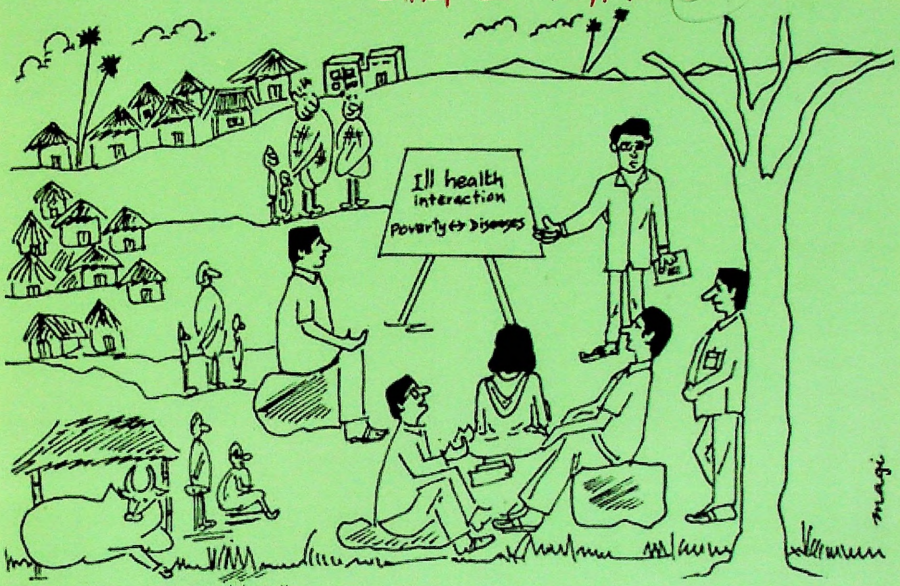
Community Health Learning Programme 2009



Source: Community Health Cell

A Report on the Community Health Learning Experience

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COMMUNITY HEALTH CELL

Community Health Learning Programme

May 2009 to November 2009

REPORT

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COMMUNITY HEALTH TRAINING PROGRAM

Orientation program of (CHLP) was to understand the concept of health and the various determinants of health of a community, It also highlighted what the other various dimensions of health were. Before this CHLP my own concept of health was limited to treatment of ill health. It included the expectation that every person who went to hospital should get proper treatment. Health care is a Right of every individual.

As WHO says "A state of complete physical, social & mental well-being". Or in general my idea of social health was related only to the struggle for life, the means availability & accessibility of health services and awareness among community towards health.

The orientation program of CHLP started with a session on learning methods that is :-

Reflection

What is involved in reflection? Own Experience, own feelings and evaluation of own experience.

Reflection involves returning to experience; acknowledging our feelings; and critically evaluating our experience. Formal education believes in only in academic pursuit and rote learning methods of education but in CHLP orientation group Laboratory & Reflection methods of learning were new concepts for me. Evaluating our own experiences is necessary to decide any conclusion. To understand community, reflection is important, and then only we can understand various aspects of community. Community health depends more on living conditions than on health care services only.

"Exploring the concept of health & community".

Some of the essential aspects of health that were highlighted in this session were the following:

a. Then multidimensional aspects of health.
b. The complexity of health & its determinants; and
c. Concept of a health as human right.

"Health means a balance with bio-medical & socio-cultural factors, both of which are essential for overall health and development".

Before this session my view of the community was based on my observation that despite availability and relative ease of access people were not utilizing the services and deriving benefit. Why? Is anything wrong with individual or community that they don't give proper attention towards available resources. But now I learn that "mere availability & accessibility of resources is not enough to getting benefits but it is also important to understand the capability of the individual". e.g. if a pregnant women suffering with anemia and is advised to take rest with iron pills & adequate diet, but due to her circumstances she is forced to go to work because she doesn't have maternity benefits, and to earn wages she has to do work. It shows that along with availability & accessibility of resources capability of an individual is also an important determinant of health. Thus health should not be only for those who are lucky, it is for all, not for particular class or caste in society. One more example, T.B is a huge problem, but its impacts are different on dalit & non- dalit patients. It is easier for a non- dalit person to get cure because his capability is more than dalit individual.

With reference to the discussion on Health for all now :- Health status is the measure of the quality of life of people people are living. Where the basic necessities are available the quality of life can be said to be good and people are healthy. Where these are not available, the health situation is bad & life is a struggle. Ultimately it is about making life worth living.
Thus I understood that:

1. The issue is for each and every person to reach up to his/her potential.
2. To reach the potential you need some resources.
3. Resources should be available to the individual in a dignified manner.

The Monsoon game was the example of the laboratory method of teaching to understand society.

Some of the issues that came out of the game were as follows:

- How particular class of society enjoys more privileges then marginalized?
- What were the Social, political & cultural factors that influences the health situation of community.
- The fact that every community has its own rules of culture & their own traditions.
- In most instances community is not interested to break the rules & think beyond it.
- Differences in society become accepted as a part of life.Many times the people who are marginalized, they accept that higher community has right to discriminate them.

It is this difference in culture, life style, rules & regulations within each community that makes society stratified & this makes some groups dominant & others vulnerable. SEPC analysis shows the true position of the society. Actually I was not aware about power due to the caste hierarchy. But this game brought this out very powerfully.

Looking inward through Johari's window. Sharing of negative feelings within group about your own experiences is hard; negative about others is easy to share. We learnt that negative feelings should not be suppressed. The sharing about 'blind spots' was a very helpful exercise to recognize our own hidden qualities or drawbacks.

The Alternative paradigm in community health. A paradigm is a set of rules that define the present state of reality. Paradigm shift is the changing of rules, "Merely changing small acts cannot make the whole change. It is by striving for change in diverse ways and approaches such as Rights based approaches or project based approaches we can achieve expected changes. It is important however that these changes should be through community perspective. In the field of health this concept of paradigm shift is important. It is obvious that the same strategies do not necessarily work all the time and in all communities or area. At these junctures we have to make some changes in our overall strategy to implement program according to the needs of that particular community.

Historical overview of health care system, the story of health & health care in India. In this session I learnt about the concept of health system. It may be defined as "Any resources/ institutions that contribute to people's health directly."It includes as a minimum the following components.

- Service provision
- Resources generation
- Financing mechanism
- Combination of planning/monitoring

Government has started public health oriented projects in which the government itself is involved. It is the responsibility of the Government to take into account inter-sectoral aspects and make policies for other related factors also such as health & sanitation, housing, food and a whole series of public health activity for the health of people.

Three levels of health care – 1) Primary 2) Secondary 3) Tertiary. The three tier concept. Mostly the first approach of patient is towards primary health level. Actually 80% illness episodes are cured at this level itself. This means that it is important to make primary level of health care stronger & that it should be provided more resources. The concept of social insurance was also new to me. Social insurance can built health pool which gives security to beneficiaries.

Documentary on Rakku. After watching the documentary we discussed – why she lost her child?

Some of the important causes that came out in the discussion were the following:
1. Child was Malnourished.
2. Infection causing the diarrhoea
3. lack of ability for immediate access to health care
4. No income therefore leading to delayed access to the appropriate treatment.
5. No support from within the family
6. No co-ordination of various sectors (intersect oral co-ordination)
7. Corruption

Thus it was quite clear that even a simple case of diarrhea has a complex set of determinants behind it. And if we are trying to cure the same / control the disease then we need to have a plan to tackle all the plans comprehensively.

Alma-Atta declaration to ensure health for all. One of the primary features of the Alma-Atta declaration was its all inclusive equity oriented approach. The declaration stresses the need for a comprehensive strategy that not only provides basic health services for all but also social, economic & political causes of poor health. It links to a strongly participatory strategy. "People centered development."

NRHM the National Rural Health Mission has been launched with the objective of improving the access to quality health care services for especially women & children. For overall socio-economic development & an improved quality of life.

"Globalization & Health" the impact of globalization on health, the concept of Neo-liberal economy was a new learning for me. I also learnt how a monopoly was created due to privatization. At the same time it forces me to think that how we can achieve a better status of health of a mal-nourished child when media is attracting mother towards the biscuits & snacks like Kurkure, Maggi & Kellogs etc telling that their child will become as strong as tiger the scene I observed in tribal area as well as in rural area that mother simply hold the biscuit in child's hand the child of 6 or 7 months cant eat it properly & this way slowly the health status goes down the child become mal-nourished. Slowly we are forgetting our traditional habbits of making *Kanji* (home made porridge) & soft food for this special age group. Even mother has to go for work not having time to feed her child it is easy to provide child biscuit like eatables & breast feeding. The awareness & importance of supplement diet is less.

Potnal visit, in this visit I observed the ground reality of the situation in which Dalits live. Before this I never saw such discrimination for Dalits We saw how PDS shopkeeper exploits these people. The same situation seems to be playing out in the health services, where even

Doctors are practicing such discrimination. During the Potnal visit I really felt very upset when I meet with the community who was boycotted by upper caste community this is the first time when I saw the example of power due to castism.

The Jagrutha Mahila Sanghatna was really a hope giving example, the main objective of this sanghatna is to empower dalit women & give voice to voiceless. This sanghatna raise issues like harassment, not getting job, discrimination & started a movement against it. We must know how to demand our Rights but before that community must be aware about the Rights. This is the gap that the sanghatna is filling Through their relentless campaigns and trainings they are making themselves as well as community aware about Rights.

In the mental health session my learning was 'the person who has developed coping mechanism is normal person & this coping mechanism differs from individual to individual, the person who can't cope up has to take help of expert to come out of that particular situation. While the logic is simple it is also an unfortunate fact that the very group who are in need of the most support and advocacy cannot do so by themselves.

Alternative medicines the traditional medicines has its own value. The National health policy is largely based on Allopathy, only 5% of importance is given to other streams of medicine. What I have observed in my experience that many traditional medicines or remedies are really very useful for many types of diseases. But now community is not giving much value to these simple medicines. This traditional knowledge is about to vanish. E.g. In tribal community the it is the older people who were having this knowledge of herbal medicines which they collect from forest. However now the younger generation is not interested in having this knowledge. At the same time because of deforestation many species are not available now. So this information of herbs will die out with the older generation. What I personally feel that if there is awareness in community for various factors how to take help from internal resources first then for external resources, it will help to achieve a sustainable strategy rather than taking or giving support and relying only on out side resources.

Transactional Analysis (T A) was new learning for me, we learnt a framework to understand why there are problems in various relationships. In the framework we mostly expect to be treated like Adults but we have to face either parental or childish behavior it is at this point that problems start.
These above are my learning's from the orientation program of (CHLP)

LEARNING OBJECTIVES:-

Towards the end of the orientation program the following are the learning objectives that I set for myself.

1. To know about mal-nutrition in depth. Why mal-nutrition?
   a. Weaning period awareness among community.
   b. Traditional knowledge transmitting factor.
   c. Efforts of local agencies (Anganwadi, SHG, health & sanitation committee) & efforts within family to achieve better status.
2. To study the government schemes related to mal-nutrition.
   a. Lacunas in present running govt. programs
3. To learn about NRHM in details.
   a. To find out opportunities in NRHM to focus on nutrition.
   b. To explore the possibilities regarding Community monitoring of mal-nutrition.

Study of Report one of the first things I did was to review the landmark on child mortality and malnutrition by the Bang committee. A few excerpts are presented below:

- **Remedies on child mortality & mal-nutrition: -** By Dr. Abhay Bang & committee
  This report lists the main reasons of mal-nutrition & child mortality. (WHO report says the 50% deaths are due to mal-nutrition) Hypothesis of this report is, most of the child deaths can be control by applying very simple public health remedies. But for this in every village. Basti & door to door awareness is important.

The major issues that are identified in this report include;

1. The prevalence of and continuing burden of diseases among children.
2. Huge burden of Child mal-nutrition
3. Mothers mal-nutrition & the fact that the mother too suffers from diseases.
4. Lack of awareness about health
5. Lack of proper health services & nutrition provisioning services
6. Lacunas in present government schemes.
7. Social & economical aspects

In this report improvisation are recommended to develop more strong strategy through ICDS:-
* Rajmata Jijau Mother & child Health Mission.
* The Target group & center point of programme should be change. Because in Anganwadi mostly 3 to 6 years child come to take the facility but many times children younger than this age group didn't come to Anganwadi.
* Proper evaluation of statistical data.
* focus on Preventive measures for mal-nutrition.
* Health facilities should be provide in Anganwadi.
* Education for proper diet to stop mal-nutrition.
* Taking participation of parents & community.
* In tribal communities this facility should provide 2 times daily to mal-nourished child.

Because mal-nourished child cannot take proper diet even once a day at home.

* Trained community health workers on every tribal pocket.
In this report committee recommended one simple project of "Home Base Neo-natal Care" because according to survey, the number of child deaths is more in 0 to 28 days.
I had an opportunity to witness this training of this "Home Base Neo-natal Care" (HBNC) practically when I was posted in the NGO- VACHAN, Nashik during the end of my internship.
This report will definitely help me because with this research experts have developed a complete base line strategy to control the mal-nutrition as well as to reduce child mortality. Simultaneously I come to know what the governments schemes linked to this issue are.

- **Experience with SATHI:-**

(Support For Advocacy & Training To Health Initiatives)

SATHI plays a crucial role in the state level coordination of community based monitoring (CBM) activities in MAHARASHTRA. Apart from this SATHI is working with 8 selected partner organizations for strengthening health rights. Partners involved in Health rights Partnerships were also involved in CBM. With SATHI I focussed on learning in more detail about the Rights Based approach. I learn the various steps of using the Rights based approach.

These are as follows:

1) Community mobilization & Capacity building. (Awareness among community, networking & coordination of community among themselves as well as various service providing agencies.)
2) Training & workshop done by SATHI for activist of particular organization. How to built capacity of ASHA, Community health worker.
3) Mass action & dialogs with service providers/ Government officers. Process of community base monitoring was new learning for me how community can keep watch on their own Rights a very simple through very simple methods like Calender Programme, coordination with DHO/TMO for this calendar programme, Checking of medicine stock in PHC, collecting evidences from partner organizations for cross check & as a proof, meetings with private doctors (participation of private sector) convince them for not use injections & saline if not necessary, same awareness among community.

- **Report on Nutritional crisis in Maharashtra**, Since November 2005, SATHI is working on a research project ' Maharashtra Health Equity & Rights Watch; which looks in to health inequities for various groups based on caste, class, gender & geographical location in the state of Maharashtra. As part of this process I had the chance to be part of a Discussion on the report "Nutritional Crisis In Maharashtra" the discussion was organized by SATHI at Pune on 27th Aug, 2009.

The sessions held by experts are as follows,

1) Inequities in food intake.
2) Issues regarding current poverty line & targeted approach to PDS.
3) Contentious policy issues relating to nutritional supplementation for children
4) Role of health care system in dealing with malnutrition.
   i. (Annexure I)

Documentation of mal-nutrition story. "LOK SANGHARSH MORCHA" Nandurbar in 1999 Taloda taluk & Akkalkua taluk of Nandurbar dist. The above organization conducted a survey to find out real numbers of Mal-nourished children. Because this organization came to know that the data of Anganwadi worker were showing less numbers of mal-nourished children than there really were, and were even showing wrong information regarding the grade of malnutrition. ut the real situation was different there was a large death rate of children and it was felt that the main reason was malnutrition. The survey was done & they found out the real data. On comparing this data with government data they found that nearly 90% malnutrition was hidden by the government statistics. This and subsequent efforts by the organization have reduced the rates of malnutrition down by nearly 66.67% as per their studies. I have documented all this above story as well as process of community mobilization, innovation, capacity building, impact & mass action & dialogues with service provider/ Govt.officers. (Annexure II)

- **Public dialogue on necessary medicine not available at Nandurbar Districts PHC's & sub PHC's**

In Nandurbar, being attached to Lok Samanvaya Pratishtan (one partner organization of SATHI) I learnt the whole process of community base monitoring. I also had the chance to attend on 17th Aug,2009 one Public dialogue. In this the issue of essential Medicines not being available at Nandurbar PHC's & sub PHC's were raised. Experts like Brian Lobo from (Kashtakari Sanghatna), Pratibhatai Shinde (Lok Sangharsha Morcha), Dr. Shyam Astekar, Dr. Dhananjay(SATHI) was present for this Public dialogue to give their comment. The responding party was DHO & TMO.

In this dialogue all community members of 20 villages were present to listen the conclusion of this dialogue.

The points were as follows:-

1) (Government recommended 187) Essential Medicines are not available at Nandurbar PHC's & sub PHC's. it is essential to keep in PHC.
2) Appointment of necessary medical staff (Doctor, ANM etc)
3) Revising the structure of PHC on map.
4) Many women didn't get benefit of Janani Suraksha Yojana.
5) Many time doctors prescribe medicines from the outside.

This was my first time to attend such public dialogue so it was very exciting picture for me, how they collect evidences, preparing data of medicines not available in PHC's

Another major activity with changing context has been training of ASHAs . In Maharashtra , the SATHI team offered its innovative training methodology & pictorial training material to the health department ASHA- TOT training for Volume 4 & 5 I attend this TOT training. With Shaku (SATHI team member) I again went to Nandurbar for ASHA training in this training I also had the chance to conduct some sessions.

The module which is developed by SATHI is really very effective for trainers as well as trainees. Because sometime ASHA's are less educated but with the help of pictorial module she can grasp every thing. Even the method of training was very good they really try to develop ASHA as an health Activist.

MEETINGS ATTENDED

* **Meeting**- Supreme Court of India Record of Proceedings. Civil Appellate Jurisdiction Writ Petition(C)No.196 of 2001
By affidavit dated March,2009 the union of India has highlighted several factor which create serious dent against mal-nutrition. It is stated that same needs to be implemented to achieve a significant reduction in the rate of mal-nutrition.

The said affidavit clarifies that these interventions include universalization of ICDS (by sanctioning 13.80 lakh Anganwadies/Mini Anganwadi centers & 20,000 Anganwadies on demand a total of 14 lakh Anganwadies/Mini Anganwadi centers as mandated by this court) & the most importantly, reduction in the gap between Recommended Dietary Allowance(RDA) & Actual Dietary Intake(ADI) on a careful consideration of the matter, the central government has revised both the nutritional & feeding norms as well as the financial norms of supplementary nutrition under the ICDS scheme. On the basis of the recommendations of this Task Force, the calorific & feeding norms for supplementary nutrition in ICDS scheme in respect of child of all categories below 6 yrs of age & pregnant women & nursing mothers have been revised.

. * **Meeting -**Jan Arogya Abhiyan
Points discussed in meeting are as follows:-

1. National Urban Health Mission
2. To arrange public hearing with the co-ordination of Human Right Commission & Jan Swastha Abhiyan.
3. To select state coordinator for Jan Swastha Abhiyan.
4. Discussion on Bombay Nursing Home Act

A deeper understanding of malnutrition

Regarding to mal-nutrition some points come out while discussing with community & observation.

This was the checklist I used to talk to people in the field.

- Period of first breast feeding.
- Awareness about exclusive breast feeding.
- Diet of 6 month to 1 yr age group child.
- Frequency of feeding to 6 months baby.
- Sources from where she get all this knowledge (family elders. health care centers, AWW)
- Contribution of family regarding to the health of child.
- Still why mal- nutrition?
- How community can get involved to achieve better status.

The major findings are recorded below.

Awareness about breast-feeding is remarkable.

- Total exclusive breast feeding is universal.
- Knowledge of appropriate baby weaning food transmitted through elders of family & AWW.
- As per traditions in every family where small baby (6months to 2yrs) is there, this community compulsory prepares one nutritious homemade porridge. (Weaning food substitutes are also provided through some Anganwadi).
- Frequently this porridge feed to child by family elders.
- Whatever they produce through agriculture is on organic fertilizers. This community aware of the benefits of organic farming.

But the same time mal-nutrition is severe problem.

This was a big puzzle. On further analysis it is probably due to the following:

- Inadequate total availability of food.
- Large population when compared to the available resources.
- Very little land holdings.
- Addiction of alcohol in both men & women. (It is their tradition to drink alcohol).
- Early marriages.
- Lack of personal hygiene because of very little availability of water.
- Vulnerable to diseases due to in hygiene.
- Health care services are not easily accessible because of remote area.
- Migration in search of employment.
- PDS is not properly working.

These are some points come out through discussion.

.These tribal communities are living with very few requirements & facilities, at every moment they have to struggle for life. For one day I stayed with this tribal community & observed their life style, where I stay, it was forest area every time there was fear of wild animals. It was thrilling experience for me. But the culture of these communities are rich & systematic, the houses are big, freedom in decisions to both male & female, less gender discrimination, knowledge about medicinal plants grows in forest. But the same time there is a severe scarcity of water and that's why there seems to be a lack of hygiene. The percentage of addiction (alcohol & tobacco) is very high, absence of facilities (transportation, health care, education) & the basic needs. However what made me feel really very sad was that these communities are struggling for the ownership of forest & forest land that they lived harmoniously with over centuries. The forest land now belongs to forest department and they don't allow them to grow

any crops , medicinal plants, to collect forest wealth etc. The forest is the only resource of livelihood to them (they are totally depend on forest for everything like medicines, to collect food, land)

What did I learn about community health in these various settings?

- Community Health what I understand is, "Working only on one particular area/issue will not work to achieve the better status of overall health one needs to have overall development. The organizations working with people need to focus on enabling people to Help themselves & mobilize peopled to identify their own issues/problems. On various issues like Right based access to public services, land rights, lack of basic necessities (food, water, shelter etc) & try to make effective & sustainable effective strategy to resolve the problems. It is this core involvement and empowerment of the people that is the hall mark of the community health approach.

ANNEXURE-I

Nutritional crisis in Maharashtra. Since November 2005, SATHI is working on a research project ' Maharashtra Health Equity & Rights Watch; which looks in to health inequities for various groups based on caste, class, gender & geographical location in the state of Maharashtra.
***Study on a report: -** Nutritional crisis in Maharashtra. (Reported by SATHI. For Maharashtra Health Equity & Right Watch)

) Ensure access to a chain of determinants of nutrition namely food, education, awareness to health care.
2) Reduced growth & development of children & ultimately reduced the potential.
3) Single solution may not fit all states analysis of poverty.

The report examines the effectiveness of the important food based interventions like the Public Distribution System (PDS), The Integrated Child Development Services (ICDS), Mid Day Meal Scheme (MDMS), & even National Rural Employment Guarantee Scheme (NREGS) because employment is also one of the important related factors. To give reference in report according to real situation of grass root level, some case studies are prepared related to these schemes.
I was involved in collecting and documenting these case studies.

ICDS – 2 (Case Studies)

***First case is of Atkarwadi is a small village near to Pune. 95% of population is a Tribal community—**
Resource Organization-- RACHANA TRUST PUNE,
Resource Person—Coordinator of above trust Mr. Konde
Members of Kondana Self Help Group
***Second case of (ICDS) is from Ganjad 19 Km. from Dahanu(Taluk).**
Resource Organization—KASHTTAKARI SANGHATTNA,DAHANU
Resource Person—Mr. Brayen Lobo & volunteer Miss Kalavati Valvi
Anganwadi teacher, Mrs. Karuna Dinde & Members of Damini Self Help Group

The summary of both cases:-
SHG group is a implementing agency of ICDS . SHG has a responsibility to supply daily diet to ANGANWADI beneficiaries. The case is that, Estimated funds for per beneficiaries are very low (Rs. 2.98 for per child, Rs.5.98 f0r adult beneficiaries) as well as receiving payment period is also irregular. So these women have to wait for 2 or 3 months to receive payment meanwhile they have to purchase raw material on credit or many times they have to spend all their savings. SHG women said that they are very much unsatisfied because of all these above problems. These groups can't even manage marginal profit from this business. But the purpose of this case study was to link that ICDS implementing agency compromise with the Quality & Quantity of food which they supply to anganwadi. e.g. With regular daily diet (Rice/ Wheat porridge/ Sprouted grams) they have to provide either eggs or dates but they provide it on alternate days only. So these types of compromises ICDS implementing agency has to make for recovery of their marginal profit. Another thing the quality of food, the food which is provided to anganwadi is not so qualitative. These types of compromises directly affects on the health status of the child.

ICDS is only major national programme that addresses the needs of children under the age of six years. It seeks to provide young children with an integrated package of services such as supplementary nutrition, health care & education. The programme also extends to adolescent girls, pregnant women & lactating mother. These services are provided through ICDS centers

also known as "anganwadies" Today there are & lakh anganwadies in the country covering 40 million children.

As per Supreme Court order:-

- Each child up to 6yrs of age to get 300 calories & 8-10 gms of protein.
- Each adolescent girl to get 500 calories & 20-25 gms protein .
- Each pregnant women & each nourishing mother to get 500 calories & 20-25 gms of protein.
- Each malnourished to get 600 calories & 16-20 gms of protein.
- Have a disbursement center in every settlement.

But the scenario is of this case study shows

- Compromise with the quality & quantity of food.
- Distribution of food is not as per the need of beneficiaries (as shown in above chart).
- The food which is prepared is total solid food so the need of 6 months to 1yr age group is not taken into consideration.
- Faulty reporting of weight & grade of child. Lack of proper monitoring of higher authorities.
- The beneficiaries who stay away from disbursement center are unable to take this facility.
- Don't have any alternative provision/or follow-up of migrated beneficiaries.
- Angawadi center is integrated package of services such as supplementary nutrition, health care & education but today angawadi become only food distribution center, education & health care is totally neglected.

PDS – 2 (Case Studies)

***First case** Resource Organization-- RACHANA TRUST PUNE,

Resource Person—Coordinator of above trust Mr. Konde & Village Members

Atkarwadi is a small village of 500 population 95% of community is Mahadev Koli (one type of tribal community in Maharashtra). But the problem is, government does not considered this community as tribal because community is not staying in area which is declared as tribal area. The funny part of this story is the relatives of this community who are staying in nearby villages are considered as tribal & enjoy all benefits of tribal schemes. Actually this whole community is tribal they all come under BPL benefits but most of them have APL card.

XXX said we don't get ration since from three months, we are so poor & we don't have land for agriculture it is very hard to manage food in whatever small quantity we get through PDS. The distribution of kerosene is also not as per the fixed quantity.

XXX say's her name is listed out in BPL list she got the benefit of "GHARKUL SCHEME" but she don't have BPL card. The person is getting BPL facilities under one scheme but the same time she don't have BPL card & they have to struggle for food. This is the contrast scenario.

XXX shows her APL ration card; on card the amount of annual income was written Rs. 10,000/- (the person whose annual income is below 15000 considered as BPL)

***Second case**

Resource Organization--KASHTTAKARI SANGHATTNA,DAHANU

Resource Person—volunteer Miss Kalavati Valve & Village Members

The case study is from tribal hamlet which is 58 km. away from Dahanu it is total tribal & remote area. The condition of PDS is worst. The PDS shop keeper is engage in black marketing of grains. The shop keeper is from another village he comes once in 2 months to distribute food items, the people who went away for work they lose their share of grains. The people are so poor can't afford their grain quota at a time, they can afford their quota (when they get payment of work) in installments. As per the supreme court order there is permission to buy in installments.

As per Supreme Court order:-

b. Identification of BPL families.

c. Accessibility of ration shops & regular supply of grain.
d. Accountability of PDS dealers.
e. Permission to buy in installments.

But the scenario is of this case study shows

i. Not proper identification of BPL families (one can get the benefit of "GHARKUL SCHEME" but don't have BPL card)
ii. Supply of food grain is irregular as well as shop is open once in a 2 months.
iii. The PDS dealer is engage in black marketing of grains.

NREGS– (Case Study)

*** Case**

Resource Organization—KASHTTAKARI SANGHATTNA, DAHANU

Resource Person—volunteer Mr. Rambhau Baraff & Village Members

Dhamanshet is very small tribal community located near to Mokhada Taluk, it is interior & remote area. Topic of this case was National Rural Employment Guarantee Scheme. The villagers took very active participation in this discussion & told reality about this scheme.

XXX gave information that in whole year he & his family got work only for 28 days, the wages of 15 days are still not paid.

OBJECTIVE OF THE ACT

The objective of the Act is to enhance livelihood security in rural areas by providing at least100 days of guaranteed wage employment in a financial year to every household whose adult members volunteer to do unskilled manual work, as well as Disbursement of wages has to be done on weekly basis & not beyond a fortnight in any case.

XXX said departments don't provide us work more than Rs50/- per day. Department only provide the work which is profitable to contractor. Department neglect the work which is recommended by Grampanchayat .

According to wage act minimum wage should be Rs.60/- per day, & The shelf of projects for a village will be recommended by the *gram sabha.*

XXX gave information that the contractor never shows them attendance sheet many times villagers demand for muster roll to see their own attendance but he always neglect them. Even contractor don't take signature of employees on original muster roll.

According to scheme guideline Social Audit has to be done by the Gram Sabha All accounts and records relating to the Scheme should be available for public scrutiny.

The objective of this project is community should get involved in development process. By deciding, planning of development projects recommended in gramsabha & sanctioned by related departments of soil & water conservations this is the actual role of forest & agriculture department. Then on this approved projects they should get employment. Means both can be achieved village development & livelihood security in rural areas.

ANNEXURE-II

"THIS WORLD IS LIVING IN DEATH" This real story/ report of Mal-nutrition in Nandurbar district.

Study group:- Pratibhatai Shinde, Smita Deshmukh & other group members of Loksamanvaya Pratishtan, Taloda

This story begins with small girl child name Pratibha. Age 4 months she was 3rd grade mal-nourished child admitted to Dhadgaon taluk PHC but when her condition become more worst Doctor refer her to District hospital. Up to district hospital PHC should give facility of vehicle but PHC didn't provide this facility to Pratibha & father was not having that much of money to shift her up to District hospital so he bring Pratibha back to village & that day only she died. She died because lack of proper support to treatment. But on government record her death was due to manengiates. This denial seems to be the root cause mal-nutrition.

Problem of Mal-nutrition is all over Nandurbar Distric. Lok Sangharsha Morcha and similar organizations are struggling for the Rights of tribal community and through that hope to overcome the problem of malnutrition.

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