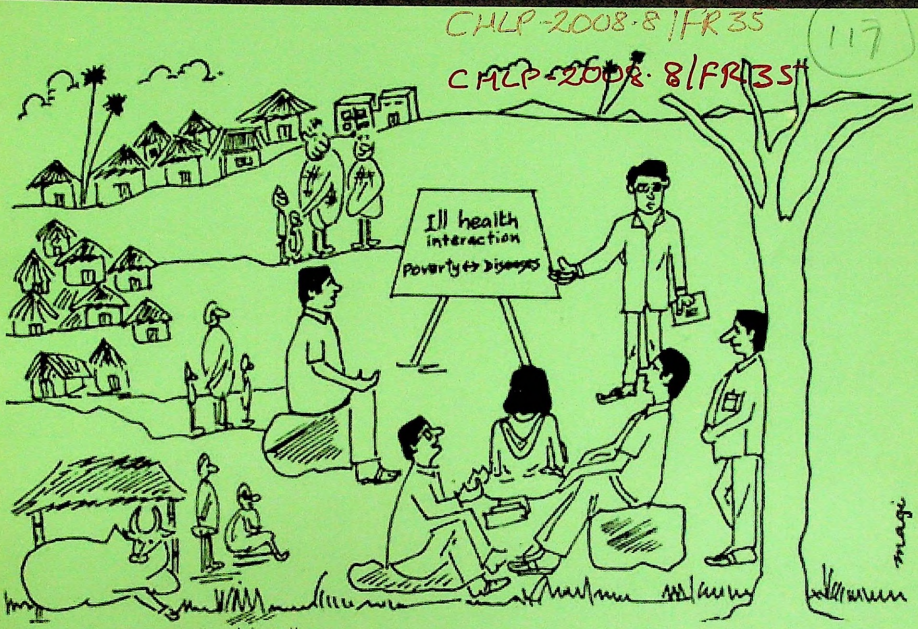
Community Health Learning Programme 2008



Source: Community Health Cell

A Report on the Community Health Learning Experience

Sapna Surendran

COMMUNITY HEALTH CELL

fellowship was what I needed then .I asked myself: did I know which area of Public Health I wanted to work in? For that too, I did not get a clear answer within myself and I suddenly realized that my understanding till date was purely theortical and nothing contextual.A mind full of noble intentions to work amongst people,but an intellect that was clearly befert of any concrete ideas on what to do. I suddenly felt like a big zero .It dawned on me that I needed some time and space to actually understand what I was getting myself into. I was in the midst of a personal crisis

Dr.Sukanya had mentioned in our discussion that one of the highlights of the program was that it was intended to be a period introspection and reflection, which goes beyond regular learning. Then, this was it ,I decided -A fellowship was what I needed to transplant and assimilate my learnings to the Indian scenario, help me find a focus and also serve as a litmus test to check if I had the mettle and actual commitment to continue my long-nursed ambitions.
Thus ,I began my journey as a Flexible fellow.....

OBJECTIVES:

1. To gain a deeper understanding on the various aspects of the Public Health system in India through readings and field visits.
2. To observe methods used in grass-roots mobilization
3. To be able to understand the various linkages in integrated development
4. To develop analytical and writing abilities for the purpose of research and communication

The Teasdale-Corti Global Health Research Partnership

South Asian Regional Training Workshop on researching "Comprehensive Primary Health Care"
Venue :St Johns Research Institute, Bangalore
Date: 13/10/2009-24/10/2009

Introduction

The Teasdale-Corti Global Health Research Partnership Program is an innovative new collaborative health research program developed by founding partners of the Global Health Research Initiative (GHRI) - CIHR, IDRC, Health Canada and CIDA – with input from the Canadian Health Services Research Foundation (CHSRF) and Canadian and developing country partners. The Teasdale-Corti program aims to contribute to improving health and strengthening health systems in low and middle income countries, by supporting innovative international approaches to integrating health knowledge generation and synthesis (including consideration of environmental, economic, socio-cultural, and public policy factors) through research, health research capacity development, and the use of research evidence for health policy and practice.

Objectives:

- to foster international partnerships and collaboration to promote the generation and effective communication and use of relevant health research in, for and by low and middle income countries (LMICs);
- to train and support researchers responsive to policy and practice priorities of LMICs relating to or influencing health; and
- to support active collaboration between researchers and research users (e.g. policy makers, practitioners, civil society organizations, and community members) to address health priorities of LMICs.

Workshop

The Teasdale Corti Program and Community Health Cell co-hosted a two week workshop for selected research teams from India, Pakistan, Bangladesh and Iran. The teams typically consisted of senior, mid -level and entry level researchers. All the teams had come prepared with their research proposals and the workshop was an avenue to firm the proposals, exchange ideas, consult senior researchers on practical difficulties .As a CHC fellow, I was allowed to participate in the workshop and had the opportunity to spend quality time with each of the teams to understand their proposals and gain an insight as to why they felt their study was pertinent and relevant. .Each team made presentations on their research proposals, existing healthcare systems, cultural settings and power equations that existed among the people, government and healthcare system in their respective countries. The core issue was"Revitalization of Primary HealthCare".Many signatory countries of the Alma Ata declaration who had pledged to work towards "Health for All by 2000" have conveniently failed to live up to their promises. We had discussions on what had gone wrong and how globalization had actually lead to a deterioration of health indicators.

Various issues were raised, but some common factors in all these countries, I noted were

1. Absence of sufficient personnel to cater to the public's healthcare needs (in the public healthcare system)

2. Lack of awareness and community participation among the public on their rights and responsibilities

3. Caste, class and gender issues that hampered optimal functioning of the systems.

4. Corruption and apathy amongst medical personnel.

5. Problems with up scaling successful models

6. Issues of accessibility-geographical, economic, cultural

7. Over-emphasis on curative as opposed to a balance of preventive, promotive and curative services

8. Chronic poverty of the rural population where health is just one among their many constant worries

The opportunity to take part in group discussions, brain-storming sessions and lectures helped me recap my public health theoretical framework. The sessions covered included:. The importance of value and context in research and designing health systems, Participatory Action Research(PAR) and Health systems research. Since one of the basic objectives of the program was develop research capabilities, many sessions were devoted to various research topics like formulating research aims and objectives, research methodologies, policy analysis and research ethics. One session, that I found particularly interesting was the "Review of grey literature on Comprehensive Primary health Care"-another objective of the Teasdale Corti program. These reviews were being done region wise to capture some widely scattered ,but significant research studies and reports that may have missed in reviews and not indexed. The grey literature review for South Asia was undertaken by Dr.Vinay Vishwanathan at CHC and revealed some important points like the "richness" and "wholeness" of many of the studies and there were significant lessons to be learnt from them.

Many did not necessarily fall into the purview of a well defined study methodology,which may have made the analysis more complicated.

Impressions and Learnings:

1. A clear understanding of the term Comprehensive Primary Health care and "Primary Care" that has been erroneously used in an interchangeable manner

2 .The need to establish a strong value system that would serve as the moral anchor of the healthcare system that we intend to develop. The system should seek to reduce to inequities in the community and improve access and social justice .

3. The importance of developing a culturally sensitive system that is relevant to people's needs. The health system should be meaningful, acceptable, effective and should incorporate the local socio-cultural-political dynamics .

LAWYERS COLLECTIVE

Date: 2/11/2008 Venue: Lawyer's Collective, Tasker Town, Shivajinagar

The Lawyers Collective HIV/AIDS Unit was set up in 1998 based on a realization that law, policy and judicial action based on the human rights framework had a central role to play in effectively containing the HIV epidemic. The Lawyers Collective has been dealing with HIV/AIDS law since the late 1980's when it handled the first HIV case in India. This case saw the incarceration of the HIV+ activist Dominic D'Souza under the Goa Public Health (Amendment) Act, 1986. It also saw, for the first time, arguments that espoused the need for human rights-based approach to deal with HIV/AIDS. Consequently, Lawyers Collective felt that a planned legal intervention was necessary to protect the rights of Persons Living with HIV/AIDS (PLHAs). It also felt the need to inform decision-makers about law and human rights and highlight its link with the public health crisis that HIV/AIDS was creating. The main mission has been to contribute to controlling the HIV/AIDS epidemic by protecting and promoting the rights of people affected by HIV/AIDS, through law reform, legal aid and allied services of advocacy, training and research. To contribute to controlling the HIV/AIDS epidemic by protecting and promoting the rights of people affected by HIV/AIDS, through law reform, legal aid and allied services of advocacy.

As part of their awareness and advocacy mission, they hold monthly meeting on various topics – legal , medical, social and political aspects of HIV/AIDS. Every month, a guest speaker is invited to talk on a chosen theme. The audience usually comprises of lawyers, PLHAs, NGOs working with them, doctors, social activists and any interested persons.

Topic: Star Health- HIV Care Insurance Policy

This meeting was a product information session for a newly launched insurance policy by Star Insurers for HIV affected persons-the first of its kind in India. The pilot project would cover six high prevalence districts in Karnataka - Bellary, Mangalore, Mandya, Kolar, Mysore and Udupi. The presentation was done by Population Foundation of India and the objective of the session was to introduce the policy clauses and receive feedback from interested parties .After the presentation(Attached the policy clauses),a discussion followed and the below concerns were raised

PLHAs

1. The premiums were very steep and not affordable unless some subsidy was offered.

2. Pre-existing diseases not covered in the policy

3. Status disclosure on the cards and confidentiality issues NGOs

1 .Group discounts and applicable slabs

2. Challenges of social marketing the policy because of stigma issues

Doctors:

1. Exclusion of supplementary medications like vitamins and minerals and ART in the policy was not acceptable as PLHAs required additional nutrients to build up their compromised immunity.

2. More clarity on any infections or diseases those are likely to excluded from coverage.

Impressions and Learnings

My work experience in the health insurance policy helped me critique the policy to a certain extent. I was personally impressed with the scheme and felt it could be very beneficial for affected persons, who are highly susceptible to co-infections and complications. The policy not only covered in-patient expenses but also had a provision where the dependents could claim an amount if the insured person passes away(provided he has not completely used up his sum insured value).I did not agree with the doctors argument on inclusion of supplementary medications as these substances are never covered in any health insurance policy, these are to be ideally obtained from the daily diet or came under the category of lifelong medications. Additionally this is a guaranteed expense in the case of PLHAs and insurance as a principle only covers a probable risk. The scheme may not be sustainable in the long run if these medications are covered.

The premiums were on the higher side especially for many who came from the poorer strata. Up to what extent would any NGO/philanthropic organisation subsidize is the question I had in my mind.

BROCHEURE
STAR HEALTH HIV CARE POLICY
There is a lot of social stigma attached to HIV, largely due to ignorance and misconceptions about the disease. This has resulted in HIV positive patients being isolated and neglected often by their own family members. Star HIV Care Policy has been devised to overcome these social barriers and pay heed to those suffering. It's a policy with several unique benefits and above all ensures care, anonymity and privacy to the policy holders.
This policy fills the gap where all other policies and insurers treat HIV as an exclusion
For the first time in India, an insurance policy that's been designed specifically for those diagnosed as HIV positive. HIV stands for Human Immunodeficiency Virus. It is the virus that causes AIDS. AIDS develops when the immune system of a person with HIV becomes very weak as a result of HIV infection.

HIV Care Unique Benefits

- Complete confidentiality of the covered persons is ensured.
- No bills/receipts. Lump sum is paid at one go once the claim is made.
- Facilitates better health care at the critical stage (AIDS) with financial support.
- This policy fills the gap where all other policies and insurers treat HIV as an exclusion.
- Extension of medical cover for hospitalisation as an option.

Eligibility-Who can apply?

- The policy will have to be proposed by governmental agencies, NGOs, societies or other registered bodies serving the cause of persons infected with HIV. The benefits-when payable, will be paid to the proposer who applies for it, for the benefit of the respective covered persons.

- The HIV Care Policy can be issued to a group of persons already infected with HIV.
- Covered patients must be members/beneficiaries of the proposer and availing its treatment/services.
- There is no age limit for the applicants.

Application Procedure

- Since the policy is for those already infected with HIV, there is a pre-insurance medical test. Cover is provided only for persons whose CD4 count is more than 350.
- Tests include CD4 or any other test as required.
- Cost of Pre-insurance Medical Tests will be borne by Star Health

Premium Details

- Premium will have to be paid to Star Health by the proposer who takes the group insurance.

Insured Amount (Rs.)	Premium (Rs.)
30,000	2,500
50,000	4,000
1,00,000	8,000

Note:
*Group discounts will be considered based on size and profile.
*Service Tax will be applicable on premium.

Additional Health Cover under HIV Care Policy (optional)

- In addition to the above, medical cover is provided covering hospitalization expenses excluding ART, tuberculosis and gastroenteritis, as per our standard Medi Classic policy on payment of additional premium as an extension of the basic AIDS cover.
- This cover will continue as long as the basic HIV policy continues. This will go a long way in providing a meaningful protection to the victims of HIV.

Exclusions

- Expenses incurred in treating HIV.
- All medical conditions that existed prior to the commencement of cover, except those specifically covered.
- AIDS confirmation within 90 days of commencement of the policy.

Claim Procedure

- The claimant has to undergo the confirmatory test for AIDS (CD4 count test or any other relevant tests as may be advised by medical practitioners).
- If the CD4 count is less than the medically prescribed levels for the first time and continues for the next 60 days and after a clinical examination, the person is declared to suffer from AIDS - the person is eligible to make a claim under the policy.
- Once a claim has been settled under the policy, the insured is not eligible to be covered under such a policy again.

Benefits of availing this policy

- 24 hour Help-line
- Company's web enabled services giving health tips to customer
- Free General Physician advice
- Cashless facility if the treatment is taken in any Network Hospital

How to buy this insurance?

- Please contact us through our Toll Free Help Line / SMS / nearest office

Peoples Health Movement,Karnataka-Jana Aarogya Aandolana Karnataka

Introductory Workshop-Bidar

Venue : Rice and Grain Merchants Office

Date: 24-25/11/2008

Jana Aarogya Andolana Karnataka is a forum of various pro- people's groups, activists, intellectuals, progressive people's movements, NGOs and CBOs working to strengthen the health sector in Karnataka. JAAK is the state unit of global People's Health Movement (PHM) and the India Jan Swasthya Abhiyaan (JSA) which is working towards ensuring universal, comprehensive health care by reviving the public health systems based on the principles of Primary Health Care . Its goal is to ensure and realize the "RIGHT TO HEALTH" of oppressed, dalit, poor, rural and all marginalized communities.
Currently ,the Andolana has units in 17 districts of the state. District Units usually include many of the local pro- people's movements and NGOs in the district.In order to achieve its goal, in the period 2003- 04 in collaboration with the National Human Rights Commission (NHRC) organized public hearings on "Denial of Right to Health Care" in different parts of the country and documented such cases in the public health system and placed it before the Commission. The Human Rights Commission responded positively to the problems and demands and has directed the national government and state governments to ensure that the public health system functions efficiently. After 2004, the Andolana initiated a movement to "REVITALIZE PRIMARY HEALTH CARE IN KARNATAKA". As part of this movement, the Andolana monitored the health systems in the districts, identified problems and gaps in the system and brought it to the notice of the department and built pressure to ensure that the health department took appropriate actions to deal with the same.

To drengthen the movement, the JAAK members hold district level meetings with various NGOs, CBOs, civil society groups, unions etc to disseminate information about the movement. This programme is usually designed to provide inputs for field level workers regarding roles and responsibilities of Primary Health Care providers and what role community and voluntary agencies can play in ensuring the same.The objective is to motivate and plant a seed of "demanding of rights" in the people's mind and put additional pressure on the governments to fulfill their promises.

I accompanied two health activists Obalesh and Akhila to Bidar in North Karnataka.Bidar is also called as Hyderabad Karnataka courtesy its geographical proximity to the metropolis.The district has historically performed very badly on the Human Development Index of Karnataka

JAAK was invited by a local Labour Union leader Mr.Shanbhag who felt that JAAK values and ideals were in resonance with those of his organisation and many other local groups.The meeting

started at 11.00 am and spread over two days to prevent the attendees from feeling overwhelmed, instead of feeling empowered after gaining new knowledge. On the first day there were around 50 participants which dwindled down to 22 on the second day. This was normal and expected, both the health activists told me. Not all NGOs and CBOs were keen to add another egg in their basket and take up additional responsibilties. The workshops are designed to be a mix of information sessions, group discussions, games and songs to keep the interest alive and maintain a informal learning environment.

The topics covered in the workshop over the 2 day period were:

1. Definition of health and how social determinants played a role

2. Health statistics in Karnataka

3 Factors affecting access to health

4. Health as a right-JAAK movement and simplified explanation of People's Health Charter

5. National Rural Health Mission (NRHM) and broad overview of the schemes available

6. Discussion on personal experiences at local Primary Health Care Centres (PHC)

7. Garnering support and commitment for the movement.

8. Enlisting their help to conduct a basic survey of local PHCs

At the end of the workshop, only three groups volunteered to conduct the survey of their local PHCs

Impressions and learnings:

Majority of the participants were women, but the men were more vociferous and dominated the discussions and voiced their opinions very often. The women were docile, meek and many times did not even participate in the discussions even after a lot of coaxing and encouragement. Most of the women were also visibly distracted by late afternoon and they told us that they were keen to return to their houses before the children came home.Very often the discussions turned into arguments between various groups. They were tendencies to digress from health issues to other local matters and both the activists had to diplomatically steer them back towards the agenda. The groups looked at JAAK as another potential funding agency and were eager to now and understand how to avail the resources from them. The concept of a people's movement did not gain immediate acceptance amongst all members in the audience.

This workshop made me realize that grassroots mobilization involves a great amount of work to ignite and sustain motivation. To convert people from simple being passive recipients(not blaming them or being insensitive to their circumstances) to active demanders is nothing short of a Herculean task, especially when all individuals have their own priorities and convictions .Money seems to be an attractive bait and a program/movement as a standalone may not attract the interest of all groups unless they are genuinely interested and committed. I observed the strong gender barriers in discussing and raising issues because of the social conditionings.

URBAN HEALTH CARE MEETING with Institute of Public Health(IPH),Association of People with Disabilities(APD),APSA (working with street kids and destitute women) and PARASPARA trust (working on child labour issues in Bangalore slums.)

Venue: CMAI office, Queens Road, Bangalore

URBAN HEALTH

There has been a progressive rise of urbanization in the country over the last decade. As per the Census 2001, there were 285 million populations living in urban areas. The decadal growth of population in rural and urban areas during the last decade (1991-2001) was 17.9% and 31.2% respectively. The urban population in the country, which is 28 percent in 2001, is expected to increase to 33 percent by 2026. This unprecedented growth in population poses challenges for the city governments in providing basic services in urban areas. Existing health and basic services like drinking water, housing, electricity, drainage, sewerage etc, are not accessible to most of urban poor populations living in slum or slum-like conditions. There exist multiple issues which limit the reach of basic provisions of health and basic services to all in urban areas. These issues range from lack of government priorities in urban health, inadequate public health infrastructure in urban areas, varying socio-economic, environment and infrastructural conditions among vulnerable and non-vulnerable slums, increase usage of private health services by urban poor to lack of social security mechanisms.

Urban areas are flooded with hospitals, nursing homes and clinic of various type and size. These institutions would continue to flourish as the environment and living conditions deteriorates. Both the urban poor and rich fall prey to this situation but the poor are the worst affected. The present health care facilities available for urban poor are family welfare and family planning focused which should move towards a comprehensive primary health care, enabling people to take care of their own health not merely providing some services.

In 1982,The government of India appointed the Krishnan Committee to address the problems of urban health.. Its report specifically outlines which services have to be provided by the health post . These services have been divided into outreach, preventive, family planning, curative, support (referral) services and reporting and record keeping. Outreach services include population education, motivation for family planning, and health education. In the present context, very few outreach services are being provided to urban slums.

Research by IPH and partners

S.J. Chander (IPH) and the members from the above mentioned NGOs are interested in urban health issues in Bangalore .They are collectively trying to do a systematic review of various Urban Health Care Centres in Bangalore to take stock of existing facilities,availability of personnel. drugs,etc.The social workers from all the organizations had conducted some surveys in the wards that they work.Each month they report of the finding of any one particular aspect of the Urban Health care syste.The meeting I attended very briefly touched upon the facilities and personnel in each UHC

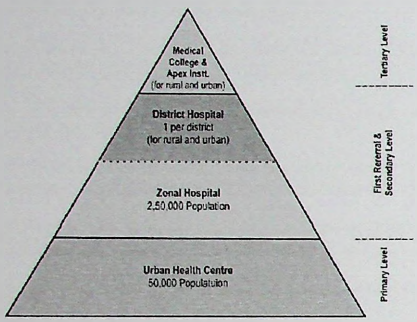
The findings of the survey broadly were

1. Most health centers had a non-working or lacked a refrigerators for storage of vaccines and other temperature sensitive drugs.

2.The Health care centre's had designated days for child clinics, maternity clinics, contraceptives and reproductive counseling which many users were not aware of. The unpleasant experience of discovering specific days after reaching the centers, dissuaded many people from returning the next time.

IMPRESSIONS and LEARNINGS

Urban health is a complex situation due to many reasons-like migrations, lack of basic amenities, high population densities,malnutrition and many more.In the past.there has been a systemic neglect of Urban Health.But in the wake of the NRHM,the National Urban Health Mission too will be launched shortly and has in the past not been paid much attention to their health. An understanding of the current state of affairs would be of utmost use and can be incorporated into the implementation and recommendations framework The survey undertaken by the NGOs show the typical lag in the forces of the supply and demand side .



Source:NRHM task force on Urban Health Model

ARGHYAM-Workshop for school teachers on India Water Portal.Org

Venue: Kendriya Vidhyala MES,Bangalore

Date:31/1/2009

Arghyam is a public charitable foundation set up in 2005.They focus on supporting strategic and sustainable efforts in the water sector that address water needs for all citizens. They work with several partners to manage the India Water Portal which is an open, web based platform for sharing knowledge, information and data on the Indian water sector.

As part of their advocacy strategy.they have designed an unique platform(sub -section on the water portal) for teachers and educators, students and parents, principals and school management to share learning resources on water.

The objectives of the workshop were to

1. Sensitize teachers to environmental issues and in particular water related issues

2. Seek to establish a dialogue between teachers and the water portal in order to develop mutual areas of cooperation

3. Enable the teachers to incorporate new and innovative techniques to highlight the importance of water to students

The workshop started with an introductory talk by Dr. Rajagopalan,a prominent environmentalist who has authored several books on environmental education .He briefed the teachers on the precarious situation of our planet and how a unified global effort could decelerate the damage rate even if a complete reversal was not possible Arundhati Nallapat, a Bangalore based artist used a story-telling telling technique with expressions, voice modulations and gesticulations to tell the story of the origin of river Kaveri -this method she said would be very appealing to younger children. This was followed by a discussion between the coordinators from Arghyam and the teachers. The points raised were:

1. The teachers voiced their concerns, doubts and even explained that it was impractical to incorporate such topics for board exam going students.

2. The teachers were also concerned that taking up additional responsibilities would mean an addition to their existing burdens.

3. Repeated use of power point presentations for various subjects had made it a less interesting medium of instruction, but also confirmed that visual images helped the children retain better.

4. Topics such as environment, climate change should form a part of the curriculum in the younger classes as they were usually more receptive and not burdened with board exams.

5. The school had a "water audit" in place and required some help with water harvesting

6 .All teachers agreed that a value-based education was a must .but was wary that switching over to such a system may take a long time and may not be feasible .

Arghyam was very happy to receive the feedback and also proposed some follow up meetings. They intended to conduct similar meetings in various other schools in Bangalore city. The last segment of the workshop was guiding the teachers through the water portal website and the various sections .The teachers browsed through various topics and worked on many of the modules .This was to give them a hands-on experience on how they could adapt the modules to the classroom setting and for some instant feedback on how to make the site more fun yet educative.

IMPRESSIONS and LEARNINGS:

Water is a precious resource and very critical in a country like India. Though the National Water Policy, 2002 and the various state water policies give first priority to drinking water amongst various water uses, we have a long way to go to achieve the Millennium Development Goal (MGD) of providing safe and adequate drinking water.Burgeoning population, unequal distribution of water resources, rapid industrialisation, climate change have all lead to an acute shortage of potable water. The effort to conserve and preserve water resources should be a collective one and imparting the importance to school children is a good step.

Subsequent to the workshop. I also browsed through the portal and found it very useful . informative and user-friendly as well.It covered a range of topics like water management, e-forums for concerend citizens, many articles by eminent resourcec persons,maps,statistics and even short films

I was impressed with the website and Argyam's efforts to mainstream the issue with educators.But this Prt,I don't feel that the buck does not have to stop with schools and teachers. Parents and the community in general also have to play a role in being role models .Neighborhood clubs, building

associations could play a more active role in this well in inculcating the importance and necessity of protecting the environment and how it is actually part of our civic duty to do so.

State Level Advocacy Meet on Implementation on Tobacco Control Laws in Karnataka

Venue: NIMHANS Convention Centre, Bangalore

Date: 6/2/2009

Introduction:

THE CIGARETTES AND OTHER TOBACCO PRODUCTS (PROHIBITION OF ADVERTISEMENT AND REGULATION OF TRADE AND COMMERCE, PRODUCTION, SUPPLY AND DISTRIBUTION) BILL, 2003 (AS PASSED BY THE HOUSES OF PARLIAMENT) is a bill to prohibit the advertisement of, and to provide for the regulation of trade and commerce in, and production, supply and distribution of, cigarettes and other tobacco products and for matters connected therewith or incidental thereto. Section 4 of the Act also prohibits smoking in Public places.

The Tobacco Control Act was passed in 2004 and the implementation is only slowly gaining momentum in the country. Today,tobacco use is not just a health issue , it is a social issue as well. The Statutory Act has gone one step ahead and even given powers in the hand of passive smokers.But the information is yet to percolate onto ground level. An inter-sectoral approach between the government, civil society, NGOs and various industries is required to make the implementation a success. Karnataka is an advantageous position as their health secretary, Shri Madan Gopal is a dynamic and progressive and very keen to work on anti-tobacco issues.

The main objective of the workshop was to create a platform for various groups to convene and work towards making the legislation a movement. The workshop had very good representation from NIMHANS, various NGOs, faculties and students of medical, dental and social work colleges, psychiatrists ,medical officers ,Industry representation- Mysore Tobacco Company, and Officers from the departments of Education, Transport, Commerce, Agriculture and Police.

The workshop commenced with a talk by Dr.Gururaj, head of epidemiology who spoke about the epidemiology, public health impact and also gave a brief talk on the history of Tobacco cultivation in India. Dr.Bengal, Professor, NIMHANS briefed the gathering about various cessation mehods that were available

1. Nicotine patches

2. Medication

3 .Nicotine partial antagonists

4. Counselling

5. Yoga and meditation

Dr.Panchmukhi, director CMDR(Centre for multi-disciplinary development research) enlightened us with the rationale of alternatives to tobacco cultivation and how many farmers were in cash crop debts and under the clutches of banks and money lenders. Ms.Bhavani Thyagarajan, Consultant,

Tobacco Control-WHO India Office, gave us a general overview of the Tobacco Control Laws and National Tobacco Control Programme and the enforcements of various sections. The workshop also included presentation of managers from the labour and transport departments on how they sought to tackle the issue ,but admitted the first step was to educate and reinforce the message among their staff members. A senior HR manager from BOSCH also spoke about how they have worked towards implementing a tobacco-free environment and how they sustained the program. The District Health Officer(D.H.O.) from Raichur spoke about on-going school awareness programmes in the district. The workshop ended with a panel discussion where representatives from various sectors were on the dais and the audience could interact with them. A very interesting point raised by the Assistant Commissioner of Police(A.C.P.),Bangalore ,Mr.Nanjappa that the Tobacco laws could have been integrated within the Indian Penal Code and also felt a lot of ground work had to be done for a well-defined implementation framework. In the absence of such an integration, he felt the Police department felt incapacitated to implement and penalise offenders under the Act.

IMPRESSIONS and LEARNINGS:

Health effects of tobacco have been proven through numerous epidemiological studies since the past 50 years .Tobacco use is rampant in India and the legislation was much needed .From the various discussions, I noted that that public education and awareness is the first step to tobacco control and the next step is in the effective implementation of the various sections .Civil society and media also have to play a very pro-active and positive in the movement.

The success of the anti-tobacco lobby could be attributed to research that provided scientific base for progress on policy front ,activism and advocacy efforts and the Commitment by the Government of India (Ministry of Health and Family Welfare) towards effective tobacco control efforts .The Tobacco industry has continued its resistance to various regulations .They also have a tendency to bring economic issues related to tobacco production and tobacco control and over emphasizing employment issues in connection with tobacco control .

A multi-sectoral approach from civil society,health professionals and various government departments would be required for successful implementation and eradication of this menace.The success stories from Bosch and The Labour office were example of how the willingness to take up an initiative,supportive management and perseverance could help in tackling the issue.

The Hindu Article date:Feb 18, 2009

Over 50 p.c. of pre-university Bangalore students are smokers

Nagesh Pabhu

Rules to discourage tobacco use have had no impact on youth

At least 18 colleges had tobacco selling points Many students influenced by peer pressure

Bangalore: The findings of a study, conducted by the Institute of Public Health (IPH), Bangalore, this year, shows that over 50 per cent of pre-university (PU) students pursuing courses in arts and humanities are smokers.

The rules and advertisements to discourage the use of tobacco products by the youth have had no impact on students in Bangalore. The study revealed that 58.9 per cent of students of arts and humanities, followed by 30.6 per cent and 10.6 per cent students of science and commerce streams, respectively, use tobacco products. The study was conducted in two stages in Bangalore's 19 PU

colleges on 1,087 students of first year PU (53 per cent) and second year PU (47 per cent). At least 18 colleges had one or more tobacco selling points within 100 yards of their campus. The Cigarettes and Other Tobacco Products Act, 2005 prohibits sale of tobacco products within 100 yards of any educational institution. As much as 55.8 per cent of students said that peer pressure had influenced them to use tobacco products.

More than 30 per cent said their teachers were smokers, while 31.74 per cent said that at least one parent used tobacco products.

Cinema influence

As much as 18 per cent felt the need to smoke or consume tobacco when they saw film stars smoking or chewing gutka in films, IPH's Upendra Bhojani, who conducted the study under the guidance of the Institute for Social and Economic Change, told *The Hindu*.

Face-to-face with an "Ever-green Hero"-Visit to the Chakashila Wildlife Sanctuary

Date:17-18/1/2009

Chakrashila Wildlife Sanctuary , covering an area of approximately 45,568 sq. kms , is located in the Dhubri District of Assam and is 68 kms from Dhubri. This area was recognised as a by the. of Assam on 14th July1994. It is surrounded by hills and there are two lakes on either side of the sanctuary.Many different mammals, birds, twenty three species of reptiles, more than forty butterfly species are found in this area.The famous "Golden Langur" also lives here.

The Ever-green Man

Saumyadeep Datta belongs to a Zamindari family of Assam.Even during his school days, he felt frustrated in closed classrooms and could not relate to blackboard teaching and preferred nature walks and bird-watching. Saumyadeep enjoyed reading books and journals on environmental issues and created his own library of ecological studies. At the age of thirteen, he established Nature's Beckon a small NGO interested in conservation issues.

In 1988, he gathered a team of friends and organized the All Assam Environment Awareness Campaign that stretched across Assam, from the Brahmaputra to the Barak valley, in collaboration with the government of Assam. Saumyadeep and his team traveled across the state, met youth groups, and urged them to set up nature clubs in their towns and cities. After its completion, over 100 nature clubs sprung up across Assam. In the late 1980s, Saumyadeep and his friends discovered the Golden Langur and four other endangered primates in Chakrashila, his home-district. Gathering his base of youth volunteers, Nature's Beckon, which he had organized earlier, Saumyadeep launched a grassroots environmental movement that succeeded in getting the state to declare Chakrashila a wildlife sanctuary. Today, it is managed completely by the villagers. Since 1994, no forest ranger or beat officer has been deputed by the government to Chakrashila – a first in the history of forest management in India

The Environmental Movement:

Saumyadeep's experience in the Chakrashila Wildlife Preserve (upgraded later in 1994 to a Wildlife Sanctuary) spawned over many years of practical learning. He has mobilized and trained a youth environmental movement of over 3,000 volunteers to return the rain forests to their indigenous people, and initiate conflict resolution, crime prevention, and peace initiatives among them. Most

importantly, it has organized rural youth leaders – most vulnerable to extremist pulls – to turn around unprotected green belts into "people's sanctuaries." By demonstrating that the youth of tribes share a common green heritage, it has shown them positive lifestyle options in eco-activism. Thus, as new youth leadership emerges around forest belts of Assam, wildlife protection is fortified and the economies of local communities are uplifted. Saumyadeep aims to replicate the model across the seven strife-torn states in the country's Northeast and is establishing linkages with citizen organizations and bureaucrats in the region. Saumyadeep defines a "people's sanctuary" as one created through grassroots pressure on the government to provide high conservation status and stringent legal protection for bio-diverse hot-spots around which communities live. In return, communities provide the management and vigilance systems for the sanctuary.

The Chakrashila Story

Saumyadeep's intervention in Chakrashila began when the law evicted villagers from a protected green belt in Chakrashila. In response, Nature's Beckon facilitated the forest communities' resettlement in the fringe areas, and trained sixteen villages around the sanctuary to regenerate their own forests around Chakrashila and establish sustainable food security and income-generation. A combination of ingenious irrigation methods and traditional forest-based food and cash-crop cultivation has led to substantial improvement in the quality of their lives. Annual income has gone up by Rs. 10,000 .The model conflict resolution center within Chakrashila is called Tapovan, which has broken the antagonism between villagers and bureaucrats, achieved state respect for Nature's Beckon's efforts, and spurred successful grassroots campaigns for governmental accountability on social-sector spending. Health and education programs are offered to children of differing ethnic groups in Tapovan.

Training takes place in villages. Saumyadeep and his team start by disseminating information on wildlife conservation. Next they walk the villagers through discussions on the tenuous links between environment, economy, and militancy, and encourage debates. They identify potential youth leaders and involve them in exhaustive nature camps, educational trails, constructive peer interaction, etc. The aim is to help them look anew at forests, which they have for so long viewed with apathy. Interactive games like "feel a tree" and family motivation programs work especially well with families of poachers and timber smugglers. Through low-cost training aids, journals, and workshops, Nature's Beckon trains these eco-emissaries in fifteen steps of biodiversity management and protection.

As the number of training programs in villages increase, so do the numbers of youth volunteers, who provide a new, young, alternative leadership to villages. Populations that were once hired by extremists, timber smugglers, poachers, etc., for nominal wages to plunder green belts, are now reducing human demand on central forest systems, relocating their economic bases away from endangered wildlife and plant species, and designing new forest-based development programs along the fringes of the forests. Saumyadeep interacts with them at regular intervals for fresh insights and to share experiences.

Our experience:

The CHC team had very long conversations with Soumyadeep .In a simple story telling fashion, he told us about Chakrashila's history and the environmental movement in Assam.He also answered our queries on various technical aspects of environmental management.We were on a two hour trek to the top of the Chakrashila mountain. Later in the evening,he also introduced us to the youth group of a neighbouring village,whom he had helped organize and set-up.The group of 30 young boys who were very deeply committed to environmental s. The boys had formed a night squad and

kept all night vigils to catch hold of any illegal smuggling of timbers from the forest..The youth group was also a forum to address many social issues.They told us that the villages had both the hindu and muslim communities ,but had always co-existed in harmony. They were a bit concerned that in the current backdrop of communalism ,factions may appear and disturb the peace.We also discussed general issues like the provisions of the NRHM(National Rural Health Mission),RTI(Right to Information, Act) and the problems with irregular supplies at the PDS(Public Distribution Systems).This informal chat was a very informative and healthy dialogue between the CHC team and the youth group.

The next day we also went to a local wetland and saw many rare birds. It was indeed a treat for all the city breds bumpkins.

IMPRESSIONS and LEARNINGS:

I could see parallels between health and environmental movements. A dynamic leadership is pre-requisite, a clear and well defined vision,p eople's ownership of the problem and the determination to be part of the solution. It was obvious that the people needed to develop a lot of trust in their leaders. The community needs to be convinced that they were the ultimate beneficiaries of what they were seeking for and there were no vested interest from outside parties. Sustainability is an issue that any leader and the community and movement needs to grapple with. There is an inherent tendency for the public to depend on their leaders directions and not wanting to take risks themselves.

Saumyadeep's was a case where he showed that Action was possible and results could be produced.In the landscape of terrorism and various other issues that plague the North-East ,he has managed to bring in solidarity to the movement.

Our chance to see the golden langur and the wetland were rare opportunities and I hope that Saumyadeep and the villagers are successful in the eco-tourism endevours and hope their message speards and the movement gets more strength and support from all.

MILANA - A Family Support Network of people living with HIV

Venue: MILANA office, Old Race Course Road, Bangalore

Date: 26/2/2009

MILANA's activities centre around providing care and support services for people living with HIV to help them lead a meaningful and positive life. Their main focus areas of work are:

1. Womens and Children Rights

2. Home based care and counselling

3. Care, support and treatment

4. Economic empowerment

5. Capacity Building and advocacy

I spent half a day with Jyothi Kiran, the founder and coordinator of MILANA. She narrated the story of the humble beginnings of MILANA and how she was inspired to start a drop –in centre for positive children.Her experience , working with them made her realise that unless the families too

were involved in the process, no progress could be achieved. Hence the program vision expanded to the families as well. With time, various support groups were formed and now MILANA has 300 families that attached to them. These families and PHLHs(People living with HIV) seek support, compainionship and guidance on various issues.

The programmes that MILANA administer are

1.Nutritional support in the form of monthly rations for 60 children and their families.

2.Educational support-additional coaching classes for Orphans and Vulnerable Children who are usually at a higher risk distress,economic hardships and exploitation.

3. Drop-in centres for PLHA and their families who are looking for support ,guidance and sense of bonding. The members receive counseling and training which works toward a holistic development.

4.Support groups for members to share their feelings and concerns openly. These meeting are very encouraging and resourceful.

5.Confidential telephonic counseling

6.Home Visits: Peer counselors visit affected individuals and their families to check on them, impart awareness and education, provide referral services and regular follow-up on their health status.

7. Alliance building with other NGOs and CBOs working on HIV/AIDS in Bangalore and Karnataka.

8. Income generation activities that are self sustaining e.g. embroidery and crafts unit and a catering unit managed by positive women.

Some of the Challenges that MILANA faces as an organisation are

1. Limited trained and professional staff

2. Practical challenges in documenting their best practices.

3. Long term funding for sustainability

I interacted with two peer counsellors who told me their tragic stories. They were inspired to join MILANA as they could empathize with the trauma of being HIV positive ,understand the bitterness and were victims of stigma. They are keen to ensure that affected people should not suffer on account of their ignorance and not to hide is shame They aim to encourage people to face life and live it to the fullest by serving as ambassadors of hope and providing support and kinship.

I also attended a support group meeting for the mother of HIV positive children. These meetings are held on third Wednesdays of the month. The topic for the month was how to help the children cope up with exam stress(March is the month of final exams in many schools).The discussions centered around delicious and nutritious recipes and morale boosting techniques.

The women knew that the children required special attention because their HIV status. The mothers explained to me how painful it was to see their children being isolated and discriminated. These kind of experiences made many resolve that they would not reveal the childrens status in school. Many of the women were single parents and had to juggle between being bread-winners and caretakers as well.

IMPRESSIONS and LEARNINGS:

As a medical professional and a public health worker ,I cant even begin to count how many times I have read and heard about the stigma surrounding HIV.During my internship at UNAIDS ,New York , I started to look at the disease through a more serious lens. Though, I was familiar with technical know-how of the disease ,its statistics and various other aspects, the MILANA visit was my first experience of directly interacting with a group of Postive People. It was very inspiring for me to meet these positive women who had decided to face life with such optimism .My previous knowledge and understanding of stigma was taken to a new level when I heard of the personal experiences of many of the women. In India, where our traditional and cultural beliefs have strong gender barriers inequality, women are often forced to live their lives feeling disempowered and inferior to their male counterparts. Many women discover their HIV status during pregnancy, and a positive diagnosis can seem like the end of the world, especially for an individual already burdened with the challenges of poverty, inequality and sometimes even domestic violence The situation can be made worse by the lack of sources of psychological support.

In such a scenario, support groups like MILANA plays the multifacted role of a friend,guide. mentor and confidante. Empowering these women through knowledge, awareness, mobilization and capacity building is very commendable.

MEDICO FRIENDS CIRCLE-ANNUAL MEETING

Venue: Bongaingaon.Assam

Date: 14-16 January 2009

The Medico Friends Circle(MFC) is a nation-wide platform of pro-poor and pro-people health practitioners,scientists and social activists who are interested in the health problems of India.The group has been actively involved in analyzing the existing system and tried to evolve a more humane and just arrroach to healthcare.

Their main activities are:

1.The MFC bulletin which acts as a medium for members to exchange views and ideas,critisize and analyze policies,reports and initiatives

2. Special Cells are units that are formed in response to certain situations that warrant detailed discussions.e.g. Primary Health Care Cells ,Women and Health cells

3. Collective Actions and campaigns to study and act on certain problems .e,g.Binayak Sen campaign,Study of health effects of Bhopal Gas Leak

4. Annual MFC Meet: A national level meet is held ever year, where the MFC members discuss and debate on a selected theme.

The 35th Annual Meeting of the MFC was held in Bongaingaon Assam on 16th and 17th January,2009.The theme for this years meet was "Displacement and its effects on health"

REPORT

Medico Friends Circle Annual Meeting 2009
January 16 and 17, 2009
Action North-East Trust, Bongaigaon, Assam

The 35th Annual Meet of the Medico Friends Circle was held at the ANT campus in Bongaingaon, Assam.

Dr. Sunil Kaul and Jennifer Liang (Jenny), the hosts for the meet welcomed all the delegates .Jenny remarked that the meet was being held during the auspicious time of the "Magh Bihu" festival in Assam and it was a great occasion for all to celebrate. This was followed by a general round of introductions by all the attendees

The MFC group has officially turned 35 this years and the group felt it would be worthwhile if senior members could recap the major events and milestones of the group.

Dhruv, Meera Sadagopal, Sarojini and Probhir contributed to this discussion.

The MFC was an off-shoot of the J.P. movement and consists of both medical and social workers, the core values being pro-people and pro-poor. The group has been built up on two pillars: One in the form of annual meetings and second as bulletins. Every few years the bulletins are compiled in the form of anthologies. With the advent of internet, the group has also formed an e-forum for debates and discussions. The group being totally voluntary based has faced problems with sustained an continuing motivation and over the years the debated have generally mellowed down. The group now consists of 50-60 members and the monthly bulletin is dispatched to around 300 members.

Meera recalled how the famine and scarcity period of 1972-1973 was a landmark period and was also the time that Jaiprakash Narayan started the Tarun Shakthi movement. Ashok Bhargawa was at this time working with some famine hit crisis in Nagpur and was very hurt and upset to see how marginalized communities were further debilitated with the famine ,He penned down his thoughts and feelings in an inland letter, cyclostated 40 copies and sent it out to various people who he felt could empathize and relate to the situation .A group of agonized doctors met in Ujjain and discussed amongst themselves how politicized health had become. Meera remembers how they all felt very useless and convinced that becoming revolutionaries was the only way forward. Over the years the MFC group has met and discussed various matters of reat concern like population issues ,etc and some of the debated points, she felt were even valid today.

Sarojini added how MFC has always maintained a secular identity.Post the Godhra carnage,MFC had filed a Public Interest Litigation(PIL) against Praveen Togodia in the Indian Medical Council asking them to revoke his license.

Sunil spoke how how MFC defined itself as a "thought current" .He pointed out that all the members were all working various issues under the social and health development umbrella , hence it was a bit difficult to garner momentum and evince equal interest from all members on some issues. Renu stressed on the fact the meet was and should always remain of an informal nature and that new members should not hesitate in raising points or asking questions. Probhir spoke about how Wardha had always been the preferred location for the annual meet by virtue of its location in Central India. Over the years, MFC felt it would be a better if a new venue was chosen every year.

INTRODUCTION:

Day 1:January 16th 2008

The topic for this years discussion was Displacement and its's ill-effects on health. The background papers were circulated on email. The discussion was to be based on the contents of the papers , general understanding of the issue and personal experiences. This was MFC's first meet in the NE,

all felt it would be pertinent to have a orientation to the NE and the issues that had made it a distant entity for the rest of India. All were also enthusiastic to understand the causes for mass displacement in the NE states.

Introduction to North-East: Raju Nazary, Sunil Kaul and Digambar Nazary

The North-eastern states are called the 7 sisters (8 including Sikkim): Assam, Arunachal Pradesh, Mizoram, Tripura, Nagland, Manipur and Meghalaya. Assam borders Bhutan, Arunachal borders Tibetian part of China. Meghalaya borders Bangladesh, Mizoram borders Myanmar and Bangladesh and Sikkim borders China and Bhutan.So it is not very difficult to understand why the area is of such huge security to India.

The "Chicken Neck" is the geographic area connecting India's mainland to the north-east, the dimension being 14 km north to south. It contains the Siliguri area of West Bengal and contains the NH 31. There is more than one definition of the chicken neck.One being the BJP government's definition in Jharkand, where the entry point to the neck has been identified as Kishanganj, the other being the north-eastern definition where Srirampur..

Assam is the largest of the NE states with 27 districts and a population of 2.26 crore. Manipur has 9 districts with a population of 26 lakh. Arunachal has 9 lakh population and Sikkim has 6 lakh. At the time of independence ,Meghalaya,Mizoram,Manipur and Arunacahal Pradesh were all part of Assam but were eventually carved out into separate states. Tripura and Manipur were princely states and were later merged and Indian states.

The Bodo movement organized by the Bodo tribal community was to demand a separate statehood. After years of resistance they were granted a special status of Tribal Council as per the Sixth Schedule of the Indian Constitution. The Bodo territorial Council was formed in 2003 and Bodoland has been carved out of Sonitpur, Darrang, Nalbari and Chirang districts. The district is giverened by Council ministers who administer the set-up,but the line department maintains links with the Asam government.One of the main demands of the Bodos were the use of Roman script for their language,they were eventually granted devanagiri script that has now been developed uptil the M.Phil level.
The health statistics are
Infant mortality rate: 68
Maternal mortality rate: 96
Sex ratio: 930 per 1000 males

A public health problem that has been found recently in Assam is the presence of high fluoride content in the water in 25 of the 27 districts. Considering the Arsenic issue in Bangladesh, there is a good chance that the same may be found here. Malaria is found everywhere here, but more in the forest fringes. Of the cases detected, 95 to 96% are falciparum positive. Chloroquine and Quinine resistance are common. There is also a high prevalence of Japanese Encephalitis. In the Karbi-Anlong region, approximately 1000 people die annually due to complications of Malaria. The west and south of Garo hills are also high prevalence areas for Malaria. The usual regime of treatment consists of a cocktail of chloroquine, quinine and artemesine.

Bhramaputra and the dams:

The NE has been touted as India's future powerhouse. The Bhramaputra enters India after traversing China.There is a project proposal to build 236 dams across the river including four super big dams. The Macmohan line is the border that separates India and China.Post the 1962 war, it is

the river in between the two mountain ranges which is accepted as the boundary. If the first 50 dams get built, the river bed of the Bhramaputra will rise by 2 metres. Approximately ten lakh people will get displaced.

Social Issues:

"Caste" is not a big issue in the NE, people are more divided along tribal lines. Untouchability is very rarely seen but does exist in subtle forms. Most of the barbers,sweepers and sanitary workers are from U.P and Bihar. There are scheduled castes in Manipur but the inequities are much lesser here as compared to mainland India. The British brought in tribals from other areas of India to the NE to the tea plantations, but these people have now been given 'OBC' category in some places and are under the general category in some places. Though 23% of Assam's population is *adivasi*, they have only 7% reservation. It is difficult to say who is SC or ST or OBC, all are *adivasi* at the end of it. There are 230 ethno-linguistic lines in the NE. "Nagamese" a mix of of Assamese, Naga and Hindi and widely spoken in Nagaland. . The Shankar Dev movement, a Bhakthi movement has been instrumental in clearing out untouchability and caste system from the NE. Most of the tribal communities also feel that people in the mainland or plains look and treat them in an inferior manner.

Contrary to the common perception, less than 13% of the people in the NE are Christians. Official statistics reveal that 30% of the people in Assam are Muslims. One cannot clearly say if they're from India or Bangladesh. People have been internally displaced in the NE since centuries. The Nepali community took the milch route to enter India and they have been involved in cattle rearing. In Meghalaya, most tribes are matrilinear. Male child neglect is also seen. Manipur has a matriarchal system, and hence the lower rate of infant mortality due to womens empowerment

In upper Assam enrollment rates are very high-90-95%, but beyond higher secondary, there is a higher drop out rate. There is also a concept of venture schools and colleges since 25 years in which youth initiate the functioning of a school or college and then the government takes over it.

The private sector is very poorly developed and government jobs continue to remain the main source of employment. The infrastructure and developmental indicators are also very poor. Mizoram is the least corrupt state in India whereas Assam, Meghalaya and Nagaland are very corrupt states.

Post lunch session:

The Armed Forces Special Power Act is a Draconian Act –that has been imposed at various times in the NE. The act has never been amended after it was passed in 1961. The AFSPA is applicable to any "disturbed area". Under the Act, the police or the military can shoot anyone or arrest anyone under suspicion; the military can destroy a place without explanation if they suspect terrorist activity there. There is a strong anti AFSPA movement building up in the NE ,but the centre has not chosen to take any action. The Act, according to many has no relevance and is just fueling the alienation gap between mainland India and the NE. The number of armed groups have, in fact increased from 7 to 34 now over the years.

Irom Sharmila Chanu, a volunteer at a human rights NGO has been on a "fast on till death" since 2000 to protest against the atrocities through the AFSPA and to repeal it. She is currently being force fed and has been in and out of the hospital repeatedly. Her demonstration has rekindled the spirit against the act. Many recommendations have been submitted to the central government, but Manmohan Singh has not considered them till date.

Historical evolution of the resistance movement in the NE:

The year 1828 was a landmark year for the British Army. The treaty of Yandavoo was signed between the Burmese and the British. After this, the NE land area came under British regime.When India was waging her freedom struggle against the British,the Naga tribesmen joint the fight as well. They sided with the Indian National Congress with the understanding that the struggle was against a common enemy and that post independence, they would be a sovereign and independent state. But in 1947, the Nagas were surprised that India's boundary spread over their territories. In 1949,The Naga people submitted a referendum to the Indian government where it is said that 99% of the Naga people voted for sovereignty. Upto 2007, there were 3 groups of Nagas fighting for sovereignty.

Mizoram became the only state in India to be bombed by the home government. In 1959, the cyclic bamboo flowering was followed by a huge rodent problem and famine. A movement for autonomy started under these circumstances .The Indian government was very angry with the stance adopted by the people ,subsequently many areas were bombed and all the people were relocated and displaced. After many years of strife, peace accords were signed and presently, Mizoram is one of the most peaceful states.

Assam has had a long history of identity conflicts. During the 1960's, there was a movement for the employment of only Assamese speaking people for government jobs. The issue was initially taken up by the student's union and later by the ULFA. The ULFA was formed in retaliation to two issues: the imperialistic role that the Indian central government was playing and the issue of immigrants into the NE. The Bodo movement was to assert the demand of a separate land for the indigenous Bodo Community. The Bodoland Monitory Force is an armed group fighting for the sovereignty of Assam. The NDFB and Ceasefire are 2 active armed groups in Assam fighting for its sovereignty.

Tripura borders Bangladesh. During the 1970s, following the creation of Bangaldesh, there was a mass influx of Bengali Hindu immigrants. Official statistics cite that, in 1947, 70% of Tripura's population was tribal, but in 1970 only 29% was tribal. Additionally, due to the formation of national parks and reserves, the tribals in Tripura have felt alienation and groups like the National Liberation Front who are voicing the opinion.

Ethnic conflict and displacement:

Following the Mizo movement, around 40-50000 Rihang refugees were displaced and Following the 1996 riots in Assam, almost 2 lakh people became homeless. Around 14-15 refugee camps still exist post these ethnic conflict riots and the people there live under very bad conditions. Many young girls disappear mysteriously from the camp-trafficking . The children who are growing in the camps have very aggressive mindsets as a result of all the psychological trauma.

In general, there has been a mass exodus of young people from the North-East to other cities in mainland India. In the NE, there are just 3 engineering colleges and many prefer to come down south to places like Bangalore where many private institutions offer courses . The NE youth have experienced this situation of tension from a very young age and hence they've become numb to an extent. The question is how the freedom of ethnic groups can be guaranteed and why more and more armed forces are being used to oppress the people. Most of the problems are due to the development model ,the Indian government has adopted. The new development models will only create further unrest. In the Indian mainland, for the 4400 dams built, still over 90% displaced people have officially not received any rehabilitation measures. The government's mindset should

move away from a population based model for health services because of the low density and long distances between health centres.
Post tea:
Introduction to theme: Displacement and its effects on health.

Flooding and erosion are two major reasons for displacement in the North-East. Floods are welcome to a certain extent because the banks are enriched after the water recedes. But erosion is more precarious since pieces of land simply get cut out and are washed away. Hydel projects and tea plantations whose creation needs bunds, embankments etc are a major cause of erosions.. These cause the water to come down with great force and erode large parts of land. This phenomenon leads to pauperizations of victims very fast. Erosion also leads to ethnic conflicts because of fights over relief land and measures. Many of these people and camps are termed as illegal .

Chattisgarh Issue: The mining work in the south of Chattisgarh, Orissa and Jharkhand is the major displacement causing factor. The burden of displacement inevitably falls on the poor, the tribals and the rural people.Lack of employment and other livelihood opportunities because of the agrarian crisis in the rural economy has also caused widescale migration to urban areas. Integration into the global economy is yet another cause leading to displacement.

If we look into some of the health effects of displacement,one would notice very high morbidity and mortality among the displaced populations as compared to the control groups. Health impact assessment should also be done along with environmental impact assessment.It has generally been noticed that post dam constructions, there has been a 32 fold increase in smear positivity for Malaria. Migration also mitigates the effect of the work of community health projects and works all over the country, as the target population is always in an unstable state. The primary victims of climate change are the rural masses and the poor.

Reading of Binayak Sen's letter:

Dr. Binayak Sen been imprisoned since over one and half years under the Chattishgarh Special Security Act. He has done a lot of work in community health and determinants of health. He also participated in the civil rights movement in Chattisgarh and has spoken against the fake encounters. He wrote a letter that was read out in the meeting, the contents of which are briefly discussed below

Diplacement has been a continous feature in human history,wether in the case of native Indian Americans,the African slaves who were transported to planatations,the Indian partition or even the situation in Palestine today.The presence of Salwa-Judum in Bastar has caused a lot of displacement. "It is important to choose your politics before politics choose you."
Continuing with the discussion:

"Displacement" is not clearly defined. Sometimes it is by choice and sometimes forced. It is important to define who is being displaced. There is a lot of influx of people into Maharashtra causing the locals to complain how they are losing out on job opportunities.
One must keep in mind the details of where the migrants are coming from and where they're going,if adequate health facilities can be made available at the site of migration.. For displaced people, two types of rehabilitation are necessary-short term and long term.
There is no clear guidelines as to what kind of health facility should be made available during times of conflicts like blasts and floods. The 3 points one needs to consider while studying displacement:

Displacement is not just an isolated phenomenon. The context of power is important. There is disposition, disparity and discrimination seen alongside displacement.

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Important concerns with issues of power: many times,displaced people often go to areas with already marginalized people.This lead to both groups fighting over existing resources. The standards of relief services sometimes is such that the relief camps have better facility than the surrounding village and this too creates conflict. References were made to how in the Narmada settlement case, the policies are getting clever. The policy on paper is to run a parallel health system for the displaced population. The situation has become such that the mainstream and the alternate systems are both washing their hands off the case.

Raju pointed out that many rehabilitation packages are incomplete and insensitive to the people's needs.The government currently offers the refugees a paltry sum of Rs 10,000 which does not amount to anything to start a new life.

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Rakhal contributed to the discussion with his experiences from the Tsunami rehabilitation.It was important he said ,to keep in mind when natural disaster strikes and we try to lean up the mess ,there are already a number of problems affecting the communities. There are disasters from the past that have not yet been tackled.He gave the example of the Pulikat lake near Sriharikota .The community there was fraught with caste issues and had evolved a caste based system for fishing i.e. inland or deep sea and fishing days and timings-called the PADI system. As a part of the rehabilitation program the government gave all the fishermen motor boats for deep sea fihing.In a community that was already in a fragile state,these measures only serves to complicate the exiting relationship.A well-established fishing rights and system therefore came into question.

A common phenomenon observed in many refugee camps is how communal groups and Right wing groups also use the situation to their advantage.

Sathyashree cited her experiences from upper Assam mainly known for floods, but also suffering from a major erosion problem erosion. Since 1952 ,the height of the bed of the Bhramaputra has increased by 5 m. Also, there was an earthquake in 1950 which increased the height of the bed in some places by 10 m. Assam has lost 7% of its fertile land to erosion since 1952. In many tribal areas there is no system of land papers, there is just acknowledgement. When they get displaced ,the people find it very difficult to prove their legal hold over the property. The government has built a lot of embankments along and this has led to increase in malaria, kala-azar, caused increased siltation and increased river height. They worsen the flood situations and also lead to conflicts between communities
Post displacement arises a situation where both the people and medical personal don't know which PHC they come. Sanitation is another major issue, especially for women.

Manisha spoke about womens role, rights and situation in disasters and conflict situation: during the tsunami many more women were killed than men duc to a variety of reasons. The remaining women survivors also had additional burden of tending to those left behind, finding firewood and cooking for all the refuges. So in effect they had become even more marginalized in the difficult situation.

Post dinner:
Dr.Binayak Sen –Action plan
Binayak is one of the most active MFC members and has always shown open willingness to go against the state.
MFC's Action Plan:

1. Keep Binayak's case alive in the media
2. Friends to go in a rotation system to attend the court hearings.-Chinnu to collect names of interested members and Anant Phadke to coordinate the schedule
3. Approach contacts who could help with an appointment with Sonia Gandhi,Catholic church,Rahul Gandhi,PM.
4. Fax-Jam of important politicians and decision makers on the 14th of every month.
5. Organise a vigil on 14th Many and conduct a peaceful demonstration to reinforce our demand for Binayak's release.

17th January:The discussion revolved around various papers and articles that had been circulated prior to the Meet.The papers focussed on various injustices meted out on adivasi communities in the name of development, how access to healthcare was very complicated in a displacement or disaster scenario.The groups also discussed various topics like safegaurds, solutions-both political and administrative. The National policy on rehabilitation was also discussed.

The Community Health Cell ,Bangalore has took up the MFC convenership for the next two years. They will be coordinating all the MFC activities over the defined time period and will remain the link connecting all the members. The proposed venue for the next annual meet is Bhopal and the theme will be on Environmental health.

COMMUNITY HEALTH CELL-SILVER JUBILEE PREPERATIONS

The Community Health Cell celebrated their Silver Jubilee Anniversary in December 2008.

An Alumni workshop was hosted on 4th and 5th of December .December 6th was celebrated in the form of cultural programs. As a Bangalore based intern with CHC,I lent a helping hand with all the preparations. The CHC core team and staff members held regular meetings from mid 2008 to plan out the events, but the pace of worked increased from November as the clock started ticking towards D Day. All team members were given specific responsibilities, but were all part of the larger group and were prepared to help out in whatever way they could. We all put in extra hours of work every day and started working on Saturdays as well to meet set deadlines. The whole experience was an eye-opener to the work culture of an NGO, which was very different from the Corporate world I was used to. The non-hierarchical and informal atmosphere made the entire experience so much more pleasant.

I was give the responsibility if designing, arranging and managing the poster exhibition on 6th December at the Bangalore Medical College Auditorium, where the Jubilee function was to be held. In addition, I also helped to edit some of the Jubilee publications.

ALUMNI WORKSHOP

The programme schedule for the alumni workshop was

1. Sharing of experiences, memories and events of their CHC association by SOCHARA members,alumni and interns

2. Health in a globalised world-macro realities, drug policy, closure of vaccine institutes.

3. Health in the context of gender, caste and identity politics

4.Film Screenings by Pervez Imam

Alumni Workshop report

Please note that I have not included notes from the sessions that I could not attend,as the Jubliee team had to be present at the BMC auditorium for preparations.

REPORT:
CHC SILVER JUBILEE-ALUMNI WORKSHOP 2008

Contents

Objective:
The objective of this workshop was to bring together alumni from various batches of the Fellowship Scheme to share their 'Community Health Journeys', on the occasion of CHC's Silver Jubilee. It was a chance to enhance our learning through collective reflections of various SOCHARA members and associates. The workshop was also an occasion for nurturing our collectivity and broadening our perspectives on how the 'social paradigm' has shaped community health action from our experiences. Community health work has taken various dimensions in the current context of macro policies of globalisation, liberalisation and privatisation; the seemingly endless identity conflicts – caste, class, religion and gender; and the potential of engaging with the State. In this workshop, we have discussed and shared practical examples of community health work in the context of such challenges and understood the communities' struggles of resistance and resilience that enable their right to health

Introduction:
The workshop began with a brief round of introduction of all the attendees which included SOCHARA members, CHFS fellows and the CHLP fellows of the current batch.

The first round was from the four co-initiators of CHC

Dr. Thelma was the first speaker of the "Sharing and Reflection" Session. She initiated her sharing by explaining how the late 70's and early 80's, was a period when a lot of projects in the field of public health were initiated. The formation of groups like Medico Friend's Circle (MFC) and studies like the Delphi Study with CHAI opened her eyes to the vast differences between community work and research and also how power was a player is "Health Politics". Dr. Thelma explained how her PhD on the T.B. policy in India from the London School of Medicine and Tropical Hygiene helped her gain exposure in policy engagement and community empowerment.

And she was appreciative of the fact that the opportunities to study in a renowned institute helped her gain exposure and understand many facets that may not have been easily possible in India. She explained that the concept of evolving the fellowship program was an innovative method to create a critical mass of activists and practitioners. She expressed her gratefulness to the CHC staff who helped both Ravi and herself in finding the time and space to evolve CPHE.

Mr. Gopinath one of the co-initiators of CHC along with Ravi, Thelma and Krishna started his sharing on how he did not have any interest in Community Health to begin with, though was working at St. Johns Medical College. But, his discussions with Dr. Ravi helped him think in an alternative style and he too took the risk of leaving St. Johns along with Ravi and Thelma. Over the years, he said CHC helped him focus and he went on to specialize in Personnel Management. In CHC, he played the role of shaping up its administration department .He ended his sharing by expressing how indebted he was to his teacher General Mahadevan .He concluded by stating that his journey with the organization still continues, though he is no longer a staff member at CHC

Mr. Krishna started his reflection with how he had known Dr. Ravi from his childhood. He initially joined CHC as an office assistant and later on developed an interest in art for the purpose of health communication. He explained how he attended several art courses and has now become a media specialist. Krishna was grateful that he was able to pursue the vocation through his experience in CHC, he has also attributed his time there is helping in his own self-transformation process.

At the completion of his sharing, Dr. Ravi was quick to add that none of the co-initiators had any form of specialization prior to coming into CHC. He cited Krishna's as an example of an individual who taught the co-initiators that it was necessary to focus on an individual's strengths rather than his weaknesses. This alone would encourage him or her to bloom. The CHC co-initiators are very happy that Krishna was able to find his niche and successful in his profession today.

Fr. Claude

Fr. Claude was one of the earliest supporters of CHC. He saw both Ravi and Thelma had a very unique approach and had their ideas set in a very different path as compared to their peers.Fr explained how he was thrust into the field of community work in the 1970's.This was a period when India was entering a revolution period and young people were all arising to do something for their country. He mentioned that two life altering experiences in his life were
1) The disaster situation of the Andhra cyclone where he witnessed a Dalit colony in Georgepet swept away.
2) Attending a pedagogical seminar Paulo Ferios in Mumbai where many revolutionary and inspirational ideas were discussed.

He mentioned that many times people questioned him as to why he had so much faith in Ravi and Thelma. His standard reply to this question was that both they were serious, persistent, determined and consistent in their beliefs and values. Fr. Claude appreciated that they had an ideology, a vision to bring about transformation and change. They targeted the weakest people. They had not changed but have grown into the change .He concluded his sharing stating that he believed that all beings were divine and the spirit of CHC continues to spread.

Dr.Mohan Issac

Dr. Mohan Issac, the SOCHARA president was pleased to note that the attendees of the alumni workshop were a mixed crowd. He remarked that all of them were co-travelers on similar yet different paths. He reflected on how his family was apprehensive with his decisions to take up

Psychiatry as his post graduation specialization and how his mother was very upset with his decision to work with mentally ill patients in a rural area of Bellary. But his commitment and faith never let him down and the lessons he learnt from the community experience have been invaluable for him.
His observations of CHC as an organization at this point in time were:

1. CHC has been able to bring changes in people's personalities.
2. They have been a group of innovators, motivational agents and a mentoring point.
3. They have all been risk takers.
4. It is a group that believed that well –taken paths are not challenging.
5. The importance in vision and faith in the work that they did.

He also pointed out that typically any organization, especially the non-profit sector would define their growth in the following ways
1. Creating an endowment
2. Building a huge infrastructure
3. Associations with bigger entities as an institutional back-up
4. Translating success as a big number on the pay-roll

Dr. Mohan expressed his happiness at that way CHC has grown and expanded over the years, he believes that an all round growth has been achieved with our foray into local, national and international movements. He is personally satisfied that we have been able to achieve great heights without dilution of our values and vision. He mentioned that his current assignment with the University of Western Australia allows him to remain associated with CHC ,thus he is still able to be an active member in the organization's activities.

Dr. Mani Kalliath

Described himself as a co-traveller in CHC. He shared how he was a confused and rebellious individual in his youth and had difficulty forming a sense of direction. It was during this phase that he met Dr. Ravi who helped him look into communities and alternative health paradigms. Over a period of time, his interest in Community Mental health grew and he chose to remain in the field as it gave him a well defined focus as opposed to a CHC's generalist philosophy. He stressed on the importance of having an organization like CHC. There may be many committed NGO's, there was clearly a lack of all of them heading in the same direction and an organization like CHC ,he felt would help define and set a common goal.

Sr. Aquinas:

Started her journey into community health around 12 years back as a disillusioned doctor at St. Johns medical hospital. She was surprised to see that conventional medical care only catered to the ailments and diseases of the affluent, whilst the diseases like T.B-those of the common man were very often neglected. She recalls crossing paths with Dr. Thelma because of their common interest in T.B and was then introduced to CHC.

Admist a lot of chaos and confusion in her mind, Sr Aquinas took a bold step to move beyond the boundaries of clinical medicine and work with marginalized communities. Her first project was with a Tibetan colony in Kodehalli. She eventually got involved with the National Tuberculosis Programme and the success rate in this mission encouraged her to get more involved with communities. Sr notes that it was during her work with rural communities she realized that health was not an isolated issue, there was the issue of basic needs like food, livelihood and non-formal

education that needed to be tackled before even addressing health matters. As Sr.Aquinas reflected on her journey, she said she has faced a lot of opposition from the religious hierarchy who felt threatened by her non-conventional mode of functioning. Looking back, she does mention the frustration in not seeing any visible efforts of her work with communities, but she still feels that the journey has been enriching and fullfiling, she is happy that she now has the credibility to encourage people onto field work. She expressed her gratefulness to CHC for their invaluable guidance, and was very appreciative that CHC has been instrumental in guiding many young professionals into the field of community health.

Fr. John started with his "Community Journey" as a social work graduate. He was offered the CHAI leadership , and one of the conditions he laid down in front of the board at that point was that Rural Health had to be incorporated as a component in their work. He recollected how he came down to Bangalore to meet Dr. C.M. Franics ,who he hoped would give him clarity on how community health functioned .It was at this juncture that he met Ravi and Thelma and was introduced to CHC. They all got together to define Community Health as a concept for CHAI .After close to six months of discussions, Fr.John says they were able to emerge with a clearer idea and understood that community health was about people's empowerment and political action .The task was now to explain this complex idea to the CHAI board and member organizations. This he said ,was implemented by holding many dissemination workshops ,where CHC took an active part.

Fr. John explained that one of his memorable achievements prior to leaving CHAI was that ,he was able to convince the association to change the name from Catholic **Hospital** Associations of India to Catholic **Health** Association of India ,despite stiff opposition and resistance. Fr. ended on the note that the CHAI is strongly advocating herbal and home remedies and was very happy to share that three member institutions were totally managing on ayurveda and alternative medicine therapies.

Ravi's Sociological Comment: In the CHAI circles, previously big hospitals like St.Martha's, Holy Cross etc were known as son-in laws and the smaller community based centers were the daughter-in- laws. With the change in name from Hospital to Health, the bigger establishments felt the roles were reversed.

S.J. Chander calls himself a product of CHC and is very privileged to be part of an organization like this .His journey started when Ravi took him into CHC after completion of a diploma in Community Health. He fondly remembered the good old days when CHC was a smaller intimate group. It was Ravi , who felt that he should build up his cadre as a resource person and encouraged him to work and study with rural, urban poor and tribal communities. He praised the organization for allowing research, training and working togo hand in hand. His experience of working with an eminent personality like Dr. Shiradi who was a great motivational speaker is also worth mentioning. He has since then worked with various organization, namely APD-(Association of People with Disabilities),was and continues to be a part of the PHM movement and mentioned that he was currently involved with the Anti-Tobacco Campaign. Chander explained that he chose to join Institute of Public Health,Bangalore in June 2007 to work and experience a different ideology-that of engaging with the state to bring about change.
He concluded his reflection by stating that he has never felt he was not a part of CHC and it was the alternate health paradigm that inspired him to work in community health with a different approach.

Dr. Ravi Narayan saga with CHC was an intertwined personal and personal journey and it would be difficult to separate the two. He belong to a refugee family who settled down in Delhi after the partition and came down to St.Johns to do his medicine. .The East-Pakistan partition was a life

altering experience, recalled Dr.Ravi.It was here that he realized that he knew very little about medicine and also that people when left to their own devices knew about survival and how to survive ,it was in fact the educated classes who had to learn from them. This experience changed his outlook and disillusioned him about hospital medicine.

After his return to Bangalore, he worked with a Corporation hospital in an urban slum area and developed an interest in Public Health. After his post-graduation in Community Medicine from AIIMS, Delhi, Dr. Ravi joined St. Johns and was associated in various projects like setting up the Malur Cooperative and designing the Community Health Worker's Training mainly for non-doctors in rural areas .He described how Anant Phadke was instrumental in introducing Social Analysis into mainstream and how he paved the way for the formation of a "though current" called Medico Friends Circle. Towards the late 70's ,early 80's ,he said that there were many community health professionals who all felt that they lacked a place in India where they could all get-together and discuss common issues and problems. It was suggested that a centre of Community Health Practice be set-up. It could be a community of Community health initiatives within a larger political and social context. The whole thing started out as a meeting place. The idea of CHC as a society of professionals thus evolved. CHC thus started as a coffee club culture, listening to the stories of realities, praxis of experiences.

Dr. Ravi stated that his two big milestones for 2008 has been

1. The launching and functioning of the WHO commission on social determinants

2. The fact that WHO has recognized the importance of Primary Health Care .

Dr. Ravi expressed his keenness in noting that civil society movements were collective voices.

Dr. Aziz briefed the workshop attendees about the impact of globalization on health. He started the discussion with the definitions of liberalization, privatization and globalization. He explained how the economic crisis in the 90's lead to inflation and budget deficits and why India was forced to borrow petro- dollars from institutions like World Bank and IMF who laid down stringent conditions- called SAP(Structural Adjustment Policies) for the purpose of debt recovery .One of the clauses that were enforced were reduced spending on social sectors like health. India had until this point adopted the NEHRUVIAN GROWTH MODEL which consisted of reforms like
1. Public sector participation
2. Protection of domestic industry against foreign players
3. Tarrif imposition on imported goods.
The borrowing from these international bodies induced us to switch from the Nehruvian model to LPG (liberalization , privatization and globalization) model. This in turn led to an market scenario which lead to an exploitation of people. Many domestic industries became vulnerable when the markets were flooded with foreign goods which were cheaper and the cut on social budgets affected the common masses. All these newly introduced measures only benefited the rich who became even wealthier. Though it cannot be denied that we have been achieving growth ,the benefits do not seem to be reaching the poorer sections and our poverty levels is currently 29% and in 1989,prior to the liberalization reforms ,poverty stood at 28%.So we need to ask ourselves if opening up our economy has changed the scenario.....

Health in the context of identity politics

Jenifer Liang works with the ANT(Action North Eastern Trust), Bongaingaon, Assam. Her presentation centered around health in an insurgency affected area in North –Eastern India. She

started her discussion giving a brief description of the seven states in the north-eastern parts of the country. The chronic insurgency has been that of the Nagas.

In lower Assam where Jenifer works was an area affected by the Bodo (a small tribal community) struggle , fraught with tension and this has led to a complete breakdown of the healthcare system. The persistent health problems in this area include loss of life- both civilians and security personnel. Additionally, because of the high level of militarization, widespread psychosis is also seen. Local medical institutes are often shut due to threats of extortion and kidnapping. Many staff members often use insurgency as an excuse not to report to work, hence absenteeism is also very common.

High levels of corruption, HIV and drug trafficking are rampant in this area. Unemployment has caused a mass exodus of young people. Under such extreme conditions, they also indulge in risk taking behaviors very quickly. Women are often targets of violence.The militant groups are often against health programs like pulse polio, family planning. There are also around one lakh IDPs-Internally Displaced persons as a result of the Bodo-Sandli conflict.these persons are still waiting to be rehabilitated and have very minimal access to healthcare.

To sum up the matter, the whole situation is politically very sensitive, the social system has become very lopsided. It has been observed that the majority groups manage to retain a stronghold and the minorities get isolated. Hence, an overall reluctance to share ideas and thoughts is seen. No new community models have evolved over the past few years and fighting for health as a right is very complicated and multi-dimensional issue.

Manjusha, an ex-fellow is an MSW graduate from Maharashtra. She described her experiences of working in integrated rural and health development programs in drought prone areas of Maharashtra. She discussed the context of gender and caste politics in the context of health. It was initially very difficult to make inroads into many of the rural communities who were caught up in poverty, illiteracy , gender imbalance and many other social issues. When the team first started working on watershed development, they had to work by the government rules which insisted that all developmental work would have to incorporate community participation. This idea was not initially well accepted by the people.

Manjusha's role was basically to work on community participation, organization and women empowerment. She recalled how she used to spend hours in various households discussing various issues and trying to secure their cooperation in the projects, but tangible outcomes were never seen. But the overall experience opened Manjusha's eyes to the extent of caste divide in the villages and how it remained a barrier to development and progress. Over a period of time, she was able to organize the women in self -help groups and the men into farmers groups. The villagers were attracted to the groups once they understood its money-making potential for e. g. in the first few years, men from the upper castes would not allow their women to get involved in the SHG's which they thought purely belonged to the lower castes, but the financial gains eventually prompted them to push their women into form groups as well. These groups eventually became information dissemination sessions where issues like governance, panchayati raj, women's rights, health and social matters were discussed. Many men and elders in the community started feeling threatened when the women started questioning them.
Manjusha quipped how she had received many death threats, but decided she would stick on to her job since she believed strongly in her principles. Though she does not remain associated with that project any longer, she is still in touch with the villagers and was very happy to know that the community participation rates have increased and ended her presentation with how the villagers had

united to make their local PHC more accountable and how they have managed to transform the same centre into a rural hospital.

Maheshwari is associated with RUSAC , Tamil Nadu narrated her experiences of being a "insider" of the "Dalit Women's Movement". RUSAC works on the principle that self-reliance is the first step to self-empowerment, that equality needs to be established and caste system should be abolished. Maheshwari pointed out that some of the major issues that dalit women like her faced were-male domination, sexual violence, domestic abuse and Sexually Transmitted Infections (STI's).Many times ,women like her were afraid to come out in the open about their problems fearing that there would be backlashes and that they would be branded as immoral women. She gave a few examples of how doctors and other personnel in medical centers took advantage of the fact that women were uneducated and ignorant. There have been cases where the doctors have not even bothered to inform the patients that they have inserted a Copper T for contraception purposes and the women have found out about it only when complications and infections arose. The doctors do not communicate and explain the consequences of tests and treatments. Since the women have no knowledge on these subjects,they have to completely rely on the doctors and have blind faith in them.She is a strong advocate of counseling centres in PHC where family planning counseling services would be offered and stressed on the importance of informed consent.

Society in her opinion has very strong discrimination rules about men and women.Men could choose to be unfaithful and even remarry but women had to remain calm and accept things as they were. Women are never party to the decisions on how many children they should bear .It is the men who make such decisions. All the women know is that they need to cooperate with their decisions. Being a dalit itself has many implications according to her, they were subject to more injustice and unfairness. Even with the advent of education, the situation has not changed too much. The Dalit women are not aware of their rights and entitlements and hence are more vulnerable to exploitation

The struggle against inequality and assertion to rights of human dignity is a long drawn and difficult struggle. She ended her presentation by giving an outline how RUSEC functioned as an organization to empower Dalit women both on the health and social front.

Sathyashree is associated with SANGAMA, a Bangalore based organization which works for the rights of sexual minorities. She began her presentation by defining who sexual minorities were. She also gave us a bit of the historical basis on the IPC 377 which states that homosexuality is unnatural and punishable under the law. The British and Dutch colonists had passed this law to oust the hijra communities who were controlling the land-holdings in the Mughal empire. Criminalising them would eliminate them and enable the colonists to gain access to the empire. Incidentally, today these very countries have repealed the law, whereas India is still on preliminary discussions.

It was during her fellowship with CHC, Sathyashree got an opportunity to delve into some a lot of issues and problems surrounding this group of people .In India, there is a lot of stigma associated with Homosexuality. Lesbian suicides are very common in India, Men who feel out of place with their bodies join the hijra communities. When men become effeminate, they are denied healthcare. With lesbians, the doctors typically get into a preachy mode. Because of the stigma attached, the incidence of HIV/AIDS and STI's are very high amongst these groups .

Sathyashree stated a few statistics about the situation in Bangalore. The prevelance of HIV/AIDS status among the *Hijras* in the city is around 25-28%.There are around 27 Hamams (bath-houses) in Bangalore city . There are high rates of anal sex in these places , no condoms are used and when anal rupture happens, they do not avail any medical help as well. Very often even though it is very

easy to track transsexual men, getting across to their clients is really not very easy, hence it is very difficult to contain the spread of infections.

Sathyashree concluded her presentation by saying that many times ,homosexuals are asked why they are unable to change and the majority(heterosexuals) who think they are normal point their fingers at them, but the situation is indeed sad.

Question and Answer session:

Q1.In Tamil Nadu,the prevelance of dowry was very high in the 60's.What is the current situation?Question directed to Maheshwari

Ans.The situation has worsened. Even with an increase in the literacy levels, we have not been able to wipe out this evil .A standard of 20-30 sovereigns of gold are typically given to the boys family. Cases of dowry harassment and deaths have only gone up.

Q2.How does one work to build on cultural identity in a positive manner?(Directed to Jenifer and Sathyashree

Ans. 1. Trying to create spaces to discuss neutral issue or national celebrations. A common platform to discuss matter would be a start.
2. Working with young people
3. Ensuring minority groups like transgenders are all united while demanding for their rights.

Q3. How to discuss the issue of dominant ideology in relation to cultural diversity in the situation of inequality?

Ans.We need to try and again find common platform to discuss matters .We need to respect the choice both individuals and groups. And, we need to find a way of celebrating diversity without resorting to violence.

Q4.What is the Dalit situation in the North-East?

Ans. Caste is not so much an issue as much the ethnicity. It is mostly inter-tribal issues there.

Q5.How does one work on intergrating the Hijra community and the general community?

Ans. Community programs are needed to educate everyone. It is heartening to note how they were now involved in some govt processes as well. But it is very difficult and will take a very long time to overcome the social paradigm.

DECEMBER 6th

The Silver Jubilee Cultural Celebrations were held in the Bangalore Medical College Auditorium. The cultural celebrations were a melting pot of dances,songs and skits by various cultural groups from Karnataka and Tamil Nadu.The CHC team also felicitated all their associates and partners who had stood by them over the years.The Centre for Public Health and Equity(CPHE) a new functional unit of CHC was also formally launched.The last segment of the cultural programs was a series of short films by renowned documentary film makers ,followed by a panel discussion.

REPORT ON POSTER EXHIBITION

As a part of the Silver Jubilee celebrations ,the Community Health Cell held a day long celebratory event on the 6th December 2008 at the Sri Rajendra Prasad Auditorium,Bangalore Medical College. The organizing committee was keen to celebrate the keen with the participation of associates,dignitaries and the communities .As a part of the day long event,CHC also hosted a poster exhibition at the venue.
The objectives were :

1.To showcase the prolific collections of poster materials collected by CHC over the years.
2.To display posters on social,economic and political factors and its relevance to health
3.To utilize the poster resources as a means to demystify health as a concept
4.To convey how the various linkages could be used in civil society movements to assert that Health is a Right for all

The CHC team chose 20 themes and selected around 6 posters per theme. The posters were chosen such that they were simple,self-explanatory , contained more visual images than written content and yet conveyed the message they was meant to . The selections were displayed all around the auditorium and hence made it easy for the attendees to walk around and browse through the posters.
The themes were:

1.Violence Against Women

2.Disability

3.Human Rights

4.Consumer Rights

5.Genetically Modified (GM) Foods

6.Mental health

7.Drug Policy in India

8.Smoking and Tobacco Use

9.Globalization

10.Environmental Health

11.National Rural Health Mission

12.Maternal and Child Health

13.Corruption and Brain Drain in the Indian Healthcare System

14.Nuclear Race in India

15.Nature's Fury-Disastrous effects of natural calamities

16.Community Health

17.Occupational Health

18.Bhopal Gas Tragedy

19.People's Health Movement(PHM)

20.Jan Swasthya Abhiyan (JSA) and Jana Aarogya Aandolana, Karnataka(JAAK)

The feedbacks received indicated the exhibition was well received and appreciated. Many attendees remarked that they were not even aware posters on some very important topics existed. The positive feedback has been very encouraging for the CHC team and we hope we can avail more opportunities to hold similar exhibitions whenever possible.

HEALTH AWARENESS CAMP at FIREWORKS COLONY

Venue: Mythri Sadan,Firworks Colony
Date:19/2/2009

The Christ University ,Bangalore has a social work department .Two undergraduate students from the department approached CHC for some guidance and help in conducting a health awareness camp in one of the slums where they were doing a field posting under the guidance of a NGO called Mythri Sarva Seva Sadan. They wanted some help from us with a poster exhibition and also wanted someone to come and give a talk to the slum dewellers on heath. Aditya ,a co-intern and myself volunteered to help out the students for the event.

MYTHRI - Mythri Sarva Seva Samithi, Bangalore (1987) is a registered, nonprofit organization involved with urban poor and waste related environmental issues. It works with waste picking groups and has specialized in urban poverty alleviation and integrated sustainable waste management. Mythri has nearly two decades of experience in pioneering number of innovative initiatives locally and nationally and is a well-known leader in the subcontinent on the subject. Health and hygiene education, ecological sanitation, neighborhood cleanliness through community participation, decentralized approach to waste management with the integration of waste pickers, small enterprise development and development of low income communities are some of the milestones Mythri has achieved as a part of its intervention. Other areas of Mythri's activities are schooling for vagrant children, medical care and skill training for street children, housing, sanitation; self help group promotion, micro credit programme for the poor, networking and child rights activism.

Mythri has been involved with WASTE for the past 9 years in promoting Integrated Sustainable Waste Management (ISWM) and currently functioning as partner in Integrated Sustainable Support of Urban Environment (ISSUE).

The students showed us around the slum area .There were around 300 residents in the area and mot of then were rag-pickers. One major self-sustaining projects in the slum is a Community toilet and bath facility maintained and run by the residents themselves. The residents pay Rs 1 ever time they use the facility and have employed 7 workers from within the slum itself to ensure that hygiene is maintained. The monthly collection is upto Rs 12,000 which goes towards the salaries of the employees and other expenses.

The exhibition and talk were attended by young women and children from the slum. Aditya gave a small talk in Kannada on health as a responsibility and how mental and physical health co-existed. This was followed by a small medical camp where the mother discussed some common ailments affecting them and children.

BASIC NEEDS seminar on sharing of Change Experiences of Persons with Mental Illness and their caregivers

Date:8/11/2008 Venue: Vidyadeep College, Bangalore

Mental illness is a problem that is often ignored and this is especially the case in the poorest countries in the world. With complete lack of locally available, free mental health care, many of the poor, mentally ill people stand little hope of recovery.

World Mental Health day falls on 10th of October every year. In this connection, Basic Needs India (BNI) organized a half-day session on change experiences of persons with mental illness (PWMI) and their caregivers on 8th November 2008, at the Vidya Deep College, Ulsoor Road, Bangalore.Since 2004, the organization has been addressing the mental health issues among the urban poor in Bangalore city, in partnership with three partner NGOs, namely Association of People with disability (APD), Association for Promoting Social Action (APSA) and Paraspara Trust.

Based on several consultations with persons with mental illness and their care givers and feedback from field staff,Basic Needs was convinced that a more holistic approach was require to deal with mental health in the urban scenario.In 2007,they initiated a pilot project to offer non-pharmacological treatment (Psychotherapy) to selected PWMI and their caregivers. The approach involved the coordination with the three NGO partners were in touch with the community and their needs, their field workers received training from the specialists in Psychotherapy from Athma Shakthi Vidyalaya. The funding came from well-wishers in Philips Medical Systems, a corporate firm based in Bangalore.

REPORT:

The programme started with a self-introduction by each of the persons assembled, which included the PWMIs from the urban project and their families, students and staff of a various of educational institutions in Bangalore,staff from the partner organizations and representatives of the Philips Medical Systems.

Mr. Naidu, the General Secretary of the Trust spoke about the vision of the programme, stressing that the approach had to be inclusive and address the causative factors for mental illness and not just the symptoms. Training in coping skills was necessary both the PWMI, as well as their primary caregivers. This was followed by a brief talk by Dr. Mani, Director of BNI, in which he spoke on: What are the needs of the PWMI,; how does the Public Health system respond to their needs, and f what is the role of non-drug therapies in treatment of mental illness. He also pointed out that the drug-based medical therapy worked also tends to cause dependency. The medical system also does little for the caregivers and the family. This was followed by a talk by Fr. Hank Nunn, who heads the Athma Shakthi Vidyalaya. Who pinted out that core to anyone's recovery is that they develop self –confidence and power of their spirit,Hence Atma Shakti.This he felt could be supplemented by medicines to aid recovery.

All the attendees were then divided into three groups, one for each partner, in which experiences were shared by one person with mental illness , caregiver and social worker. In some cases the field workers also shared their experiences. As one of the outcomes of this community outreach it was being discussed whether the caregivers could be used as community-level barefoot mental health counselors. The social workers explained how working in mental health had been a huge step for them as well.The difficulties in even approaching and building a rapport with mentally ill persons and families is not an easy task,especially when most of them already lived in difficult

circumstances in slums.Persistent efforts and sustained motivation in the form of regular home visits is almost a daily feature in their schedules.But,it was certainly an achievement worth celebrating when patients slowly start recovering and started coming back to a normal life.They also listed issues within the health system-shortage of essential psychiatric drugs and mental health personnel.

The seminar ended with an open session. questions were invited from the participants.

IMPRESSIONS and LEARNINGS:

Personally for me,the whole session was extremely moving. The Mentally ill-community has been neglected by us-society, policy makers and even the medical fraternity. The incorrect images and incomplete understanding of the spectrum of diseases has made the community even more vulnerable .Our medical education system has also failed to understand and incorporate the Psychiatric needs of our country. In such a scenario, the importance of sensitizing general practitioners on appropriate and timely diagnosis cannot be over-emphasized.

The seminar also opened by eyes to the "unmet needs" of the care-givers who were themselves in need of support and help. Care-givers and family members are valuable resource persons from whom we can learn lessons to create community awareness and help to fight stigma.Aftr listening to various care-givers,I noted the following:

1. Mental strain and exhaustion :Faced with looking after a mentally ill person who needs to be monitored throughout adds extra pressure on the care-giver to remain vigilant to the patients needs and demands.In the long term,they too face depression and feel an overwhelming sense of hopelessness' ,especially if the recovery is not hopeful. Spouse care givers often face the double burden of managing the household and looking after the patient. Parent care-givers live in a perpetual state of worry about who will look after their mentally ill child after their demise

2.Financial liabilities and livelihood issues: The long drawn treatment of mentally ill persons take a toll on family finances and many times they also have to quit their jobs to remain at home and take care of their mentally ill family member.This adds to the financial distress.

3. Stigma: Society generally tends to discriminate against both the affected person and their family members and do not prefer to associate with them.Affected families are generally looked down upon and this too adds to a form of social stress and isolation.

4. Lack of awareness :Mental health has been under a shroud for a very long time doe to the negative branding by our society.Like many other issues in our country, people to do not come out openly to discuss the problems they face. Due to ignorance and lack o avenues to gain the right information ,family members do not even know that many mental conditions are treatable, leading to a delay in treatment administration. They are also not aware of the various government schemes that the disabled persons could avail of.

5. Absence of a community support system:The stigma widens the gap between the families and the outside world.In a highly prejudiced society,t he lack of community support and empathy hinders the rehabilitation process.

2. Field Visit with BASIC NEED and APD(Association of People with Disability)

Location,:Chamrajpet,Bangalore

Basic Needs and APD partner to provide mental health facilities in parts of Urban Bangalore. I visited the APD field office with a Basic Needs staffer Muniraju and a Mental Health researcher from Canada named Farah. The objective of this field visit was to gain a snapshot of how an Urban mental health programme functioned.

The APD field office primarily served as a reporting station for 5-6 field staff who were mainly involved in identification of persons with mental illness, awareness building and follow-up. Additionally the office also has a physiotherapy and rehabilitation section, a counseling centre and houses a small special needs educational unit as well. This unit designs both vocational and cognitive development based education for both adults and children with disabilities. Counselling sessions are held twice a week for both disabled persons and care-givers. The staff are also trained to refer the clients to appropriate centres for further treatment and care. After a brief round of introductions to the centre's staff members and a small tour of the facilities,we were taken for two home visits.

The clients in both the homes with persons with mental illness and were not financially well off.
HOME VISIT 1:A 19 year old girl who was diagnosed with hyperactivity, attention defecit disorder, epilepsy and behavioral problems from the age of 5.The family of 5 lived in a tiny cramped room.For many years ,the family fearing stigma and discrimination never revealed it or discussed it with anyone. But as the client grew older, her tantrums , outburst and convulsions become worse and increased in frequency.She repeatedly ran away from her house and hid in some relatives or neighbours house till the family came searching for her, she refused to return home many times .They took her to a local doctor who prescribed some medication,but she was not very compliant with the regime.APD identified the case last year and have been working with her and the family since then.Many follow up visits were required to convince the family to take the girl to see a psychiatrist again. With consistent follow up and counseling ,she has become much more cooperative ,takes her medicines regularly and there is a substantial improvement in her disposition.The convulsions have almost disappeared but does become hyperactive on occasions.

The mother is the main care-giver .She appeared to be highly stressed and expressed to us that she was feeling hopeless about the girls case. She told us that she was previously working as a domestic helper, but was forced to quit the job because of her daughter's condition. Her husband is a chronic alcoholic and did not contribute much to the family income. In this scenario,they were in perpetual debt. Two of the elder children were girls who were married and could not help the family financially.And the boy was much younger to the client. To us it appeared that the household had actually 3 persons with mental health problems-The girl herself, the father with his alcohol addiction problem and the mother in a state of depression but who was not even aware that she was suffering with a condition with the crumbling state of affairs around her. Though the girl's condition had improved,the mother was still not confident to leave her alone.As she got better, APD found an employment with a neighbourhood screen printing press.She had grasped the job and was gaining confidence,but unfortunately, the employer had to downsize his unit because of a drop in business.APD was now trying to place her elsewhere or train her in some home based livelihood activity.

HOME VISIT 2:A 25 year old man was diagnosed with psychosis, hyperactivity and loss of memory since the age of 20.He is the youngest of 5 children and had a very normal childhood and adolescence. After junior college, he was working along with his brother as a graphic designer in a

family owned set-up. The family recollected how active and helpful he was prior to his illness. Five years ago, he came home one night and said that a bird him on his head,he went to sleep and after he got up, he was never the old person they knew. He could not recognize any family member and also started behaving in a strange manner.He refused to eat food or take a bath and kept pacing up and down the house the whole day.Gradually,he started confining himself only to the house and refused to even step out.The family feels that the illness could be a combination of

1.Dejection in a love –affair,where the family did not approve the girl of his choice
2.Financial liabilities in business
3.Black magic by some enemies

They have since the onset of illness been very regular in taking him to NIMHANS ,Bangalore.The pharmacological therapy did help in calming doen his restlessness to a certain extent,but the other symptoms still persisted. On a couple of occasions, he even left home and was found by the Police in the outskirts of Bangalore. They family has now started taking him to a "Dargah"-(a Muslim religious place where prayers are offered at a saints tomb) once a month and feel that he has certainly improved a bit, he has started bathing and dressing himself and also has an appetite, but his psychosis and non-recognition of family members still exists.

VOCATIONAL TRAINING CENTRE, Magadi Road: APD also runs a vocational training centre where 10-12 persons with different mental illnesses and a case of mental retardation are.The centre is a two room structure located in a public park on the Magadi Road ..APD secured Bangalore Municipal Corporations(BBMP) permission for the purpose of converting it into a centre which would cater to the needs of disabled persons .

The group is involved in assembling of some small electronic devices for a ship repair company.The goal of such a vocational centre is to provide a therapeutic employment and also as a means of earning their livelihoods."Art therapy" is also offered in the centre twice a week. A social worker was in-charge of the centre and maintained the quality control of the devices and ensured that they take their food and medication on time.

IMPRESSIONS and LEARNINGS:

Both the home visits were eye openers on how an entire families could be devastated both emotionally and financially when they have a mentally ill person in their house.The stigma and fear of society's reactions did force them to not think of treatment as a possibility.The care-givers in both houses were also drained to a big extent,but kept their morale going.Both these cases were examples of how non-institutional rehabilitation approach could be used more often.I refrain from saying Community based rehabilitation as I was not convinced or did not see any support from the external community to the special needs of these members,both these were vases of family supported rehabilitation. None of the families thought access to doctors or medicines were an issue. I felt this could have partly been because they were based in an urban location and had a well known establishment like NIMHANS.Also ,once they came under Basic Needs and APDs scanner ,they were regularly visited and monitered

Persistent follow up sessions are required to track any changes in these individuals,which APD has been successfully doing under the guidance of Basic Needs.I also appreciated the fact that the rehabilitation model focused on the sustainable livelihood module as a form of rehabilitation .

UNDERSTANDING INTEGRATED DEVELOPMENT

1. Tribal health Initiative, Sittlingi Tamil Nadu

The Tribal health Initiative is a non for profit organisation in Sittilingi valley, Dharmapuri District of Tamil Nadu. It was founded by a doctor couple Drs Lalita and Regi in the late 90's.

Gi and Tha ,as they are fondly known here in Sittlingi finished their post graduation medical education and were working in Gandhigram Hospital in Tamil Nadu.Within a few years ,they felt that the hospital was slowly digressing from the original values on which it was founded . On their personal agenda, community health was a priority as opposed to merely treating diseases.They felt the urgent need to move out of an institutional set-up and work amongst the people.After visiting many projects and scouting locations and studying their conditions,they finalized on Sitttlingi in Tamil Nadu for two reasons

1. This tribal belt was an interior location with very less access to medical facilties.The closest hospital was at Harur around 50 kms away
2. The location in South India was preferable, as the couple were more comfortable and familiar with the culture and language.
3. The area had abysmal maternal and infant mortality rates which they felt could be considerably reduced

The Sittilingi valley and the surrounding Kalvarayan and Sitteri Hills, are inhabited primarily by tribals known "Malayalis" or "Hill People" ,Their main sorce of sustenance was and remains agriculture.

Their first set-up was in a thatched hut which served as both an Out –patient clinic and a basic operation theatre.From such humble beginnings in 1993 , the initiative has become a 30 bedded hospital.It has an emergency room, diagnostic laborotary,a neonatal unit.It is also a govt recognise ICTC and DOTS ccentre a(Govt sponsored).Along the way ,Gi and Tha got into an integrated development mode of working.This they say was not intentional or planned at their end.They got into various other projects and initiatives as and when the needs of the people arose and priorities had to be attended to.

The Trust has been supported by various funding agencies at different point in time.But the major benefactor is a group called "Friends of Sittlingi" who not just help the initiative monetarily,but also contribute and assist in developing and planning strategies ahead.

HEALTH INITIATIVE:

a)Hospital:The hospital is now a thirty bedded unit with two wards and has surgical, medical and obstetric patients. There are two operating theatre with appropriate sterilisation and anaesthetic facilities., The hospital also has an electrocardiogram ,defibrillator ,ultrasound scan machine and an incubator. Separate buildings house the out-patient pharmacy,X-ray units and laborotary and hospital office. The hospital is also a govet recognized ICTC and DOTS centre.The campus tries and meets more of its energy needs from solar power.They also have a unique biogas machine where placenta is the raw material. The Parmacy is equipped with almost all essential allopathic medicines and also have a few ayurvedic preparations as well.Most of the medicines are procured from LOCOST-a Vadodara based NGO ,that manufactures quality drugs at reasonable costs.

b) Health Workers:Gi and That felt it was essential to develop a cadre of workers equivalent to nurses. They trained the first batch of tribal girls in 1996 .These women They are able to diagnose and treat common problems, assist in the operating theatre, care for inpatients , go out to the villages for antenatal and child health checks and even give spinal anaesthesis!!. It is now evolved into a non –formal two year program ,where young girls who have passed SSLC are inducted into not just health care, but general community issues as well .After their training the women are employed in the hospital

c) Health Auxillaries are a second group of slightly more older women are chosen by their communities. They basically live in the villages from all parts of the valley and the hills as well. They come to Sittilingi once a month for reporting and training. They offer advice on good nutrition, hygiene, birthing practices and simple ailments. They host the field clinics for pregnant mothers and children. Tha explained to the CHC interns how she struggled with training of the first batch.Many of these women were simple and illiterate as well.It was not easy for them to easily accept and understand the seriousness of the work they were doing.But persistent efforts and constant encouragement helped these women bloom into confident workers who now act as a link between the communities and the hospital. They have mapped every village, filed every family's profile, and recorded every individual's health status. Mothers are being made aware of feeding and basic health and hygiene advice imparted has also improved the survival prospects for pre-term and low birth weight babies and also anaemic and malnourished mothers

AGRICULTURE INITIATIVE:

In 2004,Gi and Tha undertook a padayatra and visted a lot of villages in the valleys and surrounding hills.They spent many days among the villagers ,talking to them and getting a pulse of the main problems that they were facing.Once recurrent issue was that of livelihoods. The tribals have always been dependent on farming and forest products. They were used to growing various varieties suited to their local environment. But, this tradition has been displaced by the pressures o to grow cash crops. Most of these water and chemical intensive as well eventually leading to vicious debt cycle.Realising the seriousness of the matter, they organized workshops on organic farming techniques and also took the farmers to various other organization and initiatives to demonstrate that these eco-friendly methods were practical .A sizeable number of convinced farmers have now growing cotton, turmeric, pulses and rice organically. They are also being encouraged to try intercropping and cultivate ragi which is far more nutritious than other cereals .We interacted with a few farmers who told us that they were initially apprehensive and thought that shifting to organic methods was a huge risk .They had observed a decrease in productivity in the first year, but by the second year,it was comparable to previous time.Some of the farmers also confessed that organic farming was not actually a new practice and was extensively practiced by their ancestors, but some where along the way,the knowledge and traditions had been lost. The organic cotton growers have found a buyer in the state Co-optex ,who have using them to manufacture Organic shirts .
Various women self-help groups have been formed to process and powder the pulses, spices market them. The products made under the name of Svad are available in select stores across India. Tha mentioned that storing and preserving the harvested crops was very difficult as they did not want to depend on the usual chemical preservative methods .This meant that all the produce had very limited shelf lives.It was also difficult to control the pest infestations.

She was also of the opinion that these products could be locally marketed instead of making it an exclusively to meet urban needs.She is also concurrently working with an SHG to understand the feasibility of manufacturing Ragi biscuits –(all the raw materials like milk,ragi and honey from Sittlingi itself and for the people of Sittilingi .This she was a local alternative to MNC biscuits and other confectionary products which were not nutritionally very rich and expensive as well.

Education Initiative:

Anu and Krishna are both architects and have worked for a long time in constructing houses in rural areas. They have been working with different NGOs, in Gandhigram near Madurai and Gudalur on sustainable and eco-friendly housing construction using local materials. They were keen to see that the tribal communities they worked with would eventually become self-reliant and confident in

handling their own construction. In course of time ,they started working with children who had dropped out of school and later, also spent time teaching younger children. The couple have also been friends with Gi and Tha for a long time. After a year of travel to various alternative education efforts in India, they moved to Sittilingi in 2003 and Thulir was started.

This initiative caters to two categories of students
1.School going students from Sittilingi and nearby villages:Thulir plays the role of an after school program for these childen.They get additional tutoring for difficult subjects at school and also get involved with art & craft workshops over the weekend.

2.High school drop-outs :Teenage boys and girls who may have discontinued their education for various reasons are impartment both academic and livelihood skills training like bee keeping, bamboo crafts, masonry, electrical wiring, plumbing, basic electronics, organic farming.

Anu and Krishna also take up and discuss various global and social issues to expose the children to what is happening out in the bigger world, thus forcing them to think out of their routine lives. They also use the environment as a focal point in learning various subjects and skills

The campus is quite unique in that it has a lot of open space for children to run and play.The little huts where they children huddle around to study are all made of mud walls and thatch roof. The school has an office,library,multipurpose room and shed for arts and crafts and livelihood trainings.It is powered by solar energy and only has dry composting toilets
CRAFT INITIATIVE:

One village in the valley has people of Lambadi origin(India's gypsy community).The local Lambadi tribe migrated from Noth India many hundred years ago and have their own distinctive dialect, costume and traditions. Their tradition of embroidery is very unique and almost been forgotten after their integration into the community where they settled.The Initiative is an attempt to revive this tradition and make it a source of livelihood for the women as well.Very few elderly women still remember the techniques and are in the process of teaching the younger ones. This tradition has now been revived by the Craft Initiative, with the older women teaching the younger women. The craft line is called "Porgai" which in their dialect means "pride",.They are currently working with a Bangalore based designer Smitha who is guiding them to make more consumer oriented products and keep in mind their preferences.

THE ANT-Action North-Eastern Trust,Bongaingaon,Assam.

The ANT is a not for profit organisation based in Bongaingaon ,Assam.It was founded by Dr.Sunil Kaul,an ex-army doctor and Jenifer Liang a social work graduate .The mission is to work towards sustainable and holistic development of the rural poor mainly in the North –East. Their inspiration-The ant ,which is a small ,unassuming creature besides being ubiquitous , well- known for its hard work, ceaseless activity, resourcefulness and its ability to work together in its community..They have primarily been working with marginalised groups of the Bodo Community –A tribal group in Assam. Admist the background of ethnic conflicts,ULFA terrorism and historical neglect of the North-East by the Indian government,this project has been working with great determination and grit to focus on development.

Both Sunil and Jenny came from the development sector and when they chose to work in the Chirang district.They were clear that they had an integrated development approach in minds. Their previous experiences had seasoned them to understand that a means of sustenance was what most

communities wanted. Money ,they realised played the role of a very strong determinant of health and development.

The ant was started in October 2000. By March 2001, villages of Rowmary were chosen as the stepping stone for future developmental activities. Currently their activities extend to other gram pachayats Malepara, Birhangaon, Amguri , Koila Moila and Amteka on the Bhutan border . Bongaigaon town was chosen as the base due to its proximity to the work area and to remain in touch other agencies who could facilitate their work.Sunil recollects that it took them almost 6 months to gain an entry to the Communities.They initially just went cycling for kilometers at a stretch to various village to gain an indepth understanding of the issues and problems that plagued the villagers. They were finally introduced to the community by the Student's Union who did not feel that the couple or their work would be a threat to them.They initially helped the community to organize Banana and mushroom cultivation as a viable means of livelihood. The project did not become a huge success due to lack of a demand for the products,inability to harness processing and storage facilities for such small units of products ,but nevertheless they had gained an entry to work with the Bodos communities in the villages.

The ANT how works in around 90 villages on issues ranging from health,livelihood,gender empowerment,agriculture and in the field of rights and entitlements.They also support and act as a technical resource for other development focused NGO's in the North-East. Additionally , they are also involved in state and national level advocacy on various issues.The campus is located in Udanshree Giri and houses a training centre for IDEA, accommodation for staff, weaving sheds and a community kitchen and dining facilities. They have their own patches of organic farming and also vermi-composting units.

HEALTH WORK:

a)Village Pharmacists- From conversations with Nandi- Village Pharmacist a.k.a. Milonee

The Village pharmacist programme was started in 2003 as a health outreach program for the far flung areas. Women volunteers selected by the village are trained to handle about 30 medicines for common ailments. Working as barefoot doctors and some as village pharmacists, they sell high quality, low-cost generic medicines that benefit the poor, especially women and children who get to access and afford essential and rational medical care at their doorsteps.These volunteers were selected by a village managing committee and were trained by Sunil and Jenny through both theory and field based practical work. The initial training was for seven days and followed up by monthly trainings and meetings. Every year, around 15 new volunteers were inducted and there were four groups in 4 years.

The training touched upon some aspects like

1 .Parts of the body,recognizing common diseases and treating them

2. In-depth training on malaria, typhoid, pneumonia, diarrhea and dysentery.

3. Health education topics for pregnant women,importance of pre-natal check up and how to use the stethoscope to detect foetal movements.

4.Preperation of ORS

Over a period of time, when the Milonees felt confident about their knowledge, they were given medicine boxes from the ANT office. These boxes typically contained antibiotics, albendazole,asprinis,neomycin,malarial drugs,cough syrups,oral contraceptive pills and condoms.It also contained a stethoscope ,thermometer, delivery forceps and speculum. Along with the medicines ,the Milonees were also given price-lists for the drugs within their kits.Some of them went around in cycles to distribute the medicines, but Nandi typically stayed at home and dispensed medicines whenever someone came to her. When the patients approached the, they knew how to use a set of questions to arrive at the diagnosis. She typically saw aound 30-40 persons a month.

Most of them were for Malaria and commom cold and fever.Many women also came to her for OCP .She has observed that condom acceptance was not very high in her village. She used to also counsel them on natural family planning methods like the Calender Method and about tubectomy.

In addition to the medicine distribution, the milonees were also expected to keep records of all the patient they saw in the month. The also had to collate the number of diarrhea cases, children and lady patients they saw in a month. Initially, the concept of Milonees was very well received ,but when a few cases were successfully treated, they gained more acceptance and demand for them grew. Personally, for Nandi ,the program helped her understand more about diseases and also gain a new degree of respect in her community. Her husband has also got high regard for her work and helps her whenever he can. With a huge smile ,she also told me that now she has no apprehensions or inhibitions in discussing or asking Sunil question related to reproductive health.

b) Community Laboratories:Conversations with Surjeet, Malaria is an endemic problem in this belt.Very often ,late diagnosis proved to be fatal. Most villages so not have any diagnostic facilities and by the time they reach one,it would be very late To address this problem, Suni designed the concept of a Community Lab technician ,who would be trained and placed within the villages for easy reach and quick diagnosis and confirmation of Malaria..

Surjit was selected by the All Bodo Students Union to undergo training under Sunil.
The mimimum criteria was 10th standard pass and an interest in this type of work. He received some basic training in both theory and practical at Rowmari for one and a half months and also went to the National Malaria Institute in Delhi for further training .In addition to this, every month, the four laboratory technicians had to come back to the base office for follow training and reporting statistics. The technicians were trained in the lab techniques of diagnosing malaria, typhoid, jaundice, diabetes and pregnancy.

ABSU helped him select and set up a shop within the Market place. ANT supplied him with the microscope and the reagents and continues to do so .To supplement his income, He also set up a stationary shop within the shop premises.Once the diagnosis is established ,the slides were also sent back to Udanshree Dera for confirmation. .Till date, Surjit has had 1695 persons visit his lab. He was kind enough to also show me one of his confirmed slides and explained to me how to identify malaria under the microscope. Some of the challenges ,he faces are

1. The venture is not a profit making one and can be very seasonal sometimes
2. Though he is trained and has provisions for testing malaria, pregenancy, hemoglobin and bilirubin, there are hardly any requests other than malaria
3. Many clients only came when the doctor asked for a lab report. People generally lacked the confidence to self-diagnose even when they knew they had symptoms.
4. NRHM has ensured that the sub-centre close by is equipped with reasonable quality of laboratory facilities

3.National Rural Health Mission:Role in Community Monitoring:Conversations with Jenny ANT's observations and experiences with Community Monitoring in Rowmari district
1.The ASHAs who form a huge component of this program are not yet appointed in many places

2. The formation of Village health and Sanitation Committee has been delayed in many villages

3. The ASHAs who were already working need a lot of support from their peers and other CBOs

4. NGO may be successful in mobilizing people to demand for their health rights. But the system has not responded as quickly as one would have desired

5 .Not all the District Program Managers are efficient and committed, hence the government system in itself is fraught in bureaucracy and red-tapism, thus delaying the delivery of services.

6 .Lack of apathy from the officials' side to respond to the publics demands and problems.

Some of the positive changes are

1. Availability of a doctor 24/7 at Subigar PHC,where previously none was available
2. Availability and reach of ambulance to remote area has improved

D) MENTAL HEALTH CAMPS: Conversation with Jenny

Like the rest of India, Assam too faces is a wide gap in the availability of mental health services and what is actually required. The ANT team also had a personal experience when one of the staff members had a manic attack and became violent. After medication was administered ,he clamed down in some time and returned to normal.This first hand experience opened their minds to the possibility of medicines to treat mental illnesses.

Recognizing the dire need to bridge the gap in Rowmari district, where not a single psychiatrist or mental health personnel is available ,the ANT has partnered with an Ashadeep,a Guwahati based NGO .

Monthly mental health camps have started from June 2007 .Till date the camp has received around 180 patients.Simultaneously, Ashadeep is also working with the ANT staff to train them in the basics of mental health interventions.

Jenny, who is trained in psychiatry social work, is aware that the services need to expand into the community and counseling services are an important component. But they are still in the process of mobilizing resources to expand the program.

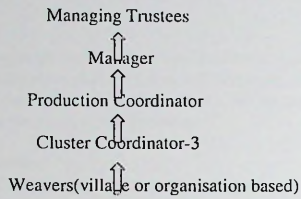
LIVELIHOOD ACTIVITIES:

1. Aagor Dafra Afad is a womens weavers collective formed in 2002 as a liveilihood initiative for some of the poorest women from the Bodo community. The Bodos have a traditional design and weaving style . Through Aagor, they have found a medium to showcase their skills as well. The strength has around 300 full time weavers spread over 15 villages and enlists additional weavers when there are big orders.This project was initiated within Ant ,but has now become a separate trust since 2005 and it completely managed by a group of trustees chosen from among the weavers. Though ,the group did face many hiccups when they started working on their own, they are learning along the way and have managed to sustain the group so far.

Smitha, a Bangalore based designer worked with the Bodo women for a few years to understand their systems and and to help them adapt their products in tune with current demand. She now manages The ANT store in Bangalore and designs most of their items.

Aagor items are also sold at Fab India and various exhibitions throughout India

PRODUCTION:
The team design in Aagor is as below:



Production process

The program when initiated in 2003 ,was intended for the poorest women in the village and the same principle is even followed now. The Managing trustees identify needy persons as and when required. Most of the weaving is for cotton fabrics-80% ,the rest of the 20% is in Eri silk.The yarn is procured from Salem and Eri is a local product.All the women have the loom and weaving units in their houses itself.The cluster coordinators hand over the designs and requirements to the weavers and also coordinate with them for the delivery dates and perform quality checks as well. Quality control is taken very seriously at Aagor and the weavers are penalized if their products don't meet the set standards. The average earning per member is usually around Rs. 2000 and they are paid on basis of how many yards they have woven. The pricing for the final product is done by the trustees based on the costs incurred. Average monthly production is around 500-600 metres. Manish Verma, Aagor's manager told me that they usually price it with a profit margin of 15-20%.In addition to paying out the salaries, the weavers also get an end of the year bonus depending on business performance. The collective is also in the process of setting up a corpus for emergency use .They also intend to set up some scholarship schemes for the weavers children, health insurance and disability benefits. The group's learning curve has been very steep over the past few years. They are slowly understanding how professional values are of paramount importance for the groups success. Manish mentioned that he was a bit disappointed that the group had still not reached the original target of proving employment to 500 weaver ,but agreed there has been improvements albeit slow.

LAIMUN - Binding Unit:

The unit is basically a womens self-help group set up in 2002 .There was a consensus that the cut pieces from woven materials could be put to use to generate some type of employment instead of being wasted.two members of the group went to Delhi to get some initial training in design and production. Now they have a full fledged catalogue that includes diaries ,photo frames, file folders, shoulder bags ,wall clocks and many more.
Their products are mostly sold at the ANT store and other craft exhibitions.

In the early years ,the group used to rent out a room to work in.With their group savings, they have now bought a piece of land and constructed a small unit .

Other Livelihoods:

The Livelihood group was started in 2003 .The team identify women and youth from financial backward backgrounds and organize them into self-help groups. In addition,they try and place them

in some skills training program and also provide small interest loans for small start up businesses within the SHG. for e.g vegetable vending, shoe store, mobile repair storea, animal husbandary-pigs,goats and poultry, sericulture. The loans are usually in the range of Rs. 5,000 to 20,000 and the interest is 1% per month.

The livelihood group is also provides loans to purchase a Solar LED Units .Eletricfication in Rowari and surrounding villages is still very less and hence the group though this environmentally friendly device would be very welcome in the villages.The set consists of two lights and a mobile charger ,but has not been a very successful program.

Some of the major achievements :
1. Increasing awareness of income generation in the villages
2. The accountability has improved
3. Various SHGs and individuals who have succeeded in their ventures stand testimony to the success of the program.

The groups also faces many challenges like
1. Identification of suitable persons for the program:The program is meant for the poorest of the poor but the group feels dissatisfied that they have not been able to reach out to much more.
2. Loan defaults are increasing because of the lack of an entrepreneurial attitude amongst the defaultors, lack of motivation and personal circumstances .

WOMENS EMPOWERMENT:

"Jagruthi" is an initiative that works on women's empowerment by training and awareness programs.They also organize the women into Self help Groups to promote economic strengthening. A unique initiative of the program is the establishment of a Cycle Bank. This project was proposed as another means to provide independence and empowerment to women by providing them a means of easy transport .It aims reaching out to rural women who need to travel very far to access medical facilities, sell their farm produce etc. The cycle bank provides cycles to women on a loan till they are able to pay off their loan and own the cycle. The cycles will be rented after a small down payment followed by easy monthly installments to cover the rest. They provide cycle riding lessons to women who do not know to cycle .The groups is a very active and enthusiastic bunch of women who have held many cycling training camps and cycle races to encourage the members .

AGRICULTURE RESOURCE GROUP:

The ANT set up resource centres in Rowmari ,Mongolian and Koila Moila to provide technical assistance to farmers on Organic Farming and also act as a platform for farmers groups to discuss important issues like water scarcity, electrification, finances etc .The main crops in this area are rice and mustard as cash crop.

Each resource centre serves around 13-14 villages. They have around 25 members. In additions to awareness building, the group also plans exposure visits to various University experimental projects and demonstration farms to orient them to of practical issues in organic farming. The group has also been popularizing SRI-Systemic rice intensification .

The farming in most of these areas are primarily rain-fed and hence the productivity is greatly affected by the monsoons.The people are totally unaware of the water-harvestingThe resource group provides information and expertise on this as well.They are also encouraging the farmers to

take up vermicomposting and are providing low interest loans of Rs 5,000 to set up the unit. The group also sells organic fertilizers, seeds, tools and other implements to farmers.

I visted a demo farm with a group of farmers from another village.The 80x 40 plot was managed by the resource group and had cauliflowers, potatoes, cucumbers and cabbage. The resource group explained to us that prolonged use of pesticides and fertilizers had contributed to increase in soil salinity thus decreasing its fertility. The productivity transition years from chemical intensive to organic were likely to be much lesser compared to preceding years.But once the soil is "healed", the yields would improve .

IDP Camp , Deoshri

In 1996 and 1998,over 200,000 people were displaced following the two waves of Bodo-Santhali ethnic violence. The Santhalis formed 80% of displaced groups while the rest were Bodos and a few Nepalis and Rabhas. The government put the refugees in make-shift relief camps in Kokrajhar and Dhubri districts. A small fraction of the displaced went back to their homes and villages ,but most of the displaced have been living in sub-human conditions in these camps for over ten years. The conditions in the camps are abysmal. Deosri and most areas where the camps are located in Chirang District are reserved forest areas. The Assam government started the second phase of the so called "rehabilitation" in 2004. Families have been given Rs.10,000 as housing grant and "released" which basically meant that theey were stopping relief rations and now the refugees had fend for themselves. The actual scenario was that many were unable to even go back home and had to restart life with money handed over.

The ANT established a cluster office in Deoshri in 2006 and have been working with these displaced populations since then.The ANT team estimates that there are around 200-300 families in the camps still waiting to be rehabilitated .The team based in the IDP conduct village profiling exercises to gather information of the demographic characteristics. They have been attempting to also coordinate activities similar to the Rowmari and other clusters in Chirang districts where they work. Hence the cycle bank initiative, formation of self help groups and similar programs are being attempted here as well.The ANT is also trying to incorporate a rights based approach in their activities at Deoshri, sensitization activities on NREGS,ICDS ,NRHM are also organized

Some of the major social and health issues in the camps include high levels of alcoholism, domestic and sexual violence and unemployment. Many of the camp dewellers worked in Bhutan for daily wages and were subject to exploitation.

I walked around the villages in the camp at Deoshri and met a few families. All of them had more or less accepted that they would never return to their villages .They were in fact scared to do so,fearing riots again. Unemployment was one of their biggest problems. The families also did not spend the rehabilitation money in an effective and efficient manner Many had ended up in wasting it rather than any using it constructively.

As I walked to the camp, I could sense despair and hopelessness and what struck me was people had actually accepted that their lives would never change and lived with the situation as if it were dust on their bodies .A very different approach to development in such a scenario would have to be worked out as opposed to the conventional model we usually understood.

IDeA-Institute of Development Action

The institute is an effort by the ANT , to help in capacity building of NGOs and other development focused groups in North East .They conduct short term courses on various development related topics throughout the year. Resource persons are brought in from all of India to give the participants a broad based understanding of issues like NGO management, accounting mechanisms etc.The Institite also designs tailor made courses depending on the needs of various groups.

INTEGRATED HEALTH and DEVELOPMENTAL PROJECTS

OBSERVATIONS AND LEARNINGS

One of the main reasons that I visited both these projects is to understand how various activities were interlinked to try and understand what Community Development actually meant. It seemed to me that no matter what the entry point into the community,e.g health in Sittilingi or Livelihoods in Chirang, eventually the project gains a life of its own and will chart out a direction. One by one either by default or design, various other activities and initiatives get added on. This felt like the communities almost knew what they wanted .But were many times not confident or knowledgeable enough to take the big steps in a new direction.

Some of the common points I noted between founders of both projects

1.The founders were strongly inspired by Gandhian values

2.Both sets of founders were couples ,who had made a joint decision to work in a rural area with a marginalized community that they did not belong to

3.They created and developed a cadre of women health care workers-equivalent to barefoot doctors.And it is these women who formed the backbone for the success in the healthcare programs and its outreach.

4. The cornerstone to womens empowerment activities in both projects was organizing Self Help Groups and group savings.

5. The initiators were convinced about the use of Organic farming techniques not just as a development activity, but also practiced it themselves in their own kitchen gardens.

6. The founders of in such projects would be looked upon to as leaders and initiators of almost any new ventures .There was surely a great deal of dependency on the founders both for a sense of concrete direction and in decision making.

7. Livelihood issues and addressing the socio-economic situation is key in community development

My over all impression and understanding of Community Development boils to Community and Individual Empowerment. Any process ,event and activity that helps the community and individuals realize their potential, look beyond their circumstances and works in manner to restore human dignity and confidence such that they have a greater degree of control of their lives is empowerment. And when individuals and the community are empowered by knowledge, self-worth and money, they know they have moved steps ahead and development has taken place.

In Sittilingi ,the first project I visited was more of a listener and was eager to grasp whatever Gi ,Tha and other staff members told us about THI.I did not take the pro-active step of interacting with the community because of the short duration of the visit and also because it was my first exposure visit and I was not very sure how to approach the community or how and what to ask them .By the time I visited ANT,I had read up about few more Integrated Developmental projects in India and also had a small though not a perfect framework on what to look out for. I was in Bongaingaon for a week and spent a lot of time speaking to various community members and got a first hand account on how they were part of the process.

CIVIDEP-GATWU-CHC Meeting

Date:7/11/2008
Attendees:
CIVIDEP: Suhasini
Munnade: Pratibha
CHC: Sukanya,Aditya,Sapna

CIVIDEP as an NGO was registered in 2000, but formalised operations in 2002.They focus on issues concerning garment industries workers in Bangalore. They have helped form a womens' group called '*Munnade'* in 2002 and the GATWU (Garment workers' union) in 2006,both which work in unison to address issues that plague these workers.

Munnade' is an organisation of women workers in the garment industry in Bangalore. Any woman garment worker in any garment factory in Bangalore can be a member paying the membership fee

The issues of concern have been:

Wage related issues, worker's bonus, provident fund, termination of work, ESI related issues, workers harassment, organizing workers, many individual cases of work related illness and workers rights.

The GATWU is now approximately 2500 members strong. The objective of CIVIDEP is to make the union strong and self reliant. So far, the workers have been bringing the issues to the notice of CIVIDEP who have been helping them through legal means, organizing the workers and drawing up strategies. They say that the higher management is usually unaware of the work situation and the ones responsible are the middle management.

1.Macro picture of the safety standards in the garment industry

The garment industry like any other industry comes under the Factory Act and hence has to provide for the workers health and safety. The structure of the factory has to be designed for adequate ventilation, lighting, toilet facility and water availability. The safety regulations are to be displayed in every workspace. Unfortunately, there are no specifications for workers in the garment factories The working conditions in these factories do not abide by any laws are often quite pathetic .Common complaints include over-crowding of workers, inadequate toilet facilities ,lack of drinking water facilities, poor ventilation etc.

Cividep and Munnade believe that the workers have very little knowledge and perception of Occupational hazards and health.Very often health issues like backache,headaches, piles (in tailors)

are assumed as individual health problems and they do not connect it as an outcome of their jobs and work schedule.
Some examples of existing regulations for the safety of the workers and prevention of occupational diseases are:

1.The workers who are involved with fabrics should be provided with appropriate masks to prevent inhalation of fibres.

2.Those working with cutting of cloth sheets should be provided with metal(steel) gloves to prevent injury.

3.Those working with power looms rubber sheets are to be provided as a foot mat to prevent electric shocks.

But the workers have complained that the use of protection equipment is only enforced when foreigners/buyers come to inspect the factory premises. These protection mechanisms are not mandatory during working hours. Also they have expressed the discomfort when using them. The workers have also pointed out that there are only signboards and instructions for the Fire/Emergency Exit and a few posters of the Labour laws. Additionally all these are in English and not local languages, thus reducing the workers understanding of the content.

Some issues concerns that were discussed in the meeting included:

1. Workers in the tailoring departments are very susceptible to needle injuries. Loss of concentration even for a second is dangerous and the needle would punch through the skin.Often the workers are taken to the ESI hospital, treated , bandaged and sanctioned leave for 7-15 days. There was one serious case where a worker lost the use of his thumb in such an accident scenario

2.Women in the ironing department are exposed to very high temperatures and very often the steam from machines blow directly onto their lower stomach. But as such no health complaints have been reported.

3 A huge number of them suffer from tuberculosis. According to an ESI doctor, 85% of the TB patients he sees are garment workers. But he was unable to confirm the statistics due to lack of identification details in the records and inadequate follow-up

The activists highlighted and pointed out that the Gokuldas industry fared much better with regards to safety compliance and Bombay Rayon fared very poorly.

2.Examples of cases dealt by CIVIDEP in the past:

In 2005 ,GATWU identified a problem in one of the factories and directly approached the brand-BabyGAP .Though the outcome was positive in the sense that the workers conditions became an International campaign, the union also had to face legal charges on account of not approaching or lodging the complaint with the local bodies/authorities and bypassing them to reach the mother company.

GATWU learnt a very important lesson from this episode and in the below case alerted the rightful authorities on the complaint . A lady worker ,eights months into her pregnancy miscarried right in front of the factory The matter was raised as to why she was working when she was so late into the

pregnancy and why maternity leave was not sanctioned. The issue taken up by the groups and an appeal was submitted to the court and also the international buyers. Since then, a register has been maintained for pregnant women and also ambulance facility has been made available.

There was a case of electric shock around two years back, for which they sent a letter across to the Inspector of Factories. An inspection was commissioned to investigate the case who found that the existing mechanisms were faulty. The factory management was instructed to make the corrective measures. Subsequently , the victim was also granted medical aid and treatment costs .

In a case of harassment, a woman was kept locked in a room for reporting late to work She was detained in the room during the work shift and was denied food or water.The worker fainted due to stress . An appeal was to the Labour Court, Police station and Inspector of factories submitted with the help of Munnade The case went on for 2 years and eventually the worker won and received a compensation of Rs. 46000.

A factory helper was killed in the factory premises by a factory bus.After enquiry and investigation ,a compensation of Rs. One lakh was awarded to her family.

3.CONCLUDING REMARKS:

GATWU has gained a lot of popularity over the past few years, though it a relatively young organization. They are known to take up serious issues ,analyze the and take the appropriate steps to resolve the issue . The workers have slowly started realising the power of collective bargaining and are now directing their problems and grievances through the Union /Munnade and not approaching the management directly.The Union workers are also more aware these days on how to approach GATWU to complain about leave issues, bonuses and harassment

CIVIDEP has also been instrumental in advocating that a strike/protest cannot be initiated without understanding the background of the issue. For e.g. The workers would like to take up the matter of raising the minimum wage with the management. But Cividep and Munnade looked into the matter and concluded that it is not the management but the government who has set the minimum wage limits, hence protesting against the factory would not yield any results.

REFLECTIONS

If anyone asked me to sum up my fellowship experiences , I would put it down as R.O.M.E.(Reorientation of My Education)- a slight modification from acronym-R.O.M.E.-Reorientation.

This I say because, the fellowship has changed the way I understand health and re-oriented my muddled professional thoughts in a more organized manner. I am now convinced and subscribe to the "iceberg theory", there is much more to learn from the communities than what meets the eye. I have learned to "learn and unlearn" and realign my thoughts along various planes and also been able to identify that lacunae's that exist within myself because of various self-introduced biases. The various reports I have submitted here have been my learning and reflection points and helped me discover where I want to go from here.

Looking Inward:

Introspection ,during the course of the fellowship has been a major step in my personal and professional journey. When I joined the CHLP,I was assailed with doubts and beset with

confusions. There were times that the whole exercise of looking in seemed so overwhelming that I would want to find some sort of escapism. More often ,I could only see my murkier side and would feel guilty and ashamed that in my state of ignorance and lack of empathy, I had possibly developed many prejudices about various communities. I knew my passion was to work with communities, but maybe the energy was misplaced, I felt I had only a superficial idea of what existed out there .My false pride in being an of having an Ivy League degree and my ability to speak good English were not the actual tools that a community would need to develop. If anything ,my additional qualifications could even be a hindrance if it blinded me from seeing the 'whole picture' .I have been brought with very middle class values and as I grew up, I simply believed that truth.love and peace were just values we all needed to have and all the worlds problems would be sorted out, but the fact is the values in itself have many ramifications and I needed to accommodate social justice and equity into my own system before I sought to change it the 'system ' that served people.

Finding the right balance is necessary for me. I could romantisize my concepts but if pragmatism did not figure into plans, then I perhaps I was fooling myself .I have begun to understand that finding that fine intersection of personal and professional life is a struggle, I would have to grapple with. I say this because the social group I move with don't share similar views.I could choose to ignore them and be in my own bubble or continue mingling with them. At what cost,I have asked myself many times?I knew that there would be a level of hypocrisy within me, If my values belonged to one set and if I would have to pretend to have another set when I move with other groups .This inner turmoil ,I am still facing.

My various readings, discussions and meeting with people have made me realize that I have been ignorant and oblivious to many things in life until now. The fellowship and my reflections has helped connect the dots and this has lead to a better understanding of the linkages that exist in our lives and the world as well.

The need for a regular internal reflection is necessary to ground myself and also take stock of all my actions and thoughts .Self evaluation and appraisal is needed to ensure my emotional and spiritual growth.

Looking Outward and my understanding of community:

The world community has now become a bigger term for me than before.In my mind,I had always defined it as a group of underprivileged people in a defined geographical are.I now understand that it is not so.Today I understand that and group of people bound by a similar set of problems and somewhat same level of resources and understandings to cope up with problems form a community.

The Socio-political-economic and cultural synergy in the mesh in which the health of the community lies. Unless these dimensions are addressed simultaneously, we cannot make inroads in health promotion.

All communities have an inbuilt potential to rise above their difficulties and circumstances. But they are struggling to even meet their basic needs, where is the question of fighting for rights here. The role that health activists play are in organizing,motivating,guiding and helping them to mobilize themselves. The initial phases are totally hand-holding, but at some point they need to be let go and allowed to evolve ,it is only then that they take ownership of their lives and work towards improving it.

The world is moving in a more materialistic direction and choosing to ignore the need for a holistic development.Money has become the passport to power .It is in this harsh reality that we work and the same reality in which all the communities co-exist.In such a scenario,the communities are being further marginalized and development seems almost like a non –existent dream that will never become a reality.

Indivial and community empowerment –physically, mentally, emotionally, spiritually, financially, socially are all required if a change it to be seen. But threading all facets is not an easy task and everyone may not exhibit similar growth rates.And without addressing people livelihood issues,we could not seek to improve their healthThis is one of the major challenges I see in working with communities.

What next?

During the course of the fellowship,I was keen to take up a job which allowed me to focus on Urban health issues.This I felt would be a practical ,doable yet community oriented and where much intervention is required. Bangalore-the city I live in is facing massive problems as a result of its rapid urbanization and unplanned growth.In the wake of the NUHM also coming,I felt I could surely take up a role that would fulfill my expectations. As I write this report, I have been offered a full time Research and Advocacy position with an NGO called Basic Needs India. BNI works on community mental health and implement a developmental model that was conceived 8 years ago after consultations with persons with mental illness and their caregivers. Their programs are mainly in rural areas of various states and Bangalore Urban. Though the focus is not exclusively Urban,I was convinced that here was one marginalized community that faced a huge level of discrimination across the social hierarchy .Till date mainstreaming them remains a challenge. This was also a community that would need to depend on some type of medical intervention for prolonged periods of time, hence the need to engage with the state for better facilities and medicine supply would mean indirectly working towards the strengthening of the health systems. The work would be a field of multi-sectoral collaboration and would offer me the opportunity to learn a lot hands –more.

I intend to pursue my reading of all community and development based literature at the same pace like I did at CHC.I would also at some point want to work on strengthening my writing skills for the purpose of effective Public Health Communication. In some sense ,I intend to keep the spirit of the fellowship alive in me for the rest of my life, by this I mean I want to always remain as enthusiastic student of the community and be ready to receive what it wants to teach me. My interaction with may activists have revealed to me that a burn out and disillusion are part of the journey in the Non-profit sector,It was natural to feel disappointed when nothing changes despite years of efforts. Should I ever reach such a point ,I hope to return to CHC to help me reflect and reinvigorate myself.

If anyone were to ask me where I saw myself 10 years from now.My reply would be simple:I want to remain a community health practitioner,an eager student for life and also a teacher who will be able to complement a theory lesson with an experience or a story from the field.

CONCLUDING NOTE

My personal observations and conclusions on various projects, readings and seminars remain my own and may not necessarily be shared by the organizations or people I have interacted with. I am aware that my "myopic vision" may have led to my partial grasp of the truth;this may have in turn impaired my explanations and understanding on many matters.

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