Community Health Cell

Community Health Internship

August 2007 – January 2008

Mentor: Dr. Thelma Narayan

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Preface

My desire to pursue an Internship with the Community Health Cell (CHC) came at a time when I craved a level of intensity and satisfaction from my work that I was not able find elsewhere. Despite working at a community health center in a low-income neighborhood in Brooklyn, New York, and working towards increasing the accessibility of health care to marginalized populations, I felt a lingering void. This drove me to seek out an Internship in an environment in which I felt culturally close and comfortable. I felt that an Internship in public health in Bangalore would effectively give me perspective into South India's social landscape and familiarize me with the conditions of people's health. Additionally, I wanted an experience that would solidify my existing interest to pursue higher studies in the public health realm of a developing nation.

My arrival in India in August 2007 was marked by a state of unanticipated culture shock. Since migrating to the United States in 1992 at the age of 10, I have returned to India 5 times during summer vacations. This trip, however, had a particularly striking impact on me from the beginning. I had heard from relatives and friends about the notorious 'westernization' and globalization of Bangalore, yet I was unprepared to accept the physical changes within the city.

I arrived at CHC in the middle of August to begin my Internship in Community Health. Since I had approached CHC independently, after learning about the organization through a random Google search, I was not sure what to expect. From the first day of the Internship, beginning from the Orientation, it was evident that CHC was a committed and professional organization. I was immediately struck by the simplicity of the CHC offices, the seriousness of the library and its literature, and the directness of the staff. I was immediately excited by the unrivaled learning experience to follow.

As a fresh Intern I came to CHC with a limited definition of health, that it is the "absence of disease". My quick introduction to the World Health Organization's holistic definition of Primary Health Care over the next few days helped shape my learning objectives for the next five months and beyond. Following this definition of health I was able to systematically learn about the various determinants that affect the health of communities within varying contexts. Visits to rural areas enriched my learning by illustrating the impacts of inaccessible and sometimes non-existent, fundamental resources such as shelter, water, sanitation, education, and job security. At the same time, living in

Bangalore with my family, I experienced the opposite lifestyle of those living in poverty in rural and urban areas. The ruthless disparity and the realization that socio-economic status serves as one of the prime factors in determining the value of an individual within society, and to some extent his/her fate is heartbreaking.

My experience of working in a low-income neighborhood of a developed nation contrasted with India showed that there is a large disparity between the provision of basic resources to the 'poor' population of each country. Those living in Bedford-Stuyvesant in Brooklyn, where I worked, were provided minimal structural support from the government. Access to water, sanitation, electricity, and food, though a struggle for the most vulnerable of marginalized communities is accessible to the remainder of the population. These elements are widely available and regarded as a basic human necessity. Many social services are adequately provided to the residents of New York City due to several factors. Some of these factors include the will of political leaders of the city, budget, a committed not-for-profit sector, and active civil society. Most importantly the combination of these factors has effectively established a system of checks and balances. I've noticed that even though money buys power and fuels inequity (just like everywhere else), common minimum standards of life are not compromised. One reason is that the United States (in the period following the exploitation of the aboriginal Native Americans) is a country that was not colonized and exploited of its resources. Secondly, the US maintains the Universal Declaration of Human Rights. The UDHR places importance civil liberties. This coupled with democratic decision making processes (there are exceptions to the rule i.e. the Iraq War) gives citizens large ownership of their rights as citizens.

In India, the magnitude of the disparity between the rich and poor shocked me; however, I was even more shocked by the disparity between the poor and the poorest. The Constitution of India which maintains the 6 Fundamental Human Rights does not fully support citizens against poverty and economic insecurity. It seems that the general state of the nation is due largely to a distracted government; one which prioritizes the growth of the private sector rather than focusing on strengthening the structure of basic services. This type of negligence, coupled with other powerful factors like caste, gender, religion, and corruption perpetuate the cycles of oppression; hinder the effective implementation of policy, and the pace of social change.

The largest difference that I have noticed in the social mindset of both countries is between Individualism in the United States and Collectivism in India. The antithetical schools of thought

place priorities on different values, which output certain distinguishable behaviors. One school condones dependency and sharing (parent-child relationship), while the other encourages a 'survival of the fittest' and capitalistic mentality. These messages of Individualism and Collectivism are present from the very early age of an individual's life within the household, the educational system, and the government. I believe that has been the strongest element which has (or has not) instilled a sense of entitlement to rights within people.

The flexible structure of the Internship effectively fostered my learning of community health and some of the issues that people in India face. My time with CHC far exceeded my learning objectives. Field visits were an enormous opportunity to witness, and to briefly experience, some of the tangible and harsh conditions experienced by communities on a daily basis. For example, at the National Alliance of People's Movements' Annual Conference in Gulbarga, Karnataka I listened to testimonials of women who face violence and oppression on a daily basis at their jobs and in their homes. The Food Sovereignty workshop organized by Svaraj taught me about the direct impact of Agribusiness on the livelihood of small farmers; and a visit to SIPCOT in Tamil Nadu effectively portrayed the detrimental health impacts on communities caused by the irresponsible and illegal behavior of manufacturing and industrial entities.

My time in India during the Internship has inspired me to pursue my graduate studies this year in the field of Global Health and International Relations. I believe that I will benefit from training and knowledge in the subjects of Health Financing, Health Economics, and Comparative Health Systems. After completing my Masters education I hope to work in the field at a community level to gain an in-depth understanding of the complex issues faced by those most negatively affected. In the distant future I look forward to utilizing the knowledge gained from community-level experiences towards a more macro/policy level to improve policy implementation.

This trip to India has affected me greatly on a personal level. It was effective in taking the initial step to bring me out of my comfort zone, to the forefront of the problems - which is a reality for the majority of Indians living in India. CHC gave me the opportunity to forge a very valuable relationship with my homeland. I feel extremely fortunate to have experienced the warmth, openness, and enthusiasm of all of CHC's staff members and friends. I am grateful to Dr. Thelma and Dr. Ravi for the opportunity to Intern at CHC. As an individual with the desire to pursue public health without a medical degree I valued the chance to freely explore my interests in the field. I am

especially thankful for having had Dr. Thelma as my mentor, who has become a source of support and inspiration. My time spent with the Technical Team during discussions within and outside of the 'work' environment has given me hope and excitement.

During my next trip to India, I look forward to involving myself directly in the field. Through this experience I would like to learn more about:

- Effective causes of social change (through the reduction of stigma) on a community-level. How to emphasize the need for the 'united we stand, divided we fall' philosophy.
- Mechanism rewarding people for good behavior in efforts of lessening corruption
- Targeting the children at an early age to get them aware and involved
- Sustaining mobilization while demanding for conditions that people have never experienced.

I look forward with keen anticipation to foster these friendships and to my next visit back to India.

Report Contents

The following report outlines my journey through the Community Health Internship with the Community Health Cell in chronological order. I have documented my impressions and thoughts on various meetings, field visits, and ideas. All of these experiences caused me to question my own status-quo and encouraged me to look outside of myself and my world.

Jan Swasthya Abhiyan - Karnataka Meeting - August 20, 2007

Background

I first learned about the Jan Swasthya Abhiyan (JSA), the Indian Circle of the People's Health Movement through the Community Health Cell's website. JSA is a movement that consists of over 20 networks and 1000 organizations as well as a large number of individuals who endorse the Indian People's Health Charter. JSA aims to establish health and equitable development as top priorities through comprehensive primary health care and action on the social determinants of health.

I attended a meeting of the Karnataka state chapter of the JSA called the Jan Aroghya Andolana - Karnataka (JAA-K). The meeting called together representatives from various districts of Karnataka to discuss issues relating to the deficiencies of the public health system in various districts of Karnataka. The representatives come together periodically to speak about issues in their respective districts and to reflect and improve up on efforts towards the strengthening of the Primary Health Center. CHC provides support to these districts through guidance on strategic planning and mobilization, dissemination of important information and literature, rights education, and through support in contacting political leaders.

This was my first exposure to a people's movement.

Reflection

The all-day Jan Aroghya Andolana meeting, which took place at the Sangama office in Gandhinagar, was an invaluable opportunity to witness the fruits of JAA-K's labor. I found several components of the meeting to be different from what I have become accustomed to while living in the United States.

Upon arriving at the Sangama office I was struck by the layout of the meeting space, a comfortable rectangular room with seating pillows arranged at the perimeter of the room. Although this was somewhat surprising for me (I was expecting a big conference table) it made perfect sense that an initiative taking place at a grassroots level would appropriately accommodate to the people and principles of justice and equity, by having equal and communal seating for all.

The meeting began with two women singing a Kannada protest song. I found this to be significant, because of the impact it had on establishing the culture of the meeting in an informal manner. I felt that the mission of making matters matter at a community level was indeed happening, that something like a simple song, which one wouldn't directly associate with the solution for the betterment of health/living conditions, is valid in inspiring and maintaining constituent morale. Next, the members proceeded to introduce themselves by name and by district/organization represented; members representing 14 districts were present. At this time I was pleasantly reminded of Kannada being the default language. Following introductions, Premdas, who served as the facilitator, outlined the agenda for the day. He solicited feedback from the members regarding the agenda to see if any additional items needed to be discussed. Members agreed that they would decide upon this matter as the meeting progressed.

The first item on the agenda called for the summarization of events of the previous JSA meeting, which took place July 15th. After this, representatives informed meeting members of the happenings in their respective districts; about what action was being taken and the progress that was being made. I had some difficulty in fully understanding what was being said during the meeting, due to my lack of competency and exposure to the level of pure Kannada which was spoken. My impression of the districts presentations was positive. I found the members to be outspoken. Mostly I was happy to see the number of women involved in the initiative, and the diversity in age among them. All members were emotionally invested in the cause and wanting to create change for themselves and for their communities. This is obvious just based on their presence at the meeting. Many traveled long distances just to attend. Additionally, I feel that these meetings are extremely helpful for the attending district members not just because it helps them receive feedback from a solid support system, but also because it presents them with a solid opportunity to build their self-confidence in public-speaking, problem assessment and action/implementation.

After lunch, Vinay gave a brief presentation on Community Monitoring. Prasanna, who helped moderate the remainder of the meeting, made an axiomatic statement on how to approach the Health for All issue. He explained that as important as it is to protest for rights from the government, it is also just as critical to work *with* the government to help properly implement these rights. This comment helped to facilitate better understanding for the members about their near future goals. It was important for Prasanna to present this point so that the members do not think of the government as their enemy, instead as a potential ally for achieving a healthier lifestyle.

The final hour of the meeting was spent discussing logistical information about the district-level action that will take place on October 8. Members placed themselves in one of three different categories expressing the amount of funding they need for transportation, accommodations, and food. 7 districts said they were able to fully fund themselves, 5 districts requested partial financial assistance, and 4 districts requested full financial assistance. This last hour of the meeting was the most vibrant, due to the varying opinions of how money should be acquired and distributed.

Overall, I learned about people's attitudes and perceptions about the health movement through this meeting, which I would not have been able to grasp simply from the gleaning of written documentation. I am curious to attend the next meeting to hear follow-up reports from representatives about the events of October 8th and the reaction of their respective districts.

India Civil Society Summit Reflection - August 25, 2007

Background

The India Civil Society Summit was organized by a group of NGOs and Civil Society Organizations and took place at Ambedkar Bhavan on August 24, 25, 26 2007. The summit was a celebration of survival, resistance, and the continuing struggles for freedom in India. It provided a space for dissent and raised issues relating to the ongoing struggles for freedom.

The purpose of the Summit was to build relationships across boundaries and to create a platform for people-centric nation building. The Civil Society Summit brought together nearly 850 participants representing 67 NGOs from 23 states in India from diverse spheres for a synergy of ideas.

The participants listened to the different points of view of the speakers and the challenges that the nation faces in ensuring "freedom for all". The overriding theme of the Summit was 'displacement' from land and governance to identity. The emphasis was on the search for solutions and working together.

Reflection

I attended the second day of the India Civil Society Summit. The session about Urbanization centered around the challenges of rural to urban migration since independence. A panel of speakers included Kathyayini Chamaraj from Civic Bangalore.

Kathyayini Chamaraj outlined a set of issues that included the side-effects of 'push' migration of people from the rural communities to metropolitan areas. The conditions in villages have generally worsened due to the absence of structured systems like reliable running water, electricity, sanitation, health care and education. However, migration is taking place due to desperation caused by poor weather conditions and the advent of private sector presence in rural areas for cash cropping and SEZs. Those desperate to sustain a minimal livelihood flee to the cities in search of employment just so they can put some food into their bellies. Most of the time these individuals survive on money obtained from begging or they are fortunate (relatively-speaking) to work as daily wage laborers in the country's exploitative informal sector – in factories or construction.

Bangalore is not equipped with the solid infrastructure needed to support migration on such a large scale. In addition to the 'push' migration outlined above, the city also attracts a less impoverished 'pull' population, those who flock to the city for employment within the IT and MNC sector. Not only is this migration fueling the number of residential development projects around town, but it is also a) increasing the number of illegal slums and b) displacing previously existing homeless people who must make way for development projects. Those migrants who do not find space in a slum resort to squatting in the train stations.

Despite the plaguing problems migrants face in the city, many refuse to return to the rural areas where they will face a much more difficult and desperate life. If a migrant is fortunate enough to acquire an identification card to establish urban citizenship then he/she can use it to feed him/herself and the family on a small amount of food.

This session was appropriate time-wise. I just arrived in India and have been shocked by the changes that I see: the increase in construction and the increase in panhandlers. The wealth and the poverty in the city have increased simultaneously. The Summit also served as a good introduction to the NGO and Civil Society community in India. I was excited to see the large number of people involved in the organizing of such an event. Even more so I was impressed by the number of people who attended.

National Rural Health Mission Dissemination Session – September 4, 2007

Background

The National Rural Health Mission was launched by the Government of India to carry out necessary architectural correction in the basic health delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health, such as water, sanitation, nutrition, and safe drinking water. It also looks at mainstreaming Indian Systems of medicine to facilitate health care. The goal of the mission is to improve availability and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

Reflection

The purpose of the National Rural Health Mission dissemination session, which took place on Tuesday September 4, at Ashirvad, was to raise awareness about the initiative that aims to increase the quality of healthcare among inhabitants of rural communities, especially women and children. Following individual introductions, the session began with a protest song sang by Mr. Basuvaraj. E. Premdas, who moderated the session followed with an introduction of the speakers: Dr. Thelma Narayan, Dr. Devadasan, Dr. Vinay, and Dr. Sylvia Selvaraj. Premdas updated participants about NRHM having been a long process to work to improve people's health through the People's Health Movement, mentioning that policies have already lapsed in two years, therefore, pronouncing the importance of starting a voluntary technical group while informing people about NRHM.

Also, Premdas alerted the session participants about a 20-district rally to take place on October 8 in efforts to demand community health care. Copies of NRHM documents were available in English and Kannada for the cost of the photocopies. In addition, a draft document had been prepared to send to the Mission Director requesting the comprehensive and effective implementation of NRHM and the construction of a website informing the people of this progress information.

Dr. Thelma Narayan: Background & Spirit of NRHM

Dr. Thelma began by providing information about the history of the Jan Swasthya Abhiyan and its view of "health as a human right". The First People's Health Assembly in 2002 led to the creation of

the People's Health Charter. Later in 2002, the JSA played an active role in helping to shape the National Health Policy. Prior to the general elections in 2004, JSA held meetings with health ministers to strengthen the public health foundation. The Common Minimum Program, which was produced after the elections, committed to raising the health budget, currently at 0.9%.

The initial approach of the NRHM was to focus on reducing the growth of population. The goals were later modified to adopt a more holistic community-based method with the utilization of ASHAs. Dr. Thelma also mentioned that Rs. 32,000 Crores has been allocated for the health sector by the Cabinet, and that it is crucial for NGOs and CSOs to be actively involved in the implementation of NRHM and making sure that the funds are effectively utilized. There is an important need for NGOs to not just offer criticism to the government about the progress of NRHM, but to also play a role in creating meaningful Public-Public partnerships. Our relationship with the frontline workers is equally important because they essentially serve as the direct links, transferring health care to the people. We must plug into the system at every possible level to utilize the scope for participation. In addition, all NRHM documents need to be translated to Kannada to help foster overall participation. Dr. Ganapathi asked whether there is a binding timeline for stages of NRHM, to prevent work from being left to the last minute. Dr. Thelma said that there is a timeline and Chandra mentioned that the government is keeping up with certain deadlines, however, there needs to be current available information from the government about progress.

Dr. Devadasan: Overview of NRHM

Dr. Devadasan began by recounting his visits to Orissa, Rajasthan, and Maharashtra and stating that their progress reports are available on the website. The NRHM website currently contains all documents up to June 2007.

The vision of the NRHM is to improve access to health care for rural communities, especially women and children, while promoting accountability, equity, and affordability. Some goals of NRHM include the reduction of IMR and MMR by half, universal access to public health, prevention and control of communicable and non-communicable diseases, population stabilization, revitalization of local health systems, and promotion of healthy lifestyles. These are to be accomplished with the help of ASHAs, strengthening of sub-centers, PHCs & CHCs, creation of district health plans, integration of sanitation & hygiene, public-private partnership, health financing mechanisms, reorienting

medical education, and strengthening of disease control programs. Community monitoring is an important component and can be accomplished through a People's Health Watch.

Financing increases by 30% each year until the money allocated towards NRHM is 2-3% of the budget. Currently, the states are not able to absorb the money; also the money bypasses the treasury and goes directly to the hands of the state and districts, therefore it is important that it is well utilized. There are several strengths and weaknesses of NRHM currently. One of which includes the District Health Officer not meeting qualifications.

Dr. Vinay: Community Action for Health

Community monitoring transfers responsibility to the people. It is a systematic way to gather information about community needs and provide feedback about key indicators. The model commands participation from the health system, NGOs/CSOs, and the community. Community mobilization is required.

Dr. Sylvia: ASHA

Karnataka plans to train 2934 ASHAs in 1931 villages. Karuna Trust has taken the responsibility of 3 districts: Chamrajnagar, Mysore, and Kodagu. There is concern about the selection process of the ASHAs and the need to not make it political. There is also concern about how the money is being utilized.

I found the meeting to be loud and boisterous during the discussion phase. It was interesting to see the interactions of many different ideologically grounded try to agree on an approach for the NRHM. I was surprised to see the amount of dissent in the process. I had automatically assumed that the N.G.O. community was fully united for the common cause of providing better social services for the marginalized populations; however, being present at the meeting made me question the agenda and context of each organization's involvement in the meeting. This experience was very important in helping me realize the importance of identifying a personal philosophy for myself and the necessity of procuring a position at an organization where it can fit.

Kanakapura Field Visit – September 7, 2007

Background

My visit to Kanakapura was the first trip that I took as an Intern at CHC. Looking back I am able to identify areas for improvement in my field research skills. I enjoyed this visit as an introduction because it gave me the opportunity to begin the development of my own style of introductory ethnographic research. Reflecting on the experience made me realize that there are many things I would do differently. This includes asking more questions. However, asking more questions changes the dynamics of my level of participation from observer to participant. Therefore, determining a few objectives prior to a visit would make information gathering a more effective process. Additionally, one visit is never enough.

Reflection

I visited the town Kanakapura through a trip organized by Dr. Saraswathi Ganapathi of Belaku Trust. We began our day in Kanakapura at an Anganwadi center. The Anganwadi had about 20 children ranging from the age of 3 to 6. The room consisted of a kitchen, a small area for the children to sit, and a small desk area with file cabinets. The white walls were stained brown and were covered with a few illustrated educational posters. The kitchen area had a stove that was made up of a stones, sticks, and paper. There was a big drum of water available in the kitchen, but I don't think it had a filter. When we entered the Anganwadi, the children were very excited to see us. In general, it seemed to me that the children had more energy than anyone knew what to do with. The children sang songs for us: the alphabet song, Kannada numbers, Twinkle Little Star, and Bus Banthu Bus. They repeated these songs numerous times. I'm not sure if it is because they prefer these songs to others, or because those are all the songs they know. There were two women who were tending to the children. One was the Anganwadi worker and the other was a lady from the community who helped out. Both women were very amicable and seemed a little bit stressed out from trying to manage the children. The desk on the in the Anganwadi center was scattered with record-keeping books, which recorded the immunization and birth and death information of everyone in the village.

After visiting this Anganwadi I strongly feel that it is unfair for both the worker and children to put so much responsibility on one woman. According to Piaget's Stages of Cognitive Development the

primary cognitive development of early childhood is language acquisition. The development of spoken language is dependent on how much the child is spoken to/heard by the age of 5. In a 1995 study by Hart and Risley they found that children who had heard the least amount of words prior to age 5 had the slowest vocabulary growth rates and knew far fewer words than the children whose parents talked to them much more. This study was based in the US, therefore I don't think the results are fully applicable to India, since the culture is already verbally-heavy. However, the study makes the point that the Anganwadi worker is given far more responsibility than she can feasibly handle without compromising the attention given to the children. An education plan that utilizes childrens' time at the Anganwadi center for even an hour a day has the power to give them a headstart in their cognitive skills. For example, another well-known research effort that reinforces the importance of an early childhood education is the Lifetime *Effects: The High/Scope Perry Preschool Study Through Age 40* (2005) which examines the lives of 123 African Americans born in poverty and at high risk of failing in school. From 1962–1967, at ages 3 and 4, the subjects were randomly divided into a program group that received a high-quality preschool program based on High/Scope's participatory learning approach and a comparison group who received no preschool program. In the study's most recent phase, 97% of the study participants still living were interviewed at age 40. Additional data were gathered from the subjects' school, social services, and arrest records. The study found that adults at age 40 who had the preschool program had higher earnings, were more likely to hold a job, had committed fewer crimes, and were more likely to have graduated from high school than adults who did not have preschool.

After the Anganwadi Center we visited an Income Generation Project in the village of Kadahalli called the Kirana project, which consists of a group of women who were trained to make paper and paper products like note-pads, writing paper, cards and bags. Attendance seemed to be a problem with one woman and when asked for the reason she was embarrassed. Later we found out that her absence was due to marital problems in her home and the issue was not pressed further. From my vantage point the project seemed sleepy and relaxed. The women seemed to enjoy being out of their homes and in the company of other women; however, I was surprised by how passive they seemed when we visited them. Dr. Saraswasthi had to ask them several questions and probe them to tell us what they do and show off their products to us. I felt that there was definitely a need for a marketing channel to engage the women in a business spirit. Perhaps having a regular client base would establish a sense of purpose and make the work more meaningful for them, rather than just a past-

time. Or maybe the women are not so much interested in the production of paper as they are in spending time with their peers and being outside of their homes.

The second Income Generation Project, the Deepa Project, was located in the village of Halasur, where women were trained in block printing. I felt that the women of Deepa were more vibrant and interested in their work. It is possible that they receive more orders than the Kirana women, therefore fostering more investment in the work. Also, the Deepa Project consists of some women who are older and widowed; therefore the need to be self-sufficient and sustainable is greater. I found the products of Deepa to be beautiful and the process of their work methodical and organized. It is possible that this disparity between the two Income Generation Projects is due to the managers of the projects.

In general, the visit was a good introduction to the field and the research this type of work involves. The trip helped me get an idea of what to look for the next time I participate in such a visit and the types of questions to ask. I feel that I can't really generalize my experience based solely on this visit. However, I will say that in regards to the Anganwadi Center, even though I understand the need for quantity and coverage, I still feel that quality of implementation should also be a priority. India is a huge country. Penetrating a population and introducing a program takes time and money; therefore I feel that prior to implementation more time on planning should be spent on the 'what-ifs' that can arise in the process. I don't think it is easy to have perfect implementation; however, streamlining the channels for dissemination will help. Although, this is probably more difficult than it sounds and involves preponderant issues, such as corruption.

Reflection on Urban Health Meeting - September 11, 2007

Background

I found the brainstorming meeting for the initiation of an urban health plan to be quite enlightening. Prior to my arrival at the CHC I was under the impression that establishing a sound rural health system would be more challenging than tackling urban health. At the time I had not considered that an urban environment posed many multi-faceted challenges, including issues of undocumented migration, illegal slum establishment, shortage of land for non-corporate use. It makes sense that due to the prevalence of health facilities in Bangalore, albeit most of them private, an effort on the part of the government to accommodate those not utilizing private facilities has been made.

Reflection

The afternoon's discussion of urban health gravitated towards Bangalore, as an example. I am still in disbelief that a city with such technological capabilities and a large cosmopolitan population is not equipped with an infrastructure to provide access of basic services to its residents.

I am in complete agreement with the point that was made during the meeting that some initiative must be taken by those who are lacking access to such services. I do believe that this is the organic and sustainable way to create positive change. I, however, sometimes find myself to be pessimistic about this viewpoint based on my experience in Bedford-Stuyvesant.

Family Support Workers (FSW) solicited women in the community, who were either pregnant and/or had a child under the age of 4, to join a program called 'Successful Start/Healthy Start'. Each FSW ensured continuity of care by conducting home visits to learn about each woman's hardships and offered advice about access to resources when appropriate. Help topics included regular health checks up for mother and child, nutrition, job preparation and readiness, public housing, food stamps etc. Periodically, the FSWs organized workshops for the clients at the office. They provided clients with food and money for transportation. Childcare was also provided at the office during these workshops. All clients of the program received products such as diapers, strollers, and cribs for participating.

Based on my observation about this program the rate of adherence and the willingness to participate regularly was limited to a small minority. I'm not fully aware of all the reasons why

adherence was low, but I am convinced that one was laziness. Some of the participants did not want to be accountable to an outsider questioning their current lifestyle. The point I am trying to make is that despite all of the efforts made by the FSWs to help the participants, most did not use the opportunities. Therefore, I am a little concerned that positive change, which is largely contingent upon the demands and the initiative of those who need it most, is an uphill battle. Perhaps I am looking at this from the wrong angle. Maybe positive change is contingent upon and caused by a committed group of a few, and slowly the rest will follow.

Dr. Ravi suggested that one approach to raising awareness about the right to health in urban areas is to start small, by having a minimal framework of mandatory services and later expanding on it. I feel that this is a realistic solution and streamlining the process as much as possible would be beneficial to all. Unlike the NRHM it will not require a large amount of start-up time and will be easy to facilitate participation among many parties. Raising awareness about 5-6 guarantees for which the government is accountable is feasible. One way this can be done is through public service announcements, word-of-mouth, and multi-lingual posters displayed ubiquitously. Also, having a free telephone number for citizens to call and report grievances would allow for direct monitoring and corrective of the system. Involving the private hospitals in this initiative, as mentioned, is crucial. I feel that the role of the private hospital in dedicating a certain percent of its beds to the underprivileged should be constantly monitored, and there should not be a disparity in the quality of care provided to patients.

I feel that this minimal rights structure can be effective in slowly and thoroughly engraining higher standards and expectations in people. If we can create an attitude of demand on a small scale in at least one area then people will start to question the status quo in other aspects of their life.

Basic Needs: Mental Health

Background

The limited exposure that I have had to mental health in India was my primary incentive for wanting to visit Basic Needs. After spending a short period of time at CHC I have gained valuable awareness about the functioning of the public health system in India. This has led to the question: if vocal and visible communicable diseases are not being effectively prevented and treated by the public health system, then what is the plight of quiet non-communicable illnesses such as schizophrenia and depression?

Basic Needs is an organization that works with mentally ill people by helping them to start to earn a living after they have been given access to regular, community-based treatment. The organization works with communities to overcome stigma and abuse. Their work strives to make mentally ill people self-sufficient and independent.

It has been estimated that there are approximately 58 million people in India with some form of mental illness. There are approximately 3.5 psychiatrists for every 1 million of the population; most of these psychiatrists are based in cities. This is a problem given that approximately 75% of the population lives in rural areas.

Mental health appears to be better addressed in the southern part of the country, especially Karnataka, than in the northern states. This is partially attributed to the presence of the National Institute of Mental Health and Neurosciences [NIMHANS] in Bangalore. Basic Needs in India is based in Karnataka and therefore has a strong presence in the urban poor communities here.

Reflection on Meeting with Mr. Naidu [Basic Needs] - September 21, 2007

Meeting Mr. Naidu at the Basic Needs office in Banaswadi was an impacting and personal experience. My intention to visit Basic Needs was to learn more about Mental Health in Karnataka. However, the conversation I had with Mr. Naidu, took a turn in a more interesting direction. Our discussion gravitated towards the state of the Indian government and its impact [detriment] on the people of India.

The discussion probed me to question the role of NGOs in India today. A few months ago I sincerely believed that all NGOs are benevolent entities committed to the betterment of the lives of marginalized populations; However, now I skeptical about whether all NGOs are 'good'. For instance, when I tell friends and distant relatives in India that I am involved with an NGO, the common initial response that I encounter is, "There is good money in that industry". This statement confuses me because my impression [based on my experience of working in a U.S. non-profit setting] is that the not-for-profit sector is not affluent. NGOs and non-profits often operate on external funding sources and employees of NGOs do not make a lot of money.

I later recalled a conversation with Rakhal about the number of new post-tsunami relief NGOs that sprouted up in Tamil Nadu with the mal-intention of capitalizing on victim-intended funds. These I would categorize as 'Bad' NGOs. In Brooklyn I have been a part of an NGO that plays a relatively passive and neutral role within a community - the type of organization that lacks motivation to be proactive, yet continues to exist because there is a need for the services in the community [and most likely because they have a steady funding source]. Some presence is better than no presence. Results of a patient satisfaction survey concluded that 15 out of 85 patients would not recommend the health center to friends/family, but utilized its service for the lack of other convenient options. These I would categorize as 'Indifferent' NGOs. Finally, there are those NGOs which actually make a positive difference. Those truly committed to the mission of improving lives. My question to these NGOs is how much of a difference can actually be made? How long can this difference sustain?

NGOs are rooted from the humane intention of increasing equity in societies; picking up the slack of the government by 1) fulfilling its responsibilities or 2) pushing the government to take responsibility. NGOs attempt to serve as the bridge the rift between what the government is not doing and the unfulfilled basic needs of the people.

Enthusiasm of NGOs + lack of enthusiasm from government = disempowerment of government + decreased investment of government in the social welfare of the citizens + decreased interest in taking matters into their own hands.

What about the danger that NGOs reduce the sense of urgency existing within government and citizens to provide and demand basic services?

Additionally, how do several distinct NGOs reconcile their agendas, to streamline progress towards the intended goal? How do we ensure the side-lining of egos and individual agendas to ensure unanimity and democratic participation?

On a more personal note, Mr. Naidu emphasized the importance to examine [everything] objectively and also maintain a sense of balance and humor in my work.

Reflection on Slum Visit [Basic Needs] - October 18, 2007

My exposure to poverty and public health so far has focused predominately on rural communities. In an attempt to obtain insight about the lifestyle of the urban poor I visited a slum on Good Shed Road near the Kempe Gowda Bus Station, where Basic Needs works to raise mental health awareness.

Basic Needs and other partner organizations like Paraspara Trust and the Association of People with Disability [APD] work together within an urban poor community to facilitate the identification of people with mental illnesses, provide access to resources and support systems, and raise awareness with community members about mental illness. A voluntary community health worker [chw] from the slum is chosen from a self -help group to work with the community to achieve the aforementioned goals. The CHW serves as a go-to person for people who have questions about symptoms they are experiencing or for information about what to do when family members are experiencing other mental health symptoms. The CHW is effective in dispelling fears and stigma about mental health in a community. The individual identified with mental illness has a caretaker from within the family to ensure treatment adherence and attendance of general visits at NIMHANS. Additionally, the identified mentally ill and their caretakers have a support network, which meet periodically to discuss relevant challenges and methods.

Our visit to the Good Shed slum was coordinated by Guru of Basic Needs. From 10am to 1pm we stopped at 3 households, where an individual with mental illness resided. Good Shed is diverse in religion and socio-economic status. Muslims and Hindus are segregated and some houses are larger than others.

- At the first home we met a 26 year old woman, who has postponed her marriage to care for her younger brother afflicted with schizophrenia. She decided to defer her marriage till her brother becomes better established and self-sufficient through work and treatment. The sister stated that there has been a vast improvement over the past few years in how community members treat her brother. Prior to Basic Needs' presence in the community, he was taunted and mocked by children throwing rocks at him. After raising awareness about mental health through self-help groups, groups for young children, and painting projects of murals, people have started to understand his situation as an illness. The stigma within the community is also disintegrating as community members are realizing that is not contagious. Currently, the brother earns money through his work at a factory. A few of his coworkers also live in the slum and he travels with them to go to work everyday. The sister recalled there are still a few worries that she faces. She recalled one disturbing incident when her brother was found at a liquor shop with other men from the slum. Following the incident, the other men had to be educated that it was not safe for the brother to mix alcohol with the medication that he was taking. This intervention by the organizations was constructive and did not place blame, rather it was conducted in a manner that encouraged openness and questioning. In regards to the treatment, the medication is provided free of cost by NIMHANS during periodic check-ups. The cost of transportation is provided for by the partner organizations. Additionally, the sister actively participates in caretaker resource meetings, which offer her support and guidance.

- The second house we visited was occupied by a family of parents and two daughters. The husband was diagnosed with schizophrenia last year. At that time, the wife was not familiar with the illness and plotted to escape with her children to her parents' village. After an intervention by the CHW and the partner organizations, the wife decided to stay. She was educated about her husband's condition. This was successful in dispelling her biggest fear, that schizophrenia is contagious. Interestingly enough, despite this acceptance of her husband's condition the wife opted to send her son away to the grandparents village, while the daughters remained. When asked why only the son had been sent away she a) is still not fully convinced about his condition and b) feels like its more important to protect the son than the daughters c) sometimes feels unsafe about how her husband might act. The husband is currently on treatment medication provided by NIMHANS and both him and his

wife attend their support group meetings. He works regularly in a factory and makes enough money to barely sustain their livelihood.

This was my first time inside a home in a slum. The living room was also the bedroom, kitchen, and closet. Bathroom facilities are centrally located outside the home and shared by the entire community. They are supposed to be cleaned by the municipality periodically; however, this does not happen. Water supply is provided on alternate days and the women are responsible for collecting it. Electricity is provided in the slums at a subsidized rate.

- The final home we visited was larger than the previous two. The household occupied two adjacent homes. The members of the household consisted of a mother, 2 sons, their wives, 1 daughter, and a baby. The sons worked for IT companies; therefore were able to afford a computer and big television. The daughter, Chitra, 26 years of age, is the youngest of the siblings. She was diagnosed with schizophrenia two years ago. According to community members, this was triggered by an incident when a boy she was in love with from a different community was married to someone else. As far as Basic Needs knows, the family never acknowledged this incident. Chitra had not been supported by her family from the beginning. They did not acknowledge her illness and attempted to marry her off. Basic Needs was able to convince the family to postpone her marriage till she gets better. She is slowly gaining acceptance from her family, but it has not been sufficient to build her confidence and desire to get better. She is reluctant to attend support group meetings and is irregular in her treatment adherence. When asked to promise that she would attend at least two meetings, she refused. Within her home she does not have the confidence to cook or care for her brother's child. Chitra is knowledgeable in sewing, but is afraid to visit the office of a partner organization to acquire a free sewing machine.

  I believe that had Chitra been a male her situation would have been much different. Her family would have been more receptive from the beginning to ensure that her confidence was built and that care was taken. Now as a 26 year old unmarried woman it is possible that she is viewed as a burden to her family. Unlike, the first house we visited, Chitra did not appear to have a strong support system within her own home. Unfortunately, without this I do not feel hopeful for her.

National Alliance of People's Movements Reflection - Gulbarga

October 6 & 7th, 2007

My trip to Gulbarga for the NAPM's 6th Annual State-level Conference was my first time traveling in India by myself. I was excited about my solo journey and the uncertainty that came with it. After boarding the bus at 8pm on Friday night I realized that I was the only female passenger present. This actually turned out to my benefit because the adjacent seat was left unoccupied for what I presume is this reason. The combination of a Kannada film (whose themes included love, violins, and pigeons), people loudly arguing about seat assignments, and a very bumpy ride gave me the opportunity to experience something very rich, semi-chaotic, and uniquely Indian.

I arrived in Gulbarga the following morning at 7:30am and caught a rickshaw to the hotel where the conference was held. I was charged too much money for a very short rickshaw ride by the aggressive drivers [there were two of them] who were not interested in hearing my rant. This brief encounter gently reminded me that I was out of my comfort zone and in their territory.

Upon my arrival at the hotel I realized that I had not enquired about the plans pertaining to accommodations beforehand. It turned out only two rooms had been reserved for NAPM use. To avoid confusion I decided to get my own single room. Later on I discovered that the two rooms were shared by many people: some attendees slept on the floor and a few on the terrace. In hindsight, this arrangement made sense to me after I became better acquainted with the spirit of NAPM. Even though having my own room was more convenient than sleeping on the floor I realized that I had prevented myself from having the full NAPM experience.

The conference began on Saturday morning after breakfast. The process of transitioning to an NAPM state of mind after traveling for twelve hours, and having to switch to Kannada mode was a bit stressful. There were a total of 77 people who came to the conference. Most attendees had traveled from southern Karnataka. It did not appear that there were many attendees from the Gulbarga area.

The first topic discussed was that of Special Economic Zones. I learned of the situation in Nandigudi, which is 60km from Bangalore, as a proposed site for an SEZ. The proposal made by SKIL Infrastructure would displace 73 villages and approximately 1.43 lakhs families. Nandigudi is a major supplier to the Hopcoms and vegetable markets in Bangalore, therefore seizing of this land

for industrial manufacturing purposes can potentially collapse food supplies to Bangalore. Following a brief discussion with Premdas I learned that NAPM is a rare platform that provides landowners and farmers an opportunity to fight in unison. In the past [and currently], the two polar groups face agrarian conflict in terms of unfair treatment, exploitation, and caste-ism. However, with the onset of globalization they have united against a threat that will paralyze all of them.

I am disappointed by the complete disregard of these Indian companies for the negative impacts they have on communities like Nandigram and Nandigudi. On one hand the intention of building 1 Lakh Rupee cars would accommodate to people's needs and allow more people the opportunity to enjoy this privilege. However, on the other hand it victimizes an already victimized population of people. Why must the same group of people always pay a hefty price [in addition to not being able to enjoy a 1 Lakh car] so that others are convenienced? Why does the government think its okay to place less value on the lives of those who are already financially disadvantaged? The concept of SEZs is perpetuating the idea that it is acceptable to accept a dismissive and indifferent attitude towards those occupying the lower rungs of the socio-economic ladder. What about the environmental impact of having too many cars - the emissions, overpopulation, having to encroach upon more villages in order to build more roads/highways to accommodate more cars, and the development of highways increasing sex work, violence, prevalence of road-side McDonalds which can lead to obesity and the entrance of more MNCs. Additionally, this development scares me because it threatens to uproot the values on which India is based therefore turning it into a America version 2.0. In the near future I am interested in learning about how SEZs have impacted China. Has the success been more beneficial for industry or for the people? How is it envisioned to work in India where there is a completely different political system?

Also discussed at the conference was the issue of Women's rights in the work place. I learned about the situation of garment workers in factories outside of Bangalore. Women work here to earn money to pay for their rent and pay for their children's school fees. The employees are from both the rural and urban communities. Groups of women are supervised by a male, who in addition to abusing them verbally and physically sets a high goal of how many products should be produced by the end of the day. Often the women end up working additional hours to meet this goal, without receiving overtime compensation. As a result of staying at work longer, they endure the wrath of their husbands upon their return home, who question where they have been. Once at home they have to cook and care for their children and husband. So, basically they are accountable to one man or

another throughout the day. Work does not give them humane and fair treatment, wages, and benefits. This presentation helped me connect my knowledge derived from this session with what I had learned after attending the Women & Social Security in the Unorganized Sector conference put on by the National Alliance of Women. I am interested in learning more about what the government is doing to establish a social security system, aside from self-help groups like the Yeshaswini Scheme.

The third topic discussed was about the sustainability of people's movements. My understanding of what was said during this discussion is limited. A question was raised about how to provoke a sense of urgency in the next generation to demand their rights. How do you convince people facing these problems that fighting for rights is a worthwhile investment, while also having to invest time into sustaining their own livelihood? Pragmatism is good, but what about passion?

The final session of the conference focused on Dalit rights. Through this session I learned about Ambedkar's thoughts about how to eradicate the caste system. Initially, he felt that inter-caste dining and inter-caste marriage was sufficient to do this, however, he later revised this by saying that inter-caste marriage would be effective in the eradication only if a higher-caste woman married a lower-caste man. A lower-caste woman marrying a higher-caste man and equal caste man and woman getting married would only encourage [generally speaking] a man's attitude that he's entitled to treat his wife like a subordinate. I am slowly starting to realize the magnitude of the impossible challenges faced by Dalit women, and the amount of change that has to take place in our society to help establish equity.

During the conference I kept my identity as an American resident concealed because I felt that it would alter the way people treat me. Based on my experience, a common misconception that people have is that my thoughts about certain issues are in agreement with what is imposed by the rulers of the United States. Towards the end of the conference, after a round of introductions my affiliation with the U.S. was revealed. Contrary to my expectations several people approached me afterwards to enquire why I was at the NAPM meeting and how I was spending my time in India. They seemed interested in helping me understand the topics at the conference and a few invited me to visit them at their work sites [such as Sister Alice from Dharwad and Ms. Sunandra Jayanth (?) from Mandya].

Even though the first day of the conference was a little stressful for me I enjoyed it immensely. Reading about issues through journals, newspapers and discussions with intellectuals is helpful, but having the opportunity to hear about them from the people in the situation made things much more real for me. I felt this trip was just the tip of the iceberg. I'm looking forward to attending more to facilitate my understanding of issues and how they fit together in the big picture. The main drawback that I faced over the weekend was the language barrier. I was able to converse with people to a certain extent, but I had some difficulty in deciphering their long and loaded responses – both contextually and in definition. Lack of fluency in the language definitely limits the depth of my interaction. Fortunately, I think this is something I can improve over time.

The biggest lesson that I learned from this weekend is that an issue cannot be resolved only when one group takes on the task of creating change. I feel that there has to be buy-in and investment from people of various backgrounds and walks of life. We're not isolated from these issues and what affects one group also affects the other, and if we want change to be sustainable then there needs to be a solid and holistic effort. Not everyone can understand the pain that marginalized communities have undergone, however, when there is willingness from different groups to help it should be captured and utilized.

Holy Cross Comprehensive Rural Health Project Reflection

October 24 - October 27

Despite my exponentially increasing confusion regarding India's state of being, my travels around Karnataka's rural communities have been successful in mitigating the confusion and facilitating a rudimentary understanding of the dichotomous situation of people in this country [urban rich : rural poor ratio]. I am realizing the importance of understanding common issues and their deeply rooted causes prevalent at a community [and even individual] level. Despite common themes throughout Karnataka that affect the health of individuals [caste, gender, socio-economic status], the opportunity that allows one to make generalizations about the state of affairs in a village, state, or nation does not exist. I am only a little short of being baffled by the layers and complexities of the mindset and social conditioning which is in existence here. This was my biggest lesson in Hanur. Also, to state the obvious, a half hour visit to a Self Help Group meeting was sufficient only to give me a momentary glimpse of efforts being made at a community level. One day in the future I hope to live in a rural environment in Karnataka for an extended period of time so that I can observe, interact, and understand the situation more deeply, without having to settle for the testimonials of SHG members given in the presence of other SHG members.

My trip to Hanur to visit the Holy Cross Comprehensive Rural Health Project [HCCRHP] was informative and insightful. I found the process of theory application to be affirming to my desire of working within the realm of community health. Similar to my visit to the Bangalore slum, I had the opportunity to witness change and empowerment at a grassroots level through my attendance at the SHG meetings and more effectively, through conversations with the Village Health Workers. Based on the multi-day exposure, HCCRHP has captured the concept of community empowerment in a *comprehensive* and holistic way - through education, health, and child empowerment. With the exception of a few quotes I have not yet read anything by Paulo Freire, but I get the impression that his ideas about empowerment through education and literacy are implemented by CRHP to not only help citizens understand their surroundings, but also understand how to make transformation within their surroundings.

I highly anticipated this trip to Hanur for learning reasons, as well as for the opportunity to relax and enjoy the rural surroundings. I did not realize until I was outside of Bangalore how badly I craved greenery, separation from the maddening traffic, and clean air. The bus ride from Bangalore

was a relatively short and relaxing one - until we had to transfer buses in Kollegal. Every morning at the Kempe Gowda [Majestic] Bus Station I witness from afar the chaos and insanity that takes place when people board a bus, however, to have experienced this insanity first-hand, with luggage in hand was an entirely different experience.

When we arrived in Hanur I was reminded of my grandad's village of Sosale. The bus stop was in the midst of a commercial area – many little shops, buses, fruit and newspaper stands, a movie theater etc. It was a lively environment, and despite it being the middle of the day I found the ratio of males and females outside to be disproportionate – it is possible that this is because it was lunch time and the women were women were inside their homes cooking. We spent the remainder of the day at Holy Cross speaking with the sisters and gleaning information on the history of the CRHP and formulating plans for the next few days. HCCRHP was established by Sister Aquinas in 1997 to address the health and education needs of the most backwards villages in Chamarajanagar District. The project evolved from a mobile medical unit and a few sisters randomly educating people in the villages to the establishment of village health workers, self-help groups, income generation projects, and a school for rescued bonded labor school children.

The morning of October 25th we arrived at the Satvidhya School for bonded labor children in Prakash Palya, to attend a program that showcased former Satvidhya students who successfully completed their year and had since then furthered their education. Satvidhya was started in 2004 by Sisters Aquinas, Fidelis, Alfie, and Anise as a one year bridge program to get children back into the formalized education system. Satvidhya is a residential school for rescued rural children who formerly did 'coolie' work to sustain their livelihood. 6 teachers in the school educate children in the 3rd, 5th and 7th standard. Their retention rate is about 50% because some children opt out of the school and return to their families. Some children have trouble adjusting to a lifestyle and unfamiliar environment without their parents and siblings. The building that houses the school is a former hospital, however, medical services are still provided to community members who ask. Medication is supplied by Low Cost.

There are 14 acres of land surrounding the building where maize, paddy, peanuts, tomatoes, and lentils are grown. Each child at the school is allocated a small plot of land for gardening. They are also educated in animal husbandry, plumbing, and electrical works. Satvidhya also has an active bakery that supplies local vendors with buns, biscuits, and cakes – all of which are delicious. Some

students work in the bakery and are responsible for the preparation of some products. In this way the bakery provides some vocational training for some selected students.

In my first impression of the children at Satvidhya, I noticed a difference in their behavior compared to other children I have visited in the past[in an urban, non-bonded labor setting]. They appeared to be more wary, less excitable, and more confident. As some time elapsed the children and I became better acquainted and it turned out that they are versatile, excited, and curious – like all other kids I have encountered.

A formal ceremony started off the program with a marching band, flowers, and lamp lighting ceremony. In addition, there was a cultural program with 4 student dances followed by speeches by some of the Sisters, Vinay, and former Satvidhya students. I found the student testimonials to be moving; they demonstrated perseverance, maturity, and appreciation of the support system they had had at the school. They encouraged the current students to stay strong through difficult times, stating that the success they would encounter in the future would be worth all of their hard work they put in now.

The former student stories were very inspiring:

- One former student, Shivaraj, is studying his B.Com at St. Joseph's evening college in Bangalore, while working at an office during the day. He wanted to study at a Kannada medium college, but the Sisters encouraged him to enroll in an English medium university. When he gave his speech I noticed that his Kannada was very similar to mine, infused with many English words.
- Another girl who had studied at the school was currently studying to be a Nurse and working at the Holy Cross Hospital in Kamegere.

From my limited exposure, I found that this program could cause very effective and sustainable change within a community and within a society. I feel that it is easier to instill confidence and a sense of leadership and confidence in children than it is in an adult. Additionally, this type of intervention can be effective in the eradication of biases relating to caste and gender.

That night we visited the site of a Weaving Income Generation Project in the village of Chikkamalapura The project site has 16 women. Each woman sat on the muddy ground, without

any cushions or a backrest, and let her legs hang in a deep dug out hole in the ground. The weaving equipment is stationed above the dug out hole and the women work in a pushing and pulling motion to set the pattern. The work station is not ergonomic, and the women complained about back aches. The women work from 9:30 in the morning to 6:30 in the evening. They go to their home for lunch, and in the evenings, upon returning home they cook dinner. Most of the women are married with children. The are paid Rs.15 for a mat that is 3ft by 1.5ft. On average they make Rs. 500 per month. The materials [waste cotton] for creating these products are provided by organizations based in Tamil Nadu. The facilitator of this project also receives a sum for his efforts. The project is situated on land donated to this cause by the panchayat raj, in addition to Rs.100,00 for the installation of the equipment. There are some women who have the weaving equipment installed in their own homes through the help of a loan.

Following the visit at the Income Generation Project we stopped at the home of a Village Health Worker. We met two workers who had been serving the community for XXXX years. The women spoke about the financial situation of people in the village. Most women do coolie work and make about Rs.60 each day.
When asked how the general health of the community has changed since the introduction of the health workers the ladies agreed that there has been an improvement. Additionally, the village health workers themselves felt that their knowledge base and confidence has risen since they have been doing this work.

The following morning a village called Arbikare recently initiated a watershed project. Basuvaraju from Holy Cross stated that he had spent 2 years building rapport with the people in this village. It took a relatively long time for him to get acquainted with the community because it is infused with casteism, and therefore not open to new people joining. After building rapport, Basuvaraju began to educate landowners in the village about the principles of efficient water management, prevention of land erosion and rain water harvesting. He said that some landowners were initially resistant to the new methods of farming, but they were convinced when they saw results after implementation. The project will take about 5 years before results can be seen. Some issues regulating the issue of land is that many landowners do not have records proving possession due a fire that burned out the registry. Back-up deeds are stored in Tamil Nadu, but they are not signed.

That evening Deepak and I attended two Self Help Group meetings. The first meeting was in a village called Chikallur. The SHG meets once a week in the evenings. There are 15 women in the self-help group and most of them do coolie work to sustain their livelihood. Any money they allocate towards savings is documented in the accounts book. The documentation that took place during this meeting was very comprehensive. Our attendance was recorded and we had to sign the book to verify that we were present at the meeting. The womens' bank account books were maintained by the record keeper – who is paid a small sum for her services. The women collectively took out a loan to help them cover some incurred expenses. One woman needed money for paying her child's hospital bill. Due to the lack of available services at the government hospital she had to travel to Bangalore and pay for services at a private hospital. The loan that they are currently repaying has not been provided at a subsidized interest rate. The women in this SHG appeared to be frustrated and not fully informed about services offered by the government, such as Yeshaswini.

The second SHG we visited in Rajappajinagar offered a different perspective. This group with 16 women appeared to be more active and well-informed than the previous group. This particular SHG had received their second loan, which was subsidized, and the money was used towards building toilets in their homes and for the start-up of small businesses. The women were knowledgeable about the Yeshaswini scheme and what needed to be done in order to receive those benefits. Generally, I was struck by the strength of the women in each of these groups. They were outspoken and bold and seemed comfortable with their responsibilities and very capable of handing much more. They also seemed frustrated that they were not able to fully spend their energy towards one cause because of daily duties to feed themselves and their children.

After the SHG meetings we visited the home of a village health worker. Jadaymaramma lives with her younger brother and his wife and has worked as a village health worker for 8 years. She is from the Soliga Tribe. Jadaymaramma has never been married and does not have any children, which is why she believes she has been able to continue this work for such a long period of time. She stated that the other women who were village health workers were not able to commit to the position fully because of their family responsibilities. She was very proud of her position in the village and enthusiastic about helping people when the need arises. When asked if she encountered any discrimination in the community, Jadaymaramma stated that people were initially skeptical about her services – partially due to caste issues – she was not allowed inside their homes, but that over the course of time they began to approach her with questions and access to resources. She also told

me about several deliveries that she had conducted because it was not possible for the patient to get to the hospital in time, due to the absence of transportation. In addition to being a village health worker and a member of a self-help group, she is also involved in an income generation project that builds furniture from sticks.

Women in the project collect sticks from the forest for a few days at a time, boil the sticks in water to shed the bark, and begin to build the furniture. There is a systematic schedule for the production of this furniture. They build sofas, chairs, and bookshelves, and upon completion, the furniture is sold in exhibitions.

I learned many different components of contributing to the betterment of health in communities in Hanur and the surrounding villages. Speaking with community members it is evident that positive change has taken over time. Although these efforts are extremely important I feel like a more aggressive effort needs to be undertaken to target problems at the root cause. The impact of globalization is taking place at the rapid speed and in order to keep the rift between Bharat and India from getting wider I feel that a more aggressive effort needs to be undertaken. We have to implement proactive measures at the root cause while simultaneously targeting existing symptoms. From my learnings so far I see that NGOs and CSOs are doing tremendous work in picking up the government's slack. It frustrates me to think that some effort by the government to provide for its marginalized population could be miraculous for a large part of India's population – especially when resources are available – but that time and money is allocated in areas where there is not as much urgency.

Chennai and Cuddalore Trip November 15 - 17, 2007

Background

My interest in visiting Tamil Nadu stemmed from a conversation with Rakhal about environmental health initiatives currently in action at various sites in Tamil Nadu. Community Health and Environmental Skill Share [CHESS] works in four different sites in Tamil Nadu including Cuddalore, Mettur, Kodaikanal and . CHESS is a process which serves as a platform for bringing many of such affected communities together with the activists, the doctors and scientists to deliberate and share experiences, skills and resources.

Reflection

The trip to Chennai opened my eyes and mind to a reality I would not have been able to comprehend through readings, videos, and discussions alone.

Day 1 of the visit began at Bala Mandir in T. Nagar, an orphanage that shelters children while dealing with issues of childcare, family welfare, educational, vocational and rehabilitations programs. The children are admitted when they are under the age of 5 and cared for until they are ready to be rehabilitated into society. In some cases Bala Mandir has also financed the education of its former students at a college level. Bala Mandir operates on funding made by individual donors. The campus hosts several different organizations including a primary school for children from low-income families and the Madhuram Narayan Center for Exceptional Children.

Upon our arrival at Bala Mandir, we met with Ms. Maya Gaitonde, who heads the parenting program. The Bala Mandir Resource Centre is a nodal point for knowing more about parenting and childcare, Among the various teaching and parenting aids available are books in various languages, recommended by the Maharashtra and Andhra Pradesh Governments for use in anganwadis. The main focus is in on children below six years of age to identify disabilities at an early age. The program uses a holistic approach; P.A.R.E.N.T. includes participation from Papa, Amma, Relatives, Environment, Neighbors, and Teachers. The program is rooted in Canada and has been adopted in Tamil Nadu and Maharashtra in 2004. Information booklets have been illustrated according to local culture and translated into the respective languages.

Following our brief meeting with Mrs. Gaithonde we toured the Bala Mandir facility. We began in the infant section. There are no more than 9 babies at the orphanage at one time. Bala Mandir is contacted by local hospitals when patients opt to put their child up for adoption. The facility was clean and the babies were happy and cared for well. Two women are always present in the facility to watch the children. Each infant had his/her own cradle, was fed whole milk and dressed in sky blue shirts. Toddlers, dressed in red shirts are situated in the adjacent room. There were 8 toddlers who were cared for by 2 women, and each child had his/her own crib. The building also housed children from the age of 2 to 5.

Later, we visited a primary school attended by on-campus residential students, as well as children who's parents work in the informal labor sector. The school fees are minimal and the education is good quality, and incorporates technology and the learning of the English language.

In the same building is the Madhuram Narayan Centre for Exceptional Children [MNC]. Established in 1989, it provides early intervention for children with developmental disabilities starting from birth to the age of 6. Some disabilities include Autism, Cerebral Palsy, Down Syndrome, and Attention Deficient Hyperactive Disorders. The program actively involves a parent of the child to help him/her better understand the child's conditions so he/she can help the child in the best way to integrate into mainstream society. MNC has a rounded staff consisting of Pediatricians, Psychiatrists, Therapists, and a Geneticist. The program focuses on 5 areas: Motor, Self Help, Language, Cognition, and Socialization. The school is highly organized and the level of involvement and attention given to each child is phenomenal. The space is divided into the sections by condition. The school was bustling with the activity of parents, children, and other caretakers. Aside from the care provided to children, parents and caretakers are also offered a therapeutic outlet through yoga.

After our tour of Bala Mandir we headed to Besant Nagar to meet Dr. Suchitra, a teacher at The School - Krishnamurti Foundation. She spoke with us about her involvement in environmental improvement efforts through the Consumer and Civic Action Group. Some of her projects have included:

1. Medical Waste Management – surveying and training of government hospital facilities to install and utilize environmentally friendly waste-treatment mechanisms. They have been implemental in establishing waste management regulations; however, the ubiquitous

problem of sustainability persists. How does one bring about accountability in the private sector hospitals when it is non-existent in the public sector?

2. Blood Bank Regulation System
3. Street Food Vendor Project – an all-India project to ensure a hygienic standard through the establishment of a licensing system.
4. Consumer Education in Schools and the banning of junk food in schools and provision of free lunch in government schools.

In the future she is interested in initiating a project to create regulations about minimal nutrition that should be offered to children in schools and orphanages.

The most emotionally twisting time of the trip took place the following day. We went to Cuddalore to visit the State Industries Promotion Corporation of Tamil Nadu, infamously known as SIPCOT. According to its website, "SIPCOT is a fully government owned premier institution, established in 1972, has been a catalyst the development of small, medium, and large scale industries in Tamil Nadu."

My understanding of SIPCOT: an area of land allocated to private industries for the manufacturing of products that emit red-level hazardous toxins. This is an area that is supposed to be quarantined, but is not because the government can charge Rs.20 Lakhs per acre to private industries, who are seeking out lands for exploitation and dumping of waste in a unregulated and unaccountable manner. A capitalistic industrial lawless utopia where there is utter disregard for the surrounding people, flora, and fauna. A place where emissions are uncontrolled and unquestioned by the State, and the sea serves as a convenient garbage for manufacturing waste.

One objective of SIPCOT listed on their website [www.sipcot.com] states:
"SIPCOT has rendered fruitful services to the state by identifying, developing, maintaining industrial areas in backward and most backward talukas of the State, which had potential to grow."

This, I find ironic.

The industrial complexes:

1. do not hire inhabitants of the neighboring villages because

a. they fear unification of people against a common problem (i.e. environmental rape) caused by the industries, which can potentially derail their operations

2. therefore, hire financially vulnerable and desperate migrants from other parts of India as daily wage laborers
3. emit detectable [and undetectable] toxins that have damaging health effects on neighboring communities, therefore, the "eventual growth of a backwards community" will be a benefit only as long as the surrounding population does not die off from industry emissions.

Our visit was facilitated by the Cuddalore District Consumer Protection Organization, which is under the umbrella of WECAN [Women development, Environment protection and Consumer]. Arul, our tour guide, is a consumer activist responsible for working the training and outreach in the Community Environmental Monitoring project in the villages neighboring SIPCOT. He has been involved in this project since its inception 4 years ago. We drove around the industrial area in a rickshaw and were exposed to the scents of a wide array of emissions. Documentation of these smells is done on a regular basis, through a method which likens the emission smells to something familiar, such as nail polish, rotten cabbage, eggs, and even a dead body.

The emissions penetrate all communities evenly because of constantly changing wind direction. No one is spared. Air samples are collected by community activists through the usage of simple contraption [like a plastic bucket with a valve and plastic pouch to collect air] and sent to a lab in California. Based on the study of these samples, the results yield that that according to the U.S. Environmental Protection Agency's guidelines the level of toxins present in the air around Cuddalore is 4000 times higher than the 'acceptable level' in the United States. This data is then presented to the Pollution Control Board so that action can be taken to regulate these industries, however, this has not yet been effective in implementing any massive change. As a result, the PCB makes compliance visits to the industries, but since they are scheduled in advance, the factories can cleverly adjust their emission output to a less detrimental level. Additionally, the greatest concentration of toxins is emitted at night, when PCB employees are not working.

Another problem posed for Community Environment Monitoring is that data collected has the likely possibility of being dismissed as 'unscientific' or 'unofficial'. Unfortunately, there is no independent environmental research facility in India or even an [effective] India version of the EPA which is equipped to take on the task of non-partisan sample analysis. Clearly, the PCB is not working out.

Speaking with a farmer and fisherman about the condition of life in a Cuddalore village highlighted the fact that this is the bane of their existence. Lands have become infertile and the number of fish in the sea has decreased. People have been forced to seek out new occupations and find alternative means of income to sustaining their livelihood.

An interesting point to consider is that some villagers are employed by the factories, causing a conflict of interest in the Community Environmental Monitoring effort. This creates a rift between community members who are fighting to improve the condition of the overall environment and those who are committed to the goal surviving on their daily wage day to day - therefore, accomplishing industry's goal of thwarting a "united we stand" approach to promote a "divided we fall" sentiment. In addition, caste and internal politics is another factor that further solidifies this dysfunction.

We learned of periodic 'health camps' which are set up by the industries, advertising specialized care for the community members. This, however, [I was told] is a farce. Providers present at these camps are not qualified to handle the cases presented, therefore appropriate medication is not provided. Even if the cases were identified the B-Complex and expired medicines available at these camps would not be an effective treatment. Clearly this is an effort of false social responsibility.

Describing my day at SIPCOT as "eye-opening" would be a huge understatement. I'm appalled and discouraged by the power of money that drives people to abuse and destroy a world that has been so good to them. My meetings with Nishi and Madhu at the Corporate Accountability Desk the following morning nicely consummated the brief learning experience about SIPCOT.

I found the conversation with Mahdu to be very interesting when she was speaking about the trouble she has had so far with the Right to Information Act, and the hostility she has faced as activist, and the law suit that is pending as a result of it. People from these private industries have called CAD to enquire about her background and to threaten her because of the work she is doing. Her fight against SEZs sounded fascinating. Hearing about the premeditated process of preparing the dysfunction of [formerly] perfectly fertile land by private industries – by covertly cutting off water and electricity supply - 10 years prior to acquiring it for manufacturing purposes was shocking. It gave me a very direct perspective of the hardships faced by activists and the relentless effort people are willing to put towards a cause they believe in.

I learned a great deal from my trip to Chennai. I am extremely grateful to CHC for providing me with the opportunity to witness these difficult realities in a guided manner, and for providing me with the resources to learn and question why the situation in India is the way it is today.

National Bioethics Conference - December 6,7,8 2007

The 2nd National Bioethics Conference took place December 6th, 7th, and 8th, 2007 at the National Institute of Mental Health and Neurosciences Convention Center (NIMHANS) in Bangalore.
The National Bioethics Conference (NBC) is a "broad, multi-disciplinary, independent, participatory and national bioethics platform of the Indian Journal of Medical Ethics (IJME). The Organising Committee (OC) of the Second National Bioethics Conference is constituted by 38 institutions and organizations, including Bangalore Medical College, St. Johns National Academy of Health Sciences, Community Health Cell, PSG Institute of Medical Schines, Vydehi Institute of Medical Sciences, Christian Medical College and Hospital, NALSAR Law University, and Christ College.
Approximately 500 people from all over India and internationally gathered for the 3-day event to understand the various dimensions of health issues, especially the ethical aspect, as being an important step towards beings a caring, responsible, and considerate healthcare professional.
The main theme of NBC was to address the Moral and Ethical Imperatives of Health Care Technologies - the scientific, legal and socioeconomic perspectives on use and misuse.

Conference sub-themes included:

- Technologies in medical practice
- Research on health care technologies
- Health care technologies, public health and policies

The NBC was kicked off with a day-long event of the Students Bioethics Forum on December 5th 2007. More than 160 Students from 10 different colleges with multi-disciplinary background in Bangalore celebrated "SOCH".

"SOCH", which means "to think" in Hindi, was organized to provoke students to reflect, debate and understand issues of ethics in healthcare. It was organized under the broad canvas of 2nd National Bioethics Conference to initiate and sensitize students to the vital issues of health and health care ethics, which they would be encountering in their professional life. The students' understanding of bio-ethics was facilitated through their participation in various cultural and social events including Debate, Mad Ads and an Art contest consisting of painting, cartooning and collage designed to stimulate their thinking on ethics in health care.

Over the course of 3 days I attended several workshops:

Women and Health

Issues discussed during this session included:

- Sex Selection among South Asian immigrants in the United States by Sunita Puri
- Ultra-sound and sex-determination in Australia

I learned a lot from the presentation by Sunita Puri, which touched on the topic of the prevalence of sex-selection in the South Asian communities of New York and New Jersey. Pre-natal and pre-conception methods of sex-determination are illegal in India but legal in the US, therefore used by some South Asian immigrants as a tool for preference.
Sunita presented her findings based on semi-structured interviews of South Asian women and men aged 19 to 65 who utilized sex selection clinic services; second-generation South Asian youth who grew up in families where sex selection was practiced; physician-providers of sex selection; and primary care physicians who had encountered requests for sex selection among their South Asian patients. Most of the couples who had been interviewed had female children, but wanted a male child, they felt their practices were ethical. On the other hand, however, primary care physicians for South Asian families argued that these services were unethical.

A presentation by Victoria Loblay who discussed ultrasound and sex determination in Australia painted a different picture. Ultrasounds in Australia are not used to determine the sex of the baby as much as they are used to ensure good health of the fetus. Given that, there is no regulation of the practice of sex-determination during routine scans. Generally, individuals are satisfied with the baby's sex no matter what it is.

Developing a South-North Advocacy for agenda for effective clinical trials: Indian and European Perspectives

Leontier Leterveer from the WEMOS Foundation spoke of health care as a right. The WEMOS Foundation aims to strengthen national health systems that contribute to the structural improvement of people's health in developing countries. They do this by targeting politicians and lobbyists to influence the health budget, medicines, and human resources. Some European pharmaceutical companies test their drugs on subjects in developing countries because of lax

regulations, less expenditure and accountability. Eastern European, Asian, and Central American subjects living in poverty tend to be the pursued and willing participants because often drug testing is the only type of treatment they receive. Often subjects are not informed that they are being tested because fewer people would be willing to participate. 40% of these clinical trials are conducted in non-traditional areas, as there is no recognized and supervisory regulatory body.

For instance, STENT produced a device that was tested on Indian patients in a Mumbai hospital. When in trouble for this, the health minister in the Netherlands said that it is the responsibility of the Indian government to regulate the testing company. STENT was let go with no consequences.

Additionally, Mr. Prathap Tharyan from the Christian Medical College, Vellore, spoke about prospective trials registration, a central database to record past, current, and future clinical trials, the negative and positive effects.

My knowledge about Bioethics prior to NBC was limited to an association with stem cells, embryos, and end-of-life decisions. Following the conference I felt overwhelmed by the range of information I had acquired about ethics in regards to the health care: the ethical including legal, social and philosophical. I found the sessions on IPR, Pharmaceuticals and Trade to be technically out of the scope of my current knowledge-base. Nonetheless, it was interesting and fitting to my future plans of learning about how decisions made at the macro-level impact those at the community-level.