 2 (25%)
Unsatisfactory - 3 (37%)

There were some discrete examples of highly unsatisfactory services -

- In Naldurg PHC, people complained that even simple delivery cases are referred to a nearby private hospital, routinely. One concrete case was reported wherein the woman who had come for delivery at 4 PM was asked to go to the private hospital. She was in no position to do so and was delivered by a nurse, who was on leave but had come to PHC for some other work. The doctor did not do anything in this case. After the delivery, the mother and baby were left alone in dark in the PHC at night.
- Jaagji PHC is supposed to be 24x7 PHC. But only 8 deliveries were conducted in this PHC during last 1 month. One of the nurses conducts deliveries at home and charges fees for it. She was suspended, but has been reinstated.
- Staff does not visit Dalit bastis in Pohner PHC area in Osmanabad Taluk.

There was a strong suggestion that the system of trained dais being paid some honorarium per delivery conducted should be revived.

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Community Health Learning Programme is the second phase of the Community Health Fellowship Scheme (2003-2007) and is supported by the Sir Ratan Tata Trust, Mumbai

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