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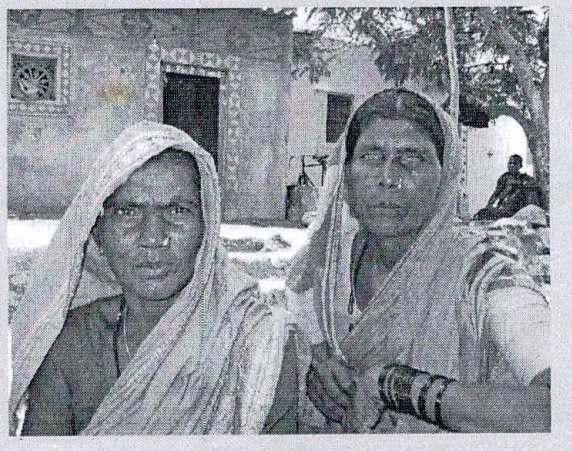

DEEPAK KUMARA SWAMY

An exploration on Health of the Communities

~~2008~~

"We have to ask ourselves whether medicine is to remain a humanitarian and respected profession or a new but depersonalized science in the service of prolonging life rather than diminishing human suffering"-
Elisabeth Kubler-Ross(1)

Acknowledgements

This report is a reflection of my understanding on state of affairs at Raichur, Karnataka, enhanced by mentorship and personal readings. I would like to thank my mentor and guide Mr. Edward Pinto Premadas, for providing me with best learning opportunities making it a memorable experience in life. I extend my gratitude towards the Sanchalakis of Jagrutha Mahila Samghatana and the community members for their honest sharing of experiences. I also thank Mr. Abhay Kumar and Miss. Manjula for their generous support and encouragement. I also thank my friend Vinay for his support during my confessions and sharing of experiences.

I express my heartfelt gratitude to my Mentor, a great friend philosopher and guide, Dr. Ravi Narayan, for his, encouragement, guidance, assessment and critique, during my course of learning. I also remember his support which has been instrumental and illustrative to shape myself as a person with humanness.

I also remember the support of my parents and CHC team and staff for their unconditional support and belief in me.

Thank you all

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Table of Content

I. Introduction

This report is a compilation of my short exploration of health in the context of community existence and what they perceive as health how do they avail and utilize it. I searched for means which improve lives of the people through the prevention and treatment of disease. The idea was to understand health from prevention of disease, prolonging life and organized efforts to provide informed choices to people to access avail and utilise the basic human needs which are food, water, shelter and employment.

It may appear that I intend to do too many things at a time, but my past experiences and unsolved questions has compelled me to explore this possibility. As a part of my fellowship I spent about 15 days in Jagrutha Mahila Samghatana, talking to people from marginalised communities. I also attempted to understand the organised efforts for social and political empowerment of Dalith women. In this report I have put together my understanding on economic and social conditions under which people live.

In the first section I have summated the history back ground, JMS organizational structure, the state of affairs in Raichur and views of people whom I interacted with. In the second section I have presented my understanding of situation based on interaction with people reflecting my thought with mentors and personal reading.

I have also expressed need to understand social and political reforms as a solution for better lively hood In an effort to get the picture of class caste barriers to health or understanding the social determinants of health.

II. Section 1

I set out to Potanal, on 30 March 2008. It is located about 400 Kms from Bangalore. It's located in north-eastern Karnataka, popularly known as Hyderabad Karnataka.

1. Exploring the historical background:

During the time of British rule, present state of Karnataka was under as many as 20 different administrative units of which the princely state of Mysore, Nizam's Hyderabad, the Bombay Presidency, the Madras Presidency and the territory of Kodagu were prominent. Princely state of Mysore was more prominent; nearly two-thirds of present Karnataka fell outside the rule of the Wodeyar's (kings of Mysore).

Following Simon commission elections were held in 1937. The Congress took the stand that it would favour the formation of separate Karnataka and Andhra states. This however met with some resistance from the British and also some of the princely states. While the princely states feared that they might stand to lose some territory, the British themselves were unsure of how they would handle the reorganisation.

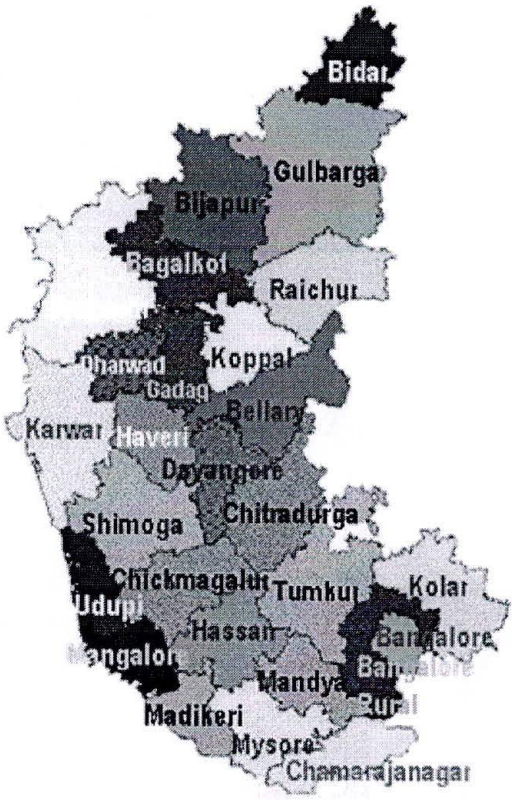


Image -1 Karnataka State Map

The movements like,

- Karnataka Vidyavardhaka Sangha, (Dharawad)
- Karnataka Sahitya Parishat (Bangalore),
- Karnataka Snagha (Shivamoga),
- Karnataka Samithi (Kasargod)

Gathered momentum, through land mark decisions at various places in Karnataka before the Indian Statutory Commission commonly referred as Simon commission which studied the constitutional reform and oversee the granting of independence.

Indian National Congress decided to from a separate Karnataka Pradesh congress committee, in the Nagpur conference 1920.The committee headed by Jawaharlal Nehru (1928) recommended for a separate province with unification of Kannada speaking territory. In 1946 Karnataka Ekikarana Movement, originated owing to unite the Kannada speaking territories, this was strongly supported by all eminent leaders and scholars. This led to formation of *Karnataka Ekikarana Paksha* which contested the 1951 polls.

1.1. Liberation of Hyderabad Karnataka

Karnataka became independent with the rest of the country on the 15th of August, 1947; the some parts of the state (Bidar, Gulbarga and Raichur) were under the rule of the Nizam of Hyderabad. The Kannadiga's in these regions were also not happy with the Nizams rule; and had a feeling that they had been neglected and felt bitter about the oppression of the Nizam and the Razakars. The Nizam refused to accede to India until his rule was overthrown by force. Following the 'police action' against the Nizam, Hyderabad province and its Kannadiga citizens became independent on 17 September 1948. This day is celebrated by the Karnataka government as the Hyderabad-Karnataka liberation day.

Before November 1st 1973, Karnataka was known as Mysore. During the period of chief minister Mr. Devaraja Urs, Mysore state was renamed as Karnataka. In 1956 when several Indian states were created by redrawing borders based on linguistic demographics. The formation of the state of Mysore was the culmination of a movement that had started several decades earlier during British rule when the first demands for a state based on Kannada demographics was put forward.

(Source: Unification of Karnataka, 15th July 2007, From Wikipedia, the free encyclopaedia, http://en.wikipedia.org/wiki/Unification_of_Karnataka)

2. About Jagruta Mahila Samghatana

Jagruta Mahila Samghatana is the successor of Vimukthi. It is the functional unit of Nava Nirmana trust. The activities of JMS focuses on the most poor, the Marginalized, the women agricultural laborers, the children especially the dropouts, child laborers and the bonded laborers, and the Dalith people, who have been subjected a lot of discrimination and oppression. They started with village campaigns for issues about child labour, literacy, non-formal education, encouraging women to form Self-Help Groups and started linking the process with local banks.

2.1. The organizational structure

There are 18 staff members; the work is carried out by people who specialise in major activities and are assisted by Sanchalakis and volunteers, the following picture represents the Organizational structure of JMS

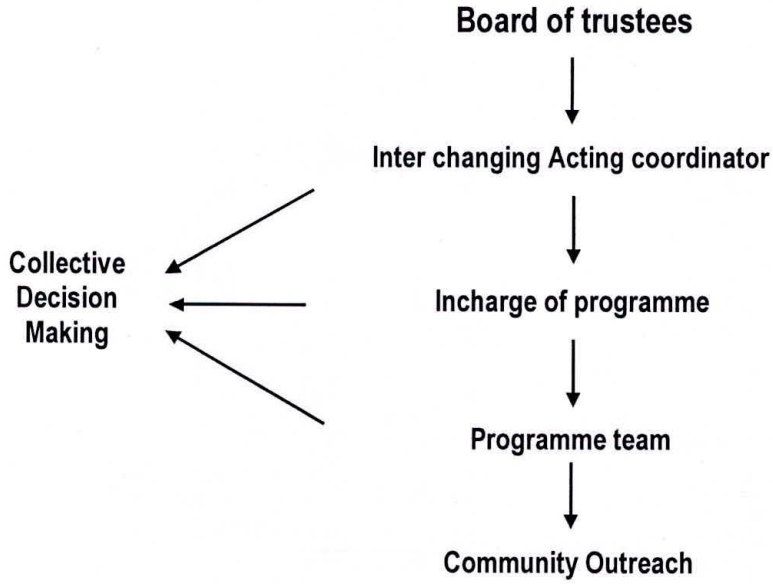


Chart -1. Organizational structure of JMS

The staff members participate in the village activities i.e. basically mobilising and organising Dalith women who are agricultural labourers, agricultural labourers and those belonging to socially and economically under resourced communities for social and political reforms. Snachalakis are basically involved in mobilising and organising people covering the major part of the work. The decision-making is a collective process with the involvement of team members. One of the members of the team will be co-ordinator (interchanging after a particular period of time), who takes charge of the various initiative of the organization.

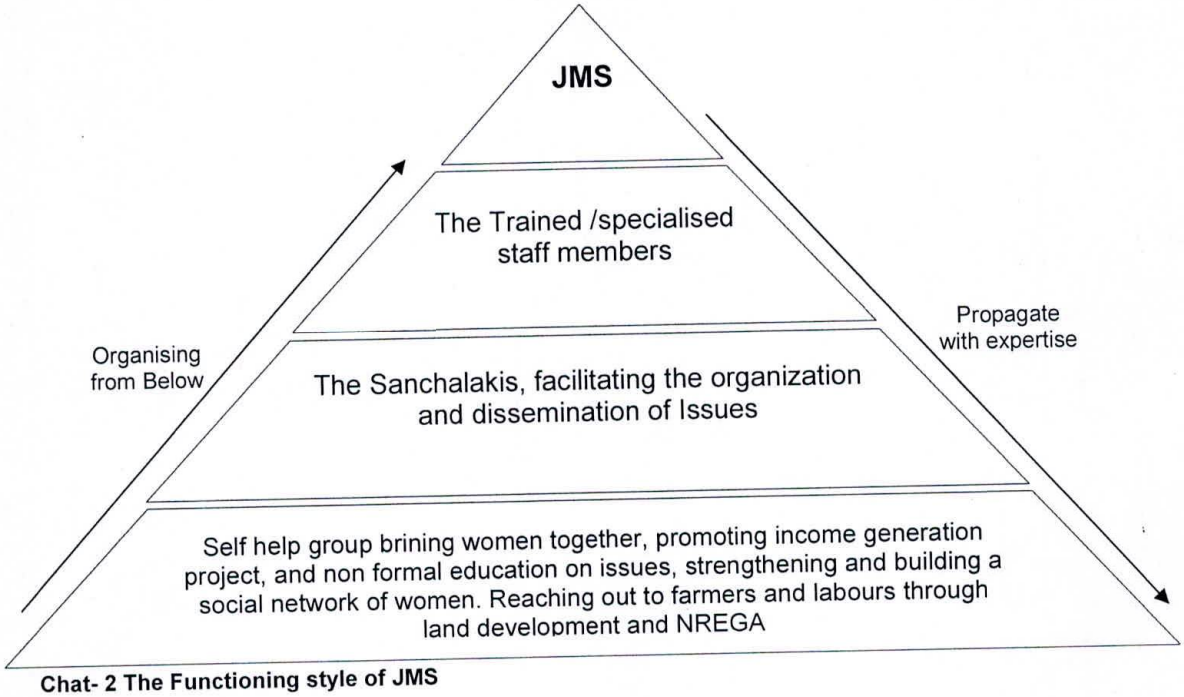
The co-ordinator takes part in

- Planning,
- Monitoring, and

- Reviewing the works of all staff

The programme in-charge will look into specific programme taken up by JMS; there are people who specialise in various fields like

- Mr. Deva putra- livestock management, provision of Government services
- Mr. Chowrappa- SHG, and Land development
- Miss. Rathnammma- Community Health and Herbal medicine
- Miss. Susheela- tailoring
- Miss. Sakina- Education
- Mr. Subhas – Education



Chat- 2 The Functioning style of JMS

The Sanchalakis from the backbone of the whole organization, supporting the overall programme and establishing crucial links between organization and people.

- Mariyamma-Hirekotnekal
- Narasamma Hirekotnekal
- Mariyamma -Malkapura
- Ruthamma- Kharabadinni
- Mariamma-Dotarabandi
- Yallamma-Muddanaguddi
- Kamalamma- Jagir Pannur
- Chandramma
- Sunandamma- Amreshwara Camp

The Self help groups are involved in micro credit, ensuring access to facilities from the government, resisting acts of violence within their homes and in the larger community and perspective building on issues of significance to their lives. These 37 Sanghas in 30 villages in the Talukas of Sindhanur and Manvi collectively comprise the constituency of JMS.

2.2. Activities of JMS

The activities of JMS can be grouped into four major components, viz

- Community Health- through herbal intervention
- Income generation programmes – Terracotta units, bio fertilizer unit, worm in compost
- Organic farming initiative
- Land developmental activities

Overall it can be represented as follows –

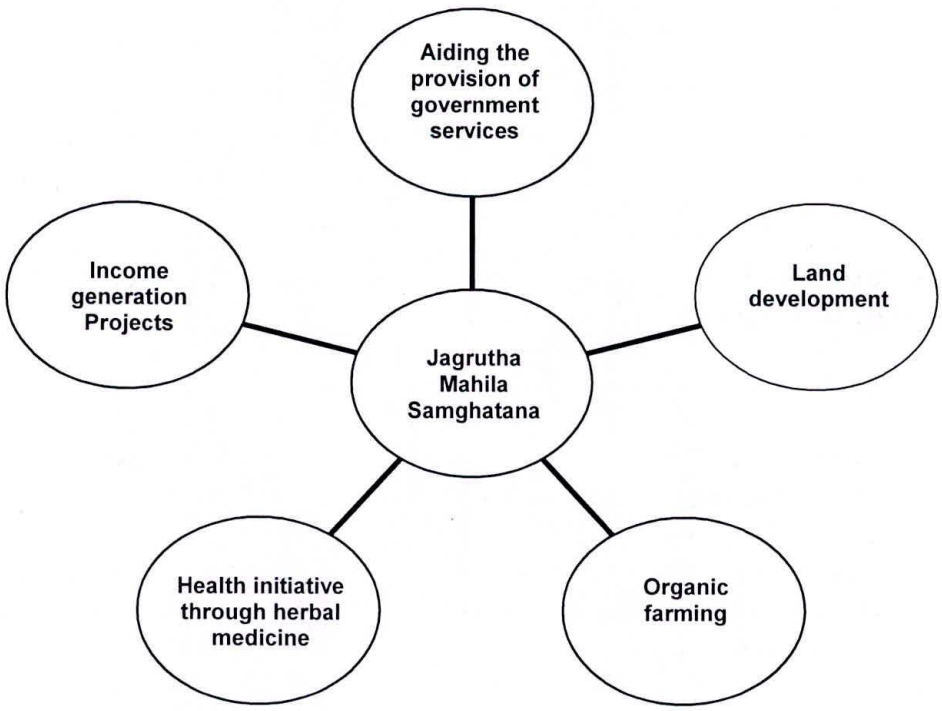


Chart 3: Activities of JMS

2.2. A. Health initiative through herbal medicine

Dalith women have to complete domestic responsibilities and work in the unorganized sector. Caste impositions dominate their lives. The onset of malnutrition set the stage for repeated infections.

Health intervention through health workers on a structural base may not help the betterment of social responsibility i.e. management of health by women in a holistic content, it can be considered as a process which is empowering for women and can lead to a understanding on the basis of health, over all combining the health activities with the organizing the women for social and political reforms is the need for such an process, as I see it they are being treated separately.

There are 14 women from 7 different villages have been subjected to an extensive training on all matters related health particularly the use of herbal medicines. Initially started off with the promoting herbal gardens in a village, with the intent of establish connection between nutrition, hygiene and health, with a slogan "Namma Aarogya Namma Kayyali" -our health in our hands. The women run a clinic every week on Thursday the shanty day of Potanal. They run it on OPD basis looking around 10 to 15 people on that day. The health workers also treat the people who approach at their home or visiting home as per the request. The health workers also generate some income through the sale of finished herbal products known as chiguru herbs. The women extensively and exclusively use exhibitions for promoting and selling the products.

2.2. B. Income generation program

As the SHG women are basically agricultural laborers, some of the SHG are involved in generating the income through means like

- Bio Fertilizer- Use of neem seeds powder as a fertilizer- Muddanaguddi
- Terracotta Unit- the People from Potanal village SHG are mainly involved in the Production of Terracotta unit.
- The Worm in compost – Use of house hold waste material to make manure- At Dotarabande, such initiatives are being taken up in other villages also.
- They also avail the loan for life stock, like sheep/goat etc which are sustain more in that environment and they generate quite good income from those.

They have their own set of criteria's for developing such an programme, like no impact on health of women and which is sustainable

2.2. C. Organic Farming

The organic farming is being encouraged among the farmers, the training and support of this initiative is established through collaborating with Green foundation Bangalore. I have not explored this in detail but based on my interaction I fell that farmers need to be sensitized about organic farming and its benefits.

2.2. D. Land development

This is taken up under the Sri Ratan Tata Trust; they basically clear the Weed and stones that are present in the land to make it suitable for cultivation. One of the noticeable fact is the land of marginalized farmers is more far from the water resources.

2.2. E. Availing the government services

This is an activity taken by JMS and Mr. Devaputra is in charge of it. As many of the Marginalized community members do not know how to read and write The process of availing the government provisions in the form of cards, provision of land and better irrigation facilitation for them, etc is huge and is time consuming. As they are very dependent on the work to fulfill their daily needs they cannot afford to cross check the progress and avail those in time. JMS as an organization takes up initiative in such processes providing them with necessary inputs for claim of such services and its follow up.

Overall the JMS as an organization is trying to help out the marginalised people who are basically deprived of basic resources and struggle to achieve it. Looking around the lives of marginalised communities it is Imposed by/characterised by

- Lack of basic resources to lifelike land and pukka house.
- Deprived of Access to basic resources like water etc
- Exploitation at they are vulnerable to power of upper caste

One starts to wonder why people from Scheduled cast/ Scheduled tribes yell at things and people (generally upper cast) believe that they often politicize things making it caste based. The reason one should understand it from a historical basis on imposing the cast systems which is majorly to exercise power over the community. Dr. B.R. Ambedkar's Annihilation of Cast has explained the condition of Dalith in India prior to independence, the description is quite horrific, and one feels there is no existence of human beings if he is from a lower cast. It's just against the human rights of an individual which is imposed in the form of separation, marginalization and contradiction to basic amenities to fulfil a normal life.

I had a few questions which were comprehensively answered by the communities to break my perception on caste class barriers for a better living. The reality needs to be understood from both the oppressors and the oppressed which seems to provide an overview of things. I have explained in detail about my interactions with community members, in cahpter4. I fell the need to express my feeling on cast, **to be a supporter of caste to understand things from the direction of what is being told or imposed not get into reality of human sufferings deny it as long as possible, hold situations responsible for what has happened and do little things that increase the gap between caste and hold yourself not accountable for things that are happening.**

Source: Nava Nirmana Trust Reports and personal Interaction

3. My Interaction with JMS and Community people

My first visit was 31 March 2008 – 3 April 2008

Day 1. 31st March

As it was my first visit, Mr. Devaputra came to receive me at Potanal Bus stop. I was given an overview of JMS and activities by Mr. Devaputra and Miss. Rathnamma. As it was month end JMS had organised meetings with its sanchalakis, all the sanchalakis assembled around 11 Am, we began the meeting with self introduction. In meetings was centred on organizational activities.

Being from a middle class background, I had no idea of marginalised communities. My understanding was Dalits are those people who are socially and economically weaker. Even I was of the opinion that they are very much organised and stage protests for any issue making it caste based. I had a lot of questions why? And what makes them do it?

Once the meting was over I got a chance to interact with JMS sanchalakis, with a bit of prior orientation, I asked a series of question to them (Iam giving a collective answer to the questions)

1. What you people do?

The answer was straight forward we organise and fight. Per say in Kannada "Sanga Kattuteve Horata Madtivi". We do it to improve our lives we need to improve from the present state.

2. How you organise people?

We go to villages particularly in evening, talk to women call them for meting and discuss about our life the current situation and encourage women to form SHG so as to accumulate some money.

3. Is untouchability practice still prevalent?

It was pretty much prevalent when we were young but now it is sort of come down you can see the glimpse of such practices in inside / deep areas.

4. Do women still get sexually exploited?

There are more than 20 cases once we started organising ourselves it has come down. They narrated a case about young married women who was allegedly raped by a person from upper cast. The women went and protested called for a panchayat meeting gave police complaint, the victim initially supported the women in their agitation but she succumbed to her family pressure and reached an agreement with the accused. The issue was quite heated up and women were retained with in JMS office for a day by police. There are many such cases, on sexual exploitation, Murder, attempt to murder which can be used in legal terms.

5. You have SHG groups do people from Upper cast join your initiative?

We had about people from upper cast they were a part of SHG initially, they came and attended meetings, but never came inside our house and never consumed what we had to offer, after some time they joined another sangha.

6. Do SHG's have a bank link and you people avail loan?

Nearly 50% of our SHG have linked up with bank and we have taken up loan for live stock and income generating activities. The women also narrated the initial difficulties faced for availing loan, and actually they had to protest. Now they have a good understanding with the bank and work is easier.

Interaction with health workers

I had an opportunity to interact with the health workers who have received training on the utilization of herbs as a resource for health care needs, and have been successful in implementing the training into practice since last four years. There are case studies on Paralysis and numerous cases of vitiligo/lukoderma; overall it is envisaged to have a primary health care using the local available resource in the surrounding areas, so as to cater for the local needs of the population.

My emphasis was to understand how these processes relate to "Social and Political empowerment of Dalith women" at a later stage.

I looked at

- Documentation of existing practices
- Herbal repository in the form of garden,
- Finished products and its usage.

I felt that first step would be to learn the method of using herbs for health care. The intent is to strengthen the existing practice, using simple tools like documentation and observation.

Day 2. 1 April

I had planed to visit, some of the villages where JMS is working

Mr. Deva Putra took me to Gonavara, which is around 20 kms from Potanal, We went on a bike, temperature was 40plus and I could feel heat. Looking around the place with less trees and houses built out of mortar (Mixture of clay and lime), stones, people their dressing style (with turbans), I could not resist my temptation to compare with Rajasthan and I even told Deva putra about it, he just laughed at it.

We reached Gonavara, after one hour as the roads were semi weather, He first took me to the church and we relaxed for some time there. Then he took me to Gonavara panchayat. He introduced me to the young man, who was working in the Gonavara Panchayat and asked him to narrate about NREGA (National Rural Employment Guarantee Act) .

They have approved nearly 20 projects for Gonavara panchayat, The Young chap was busy making Id cards, Since Raichur is one of the pilot districts in Karnataka, they were in the process of distributing Cards.

I In-fact had a chance to look into one of the proposals..... I asked him **how many people have got employment this year?**.... He told about 150, on enquiring **why?** He told me about the procedure to get employment, actually people who wants employment should produce a formal request and which is methodical..... I asked him what about people who could not read and write. He told they have to find methods to do it, and told he was willing to help to an extent if required..... I appreciated

Interaction with community members at Gonovara.

JMS had initiated organic farming in that village, I was interested in to understand peoples responses towards that. They told the yield was quite less i.e. 50% of what they expect in normal conditions. I had more questions about weather, fertilizers, de - weeding and what made them feel that is less productive. They told the rain were bit less, since they are small land holders they expect at lest food security for their family and some income to thrive. They usually cultivate 2craops an year and second crop usually from November would be commercial. As they depended more on primary crop that i.e. paddy for they food security to a certain extent they felt it was not dependable and in fact would be a burden on them.

With my very narrow understanding of agriculture I tried to explain them how crop get disease because crop/or a piece of field gets affected and how it spreads through water leading to infection of other crops. They agreed to it but were still expressed doubts about organic farming. The responses made be feel people had little idea about organic farming.

In the end I had questions to myself

- May be I was too romantic about organic farming as I was quite resistant to conventional methods which used pesticides which contributes to the process of biomagnifications.
- May be I dint understand what is the need of people as they struggle for basic sustenance.

Recently people in Gonavara have been coming to Bangalore in search of work and they would stay in Bangalore with families (a size of 6) for 6 months all of them could work and save up to 25,0000 in 6 months. I enquired about their stay they told they would live in a small tent cook outside, I enquired about comfort zone, they told me initially they were and got to terms with time. They were quite happy as could save some money.

I asked them how much could they earn per month. They told a minimum of 2000 for adults and could make nearly 8 thousand per month compared to only 1500 in Gonovara. They went ahead and told me they could save some thing if they come to Bangalore.

I enquired about health status during their stay in Bangalore, They said it was also a major expenditure as they would spend nearly 500/- per visit. They told that they could make their life better by saving some money and repay their debts and think of new beginning.

I asked them about NREGA, which is supposed give employment to people in village and make sure they have enough of earning to live a sustainable life. They told we get only 72 rupees under NREGA and you have to work in hot sun while climatic conditions are better in Bangalore.

After lunch we went to Dotarabande; where an incident had happened 2 days back. When I went there was a gathering of village people. I I was introduced to Mr. Bastinappa, a retired school teacher. He had a lot of questions for me.
He wanted to find out why Iam here?
I am here to understand the work of JMS.
He asked me about my cast background and told me not to be offended by that as it was just a friendly discussion. I told him Iam a lingayat.
Then he shared about his experiences on caste, he told that I being from not so oppressed caste, my blood will be soft, per say in kannada "neevu sukhma rakta davaru" (he ment that you will be of soft nature and you have not been subjected to discrimination for what you want to achieve), and told he being a lower cast has been subjected to lot of discrimination to lead a good life with out much difficulties. He went on to explain how where what when etc ...

He emphasised on grouping people based on caste and dalits are discriminated from sources like water, access to education etc as they belonged to lower cast.

I asked him government has provided so much of opportunities in the form of education, reservation which will provide an opportunity for Dalith to come up in life and possess the basic needs which were deprived earlier.

He responded that the people, who have become leaders, are from our community only. They have worked hard for the up lift ment of Dalith. He then told an interesting scenario that Dalith leaders when they attain a certain status will behave like an upper cast and will not give sufficient attention to them.
Why? His answer was quite simple oppression "naavu Tulitakke olapattavaru" we are subjected to oppression. First he told the upper cast oppressed us now our own people are oppressing us. May be the position they hold demands oppression or may be they do not want to reach out to us as we still are in the same state and its left for me to understand the way I want.
He kept silence for a minute and then told that I should basically understand that every one who is poor and struggle to meet the basic needs for himself and his family will be always used by people who are in the higher level and it becomes more pronounced in Dalith as they are deprived of resources, especially land.

Then people started discussing about the incident, and went on to conclude that a collective decision is to be taken as the issue was connecting two villages. Mr. Bastinappa asked me about my contribution in connection to this case, I wanted a clear picture and asked for FIR so that I could take up this issue and ask for solidarity from people who work in social sector. Unfortunately the case ended in a compromise.

Day three- 2nd April

On the third day I spent time with school children, I went and attended class with students where they were being taught basic mathematics, it was nice to children's responses and the enthusiasm they displayed, All the children wanted me to take class, after a lot of thinking I decided to teach them how to brush, In my observation I saw only few of them use brush, My suggestion was to use tree twigs like neem as brush and its as good as using brush and paste. I gave an hour class on why we should brush, when to brush and how to brush.

Day Four- 3rd April

I attended the clinic where in health workers treat certain conditions on cost effective basis, I met a lady who had been treated for skin ailment, she had white patches which produced silver grey scales, It was initially in the left leg which spread all over the body. Later her husband left her and was subjected to sever stigma of discrimination, he approached every hospital possible to find a cue for but in vain, later she approached JMS women for which she had been treated since last two years. She says it's totally gone from other parts of the body but it is still present in the place of origin.

The women asked me to have a look at her and tell them about might be the disease, I felt I should not intervene between health workers and people whom they treat, I told them we will do a separate documentation of cases and lets get on with number of cases they treated.

Later I sat down with Rathnamma and started looking at the document the women had maintained since the initiation of the JMS. I asked Rathnamma to group the cases into skin, etc for which they were being treated.

We went ahead to look at the medicine and how it is being stocked and discussed a plan with health workers on how to strengthen the existing practices, which mainly focussed on quality and promotion of better working knowledge.

The questions I had

- Why are people discriminated on basis of cast?
- Why should some people remain at the bottom of pyramid while other can climb to top?
- Is improvement of people's life dependent on education and better job opportunities?
- Development in the form of land distribution, creating better access and provision of basic services is a need for better living conditions?

Second visit 4th May to 12th May 2008.

My second visit was preceded with pilot study of community monitoring, Raichur is one of the pilot districts in community monitoring and JMS happens to be one of the

Taluka ngo taking up the pilot study. A meeting was called on Monday for information on dissemination of meeting proceedings and to draw a tentative plan of action.

The prior to this meeting sancahlakis and the resource persons of JMS assembled to discuss on the issue. I gave them a back ground on the concept of community monitoring and how to take this up further. My appraisal was based on simple understanding of things, with intent to evoke a participatory response to implement the NRHM in a true participatory manner. I gave them examples of how a programme can be made better when through community participation and giving feed back to the implementor's on services that are available and planning according to community needs could help in availing and strengthening of government health services which is a comprehensive one than availing medicines for disease conditions.

The meeting was attended by NJMO (Nava Jeevana Mahila Okkuta) Mr. Abhay Kumar and Ms. Majula along with JMS members. They decided that on tentative plan of action which would be

- Get the ground situation of Village health and sanitation committees , The PHC committees and Aarogya rakshana samithis, through RTI.
- Counduct surveys on its existence so as have reality check
- Training of trainers at all levels after District training.
- Plan for public hearings

Rest to be decided based on the outcomes of above. This was the plan till august 2008.

I had a chance to interact with Abhay, Who is working on Right to food through NJMO a movement of Dalith women for better lively hood and social security. They have started off with forming SHG encouraging women to pool in savings, and also avail loan for income generation. They also have started off the life insurance with New India Assurance so as to provide some social security to the Dalith family. They are planning out to develop a co-operative so as to avail Yeshasiwini A co-operative collective on community health insurance. He asked me to meet the women who are involved with their movement, as I was pretty much oriented towards sanitation as a means for better health, he asked me to visit a few places and find out why people perceive about sanitation.

Next day I set out for out for Narabandi and Ameen gada located in Manvi taluk, Raichur. I met Basavaraju a volunteer at NJMO, who facilitate the interaction with Narabandi and Ameen gada SHG women.

Narabandi is located about 50 kms from Potanal a dry area. There 20 women in Narabandi SHG, like other SHG the women also pool in money on a weekly basis and have availed loan for purchase of live stock.

The village seem to be divided into two halves by a road, on the right had side was the upper cast community and the Dalith community was on the left hand side, The houses were the built under ashraya yogane a housing scheme for marginalised, the

electricity was not connected to houses. Basavaraju introduced me to them with my background and we started off with interaction. As mentioned earlier I was pretty much oriented towards the toilets as a better means of promoting health as toilets by conception and practice meant to promote better hygiene.

We started off with introduction and then I enquired about their SHG and activities trying to get a picture of what they were doing. Since it was election time at Raichur, the congress party volunteers came in asked about to vote in favour of their party, NJMO had a list of their problems and what was to be done for it. It was presented and congress workers were pretty much happy to accept it. I interfered in the middle and asked women to be practical in approach for whom they vote as it decides their future, and make sure they accept their demands and give a assurance of what can be done and how much to be done in their demands. I also asked them to have a representation from their side as it is very important.

Later the discussion shifted to NREGA, where in the community member were yet to receive payment for their work for a period of 15 days, Basavaraju was collecting basic data on name and number of days for which they were supposed to get income. When it came to availing option under government services, one women was not happy as she did not receive any institutional devilry allowance 2 years back while other have been receiving it. Her daughter in law gave birth to third child, and ANM had promised that she would try for the allowance and later is not responding to her quires about it. She had been consistently asking about it. Then I started talking about toilets,
How many toilets are there in your corner?
None, Later I explained how toilets can help in prevention of major women health problems like UTI, and Women told they are ready to have toilets but they do not have luxury to afford for it.

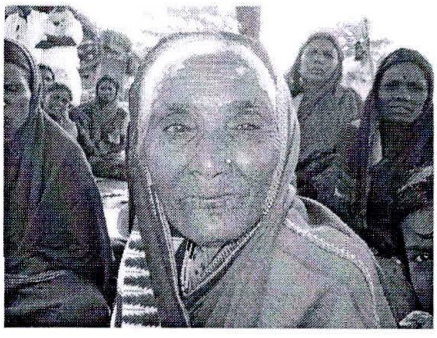
I was more interested in toilets and started thinking about generating funds through the donors and undertaking toilet construction on a large scale. Even I talked about this issue with basavaraju for an hour and asked him if could be reduced to 2,400-3,000 so that construction could be taken up on large scale basis, incorporating at least 5,000/- population. Then I started enquiring about the toilets built, with minimum facilities and he told it would cost nearly 3,500 and make shift walls built out of bamboo and smeared with concrete. I was told that nearly 55% of construction was for the soakage pit, and labour was costing equal as materials.

After hearing to this I felt I should ask more people on their perception of toilets, and then decide take up further plan, we had a quick lunch and started off towards Ameen gada.

At Ameen gada Basavaraju started off the proceedings by enquiring about work undertaken by NREGA, and the payment received by them. After that he briefed them about the demands that women should put up in case of coming elections.

It had a set of demands for the following things, Later I was asked to take over from him, I just started off telling them what health it was on a pretty high note is and I intended to convey the message to them. I related the use of toilets to women health problem and argued that having toilets could actually reduce the common gynaecological problems.

How many houses in the area has toilets?
None. One woman started to explain its not that we don't recognise the issue of having toilets. We in fact want to build toilets, but here we don't get sufficient water to consume, in that condition how can we afford toilets. An old lady nearing her 70's got up and started asking me about to find some solution to the situation of water, and



she threatened me that she would not let me go out of this place until I assure her of water supply every day.

I asked her what your problem is. She kept quite for few seconds and started her story, I do not have any one to depend on if I do not get water near my place I should go around to fetch it. Now that Iam old it is difficult for me to go and fetch water for myself. Iam alone and no body is there to look after me and body cares for me. I don't care who you are but you get some arrangement for water and then leave this place, I do not like to fetch water at this age.

As I entered this area I saw a huge water tank near the entrance? And one more is there just behind this house how can you tell there is acute water shortage?
Yes there are tanks which are quite capable of sustaining the families around this place but what is the use of the tank when you do not have a supply chain.

Ok what is the panchayat doing?
Panchayat supplies water to us. But half of the time the motor could gets burnt. We are not telling this to you this is what panchayat tells us.

Do panchayat repair it?
They do but since last six months the secretary is not in place and he has taken 6 months leave as he is on the verge of retirement.

Are there any other water sources like pond, well, bore well?
Yes there are, but pond gets dried in summer, well also get dry in summer.
Bore well?
Here the salt content in water is more bore functions well when newly installed. After certrin period salt gets accumulated and no body take the responsibility to clean and install it.

Is water problem only to marginalised communities?
No it's not only limited for us its in fact a whole village problem.

What do upper caste people do in this situation? What are their resources?
They have well. During sever crises they also help us, they allow us to take some water from the source. But you cant expect them to fuly take care of us as they have their own needs which are to be fulfilled.

What is the source of water for you apart from this?
There are ponds. Our man and children fetch water for us on cycles. But we need to mange our selves with minimal water.

When water source is nearby why can't you transport water in bullock cart?
Its not the question of getting water during summer you can't consume water its too salty and canot be used for domestic purposes.

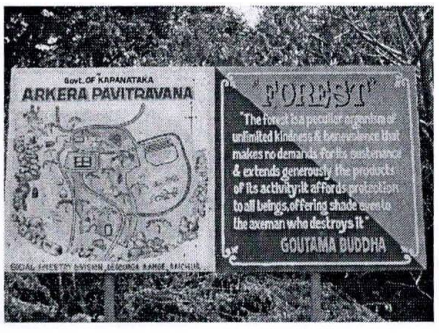
I tried every way out to get water to the community but in vain, I felt helpless for them I personally felt bad because I tried to enforce toilet instead of water. I even attempted to mobilise women to get more water.

I had huge question for myself
Are toilets a necessary when they struggle for food?
What does a toilet do when you eat less? Does it really prevent people from getting disease.

That Evening I went and met Abhay, as I had too many questions about community? He asked me to understand the problem from people's perspective?

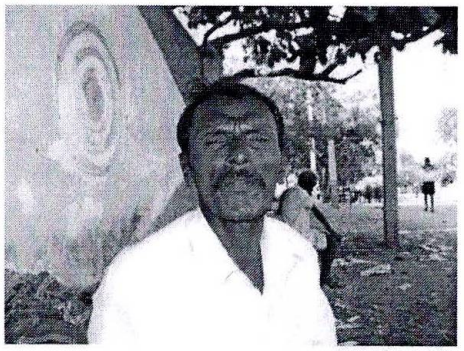
My romanticism for toilets had not died but still felt toilets are of great need like basic amenities of life, and asked for other places where I could find toilets to ask people who are using it?

Abhay told me to visit a place of lambani settlements, where in the community it self had taken an initiative to construct toilets. They had build community toilets they used it initiatily and later on they were not able to make use of it. As mentioned earlier, I was pretty much disturbed with situation in Ameen gada, there are ways to acknowledge it and appreciate it. But it becomes difficult for a person who goes to the communities to find solution. I did not feel the need to visit that place as water was of much priority to people, and felt the need to work on water purification and make the available water palatable.



Next day started off to Arkera, a place in between Raichur and Devadurga. I was told about pavitra vana a place for conservation of medicinal plants. This place is of historical importance, it is belief that one some of the

sages were taking medicinal plants from Kashmir to kanyakumarai. On their way they rested in surrounding area of Arkera, it is believed that one of the carts carrying medicinal plants tumbled over and rare species of plants thus started growing there. It is also evident that certain species of plants which are not suitable for such climatic conditions are present there. I had a look at them I tried to find out more about that place but since the guard was not in station I could not get in depth information on how and whereabouts of that place, at the same time I tried to gather information from the locals but in vein.



I was waiting for a bus to devadurga, for my way to Bidar to explore possibilities on involving PG (AYUSH) students in the community health work. At the Bus stop of Arkera I happened to meet Mr. Krishnappa, a resident of Narabande about .... Kms. I explored strange things with him, since it appeared to be small town I was interested to find out is there any PHC in that place. He told me its on the backside of this compound. I went inside the PHC it was a new building which was under construction and was on the verge of completion. I enquired about the Doctor, the workers directed me towards the lab attendants. They asked to come on next day if I wanted to meet the doctor, and if I was happy with them treating me they would do so. I told them that I was from Bangalore and wanted to talk to doctor about PHC.

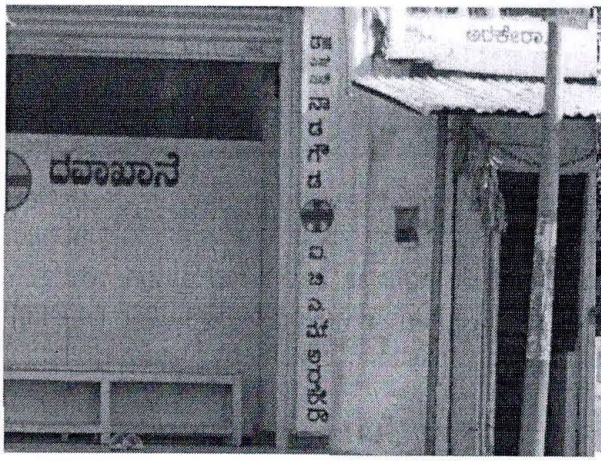
Incidentally I met Mr. Krishnappa again and introduced my self and started talking to him about me and why I came to Raichur. I stopped in the middle and asked him, about his experiences with PHC.

DO you go to PHC for treatment?
Yes I do go but they do not treat the poor well and if you have good money you will be treated better.

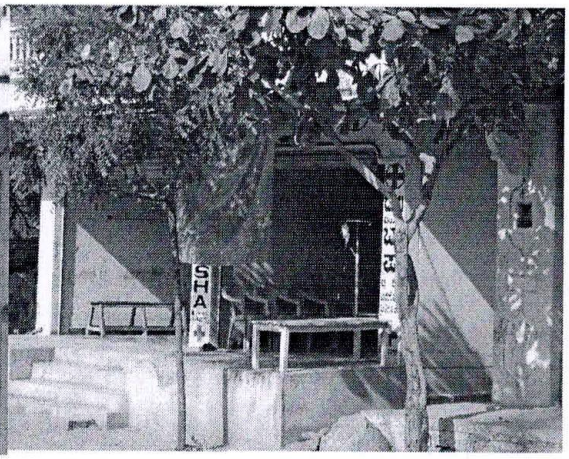
How does the doctor respond to you?
If I go this PHC the doctor will chase me out. I started wondering why, He added that no body believes me when I tell this, please stand at some distance from PHC and watch what happens when I go in and how I will be chased out.

Do you get medicines free of cost?
No for injection you have to pay 10/- and for tablets you have pay 5/-.

DO you go to private doctor?
Yes I do There are a bunch of them around this place and just look around you will find at least 5.... I got interested and just took a walk around for 100 mts and found two.....



Clinic 1



Clinic 2

I went back and told him I found two, he just laughed and told there are many inside you just need to explore. I had further more questions to him

Which one do you feel is better government or private?
He was got a bit angry and told both do not care for poor if you have money every thing works out.

But in private you get better treatment and better care that's why you find lots of doctors?
Yes I do agree but if you ask me personally money is the thing they want money that's all. If you go to government they give only white, red and yellow colour tablets for all disease, if you ask for more they give tablets from outside which costs more.

That why people go to private Na?
Government is much better. See I had a problem with my left knee. I went to government hospital every time he gave same tablets which reduced pain but no use it won't heal you, its temporary relief. If you go to private set up the first thing they do is to put a glucose and then they prescribe medicines form shop.

He further added that if you go government doctor you spend 30/- if you go to private you spend 300/- per visit, after 3 visits they sent me to Raichur hospital where I underwent investigation and the cost reached up to 1,000/-, after three visits they sent me to Bangalore and I spent 10 days in hospital spent 10,000/-. I felt better after 6 months its back to same position.

I man a poor man who is surviving on my bit of land and work that I do with other people? If I go to hospital my wages are lost. If I take rest who will feed my family

Namma Hotte Beyutte- per say we will be put to starvation
Yaru Duddu Kodtare- who will pay the money
Yarana Kelana- Whom to ask

Mean while his bus arrived and before he left he told me that he will be around this place and told has more stories to tell in this regard. I said bye to him and continued my journey to Bidar

I reached Bidar at 3 am in the morning and took tried to work on possibilities of involving the post graduate students for community health workers training. I met Dr. Guru raj, Dr. Sheik Matin, Dr. K.S. Praveen Kumar and told about the idea and intensions they told its good to take up such initiative but they are unable to help as they are busy with their academics.

Next day I was supposed to conduct training at Potanal

The Ms. Susheela welcomed the participants and shared the agenda of the meeting. There were 30 participants of which 6 Sanchalakis, 9Arogya Karyakartas Session started off with a formal Introduction,

I started the proceedings bys enquiring about what is health to them, as people had already undergone training on health there was a unanimous response to the question as "good water, air, housing food and also conflict free life".

My immediate question was how many of you are in possession of it. The response was nil. Later I turned around the topic and asked a lady to explain her daily activity. Huligamma Explained her daily schedule from morning till evening, which coincided daily activity of almost all women (after enquiry with the rest about weather it suits their daily activity) and again asked them weather you can devote some time for health, there was a unanimous denial to it.

I hinted at the cleanliness and its relation to health and asked them how many of them have toilets at home. The response was they cannot have the luxury of having toilets as toilet and bathroom construction will cost nearly 12000/- and they are still struggling to meet the basic needs of life, and the 1,500/- provided by panchayat will not serve the purpose and will take at least 4,500 for all-weather/ pukka toilet. I unhygienic condition the unhygienic condition (work/home) which will lead white discharge and its one of the common problems faced by most of the working women. Further the emphasis was laid to use of toilets and better hygienic conditions with good nutrition can help them reduce the white discharge.

I shifted the focus from hygiene to hospitals and posed a question how many would go to hospital for treatment of Leucorrhoea. The response was sluggish one or two of them spoke out saying that they would approach hospitals only if the condition is unbearable. The whole focus of discussion shifted to public and private set up, and its access.

I drew out basic understanding from responses to my question "what makes you go to a private doctor?" which are;

The private doctor is more friendly and gives treatment which is costly (Often have to spend nearly 500/- per visit.)

The government hospital does not provide a good treatment and the condition is even worst and even they have spend nearly half a day in waiting,

Ultimately were the patients go the money goes even government doctor takes money and they have to spend two to three times of money against what they are spending at government hospital.

The people who some of the aarogya Karayakartas have constructed Toilets but are not using it, and have converted it to storeroom.

I asked them why?

They told they are not comfortable with toilets in their language (adu Bhesh illa ri) and they feel knee pain and headache some times. When they come out they eye takes some times to adjust to outside environment.

Later After the lunch break there was a movie on how to use herbs in primary care. The CHAI CD which had three herbs, Tulasi, Turmeric and Neem and I translated use part in kannada.

In Conclusion I requested the participants to at least start using the toilets when they come to JMS. The interesting Response was we do not use it as it gets spoiled by number of people using it.

The important aspect I noticed during this session was community understanding about things. The government doctor feels

The next day I spent time looking around medicinal pants where they collect and finished herbal products

The next two days I spent time with JMS Aarogya Karyakartas with the intent of revivivg their knowledge I have put down the recommendations in the next section

Section II

This section contains my Reflection and proposals for reviving the herbal health practices of JMS aarogya karyakartas

Understanding Health:

The first question is do we need to understand health when it is already defined by WHO as "health is a state of complete, physical, mental and social welling and not merely the absence of disease or infirmity". It has been taught this at various levels and never provided with an opportunity to understand it. It is just like going through the book and writing the exam, which was pretty much focussed on obtaining marks. The same thing happens to people who study medicine (both AYUSH and conventional) and practice it. It may be a biased opinion but I feel the need to put across what is happening and how is it perceived from an overview that I have since my college days in 1998. Realization was late for me also, but I took a chance to reflect on it.

Any student would go to college study the text books finish assignments at time submit it and prepare well for exams and obtain good marks from it, which in turn helps in better employment opportunities and further education. Positioning my view, on practical application of the gained knowledge, for doctors it comes down to practice (surgery /medicine) with what they have /been taught/ learnt making sure not to cause unnecessary harm to clients (a new term used for patients as it is to treat them more respectfully!) its totally good. Considering the fact that majority of people think its good I would like argue, that the good is only perceived from one angle i.e. to say what the doctors want to. Even though there are code of ethics which tell how to behave with clients, it comes down to what happens in clinics. The code of conduct demands an integrity, accountability, continued medical education and basic principles of medical ethics to be followed; however there are not enough mechanics to counter check what is happening at a doctor patient level, I mean the laws and statutes for audits and rational use and its proper implementation.

A medical student subjected to understand health from Social Economic Political Cultural and Environmental means is no way prepared to perceive it as there is only a limited understanding of such dimensions through his studies. One of the ways is to challenge that perception, believing that knowledge is an open source and all knowledge resources are for betterment of humans.

Taking health services as a means to understand health In our country, "the private health sector provides more than 80 per cent of curative services for rich and poor; urban and rural alike. The private sector has grown without any direction or planning and without standards for quality or public disclosure on practices and pricing. There are large variations from state to state. In rural as well as urban areas, untrained providers offer a combination of systems of medicine. In the absence of formal studies on pricing, quality and appropriateness of care, it is impossible to draw any conclusions". (1)

Health is very complex and huge concept and these conceptions of health by providers and recipients necessarily do not compliment each other. These concepts have been changing with the addition of new dimensions from time to time (2). The

biggest question will be to understand health as a concept or state of health with the tools to measure it. Based on the above understanding it becomes necessary to distinguish between health as a social goal and provision of services through rational use of medicine.

WHO in its efforts to promote rationale use of medicines have has created a database of un/published PHC surveys in low/middle income countries from 1990-2006 and found that

- >800 drug use surveys using standardised indicators
- 30-50% patients treated as per STGs in public sector
- Worse in the private sector
- Not improving over last 17 years
- Very few scaled-up interventions implemented

STG- standard treatment guidelines

WHO database of pharmaceutical policy in 2003 based on questionnaire by more than 100 MOHs (Ministry Of Health) has concluded that many basic policies to promote rational use of medicines has been implemented by 50% or less of countries

This has led to increased adverse drug reactions and drug events

- morbidity and death
- costs US$ 5.6 million / hospital / year in USA (Agency for health care research and quality 2000), and £380 million / year in UK (Wiffen et al 2002)

Increasing antimicrobial resistance

- Up to 70-90% resistance to original 1st line antibiotics for dysentery (shigella), pneumonia (pneumococcal), gonorrhoea, hospital infections (staph. aureus)
- Alternative drugs 2-90 times costlier
- Costs US$ 4000-5000 million in the USA (Inst. of Med. 1998) and €9000 million in Europe (SCORE 2004) (3)

I had been interacting with health workers in Raichur and Hanur along with community members through JAA-K (Jana Aarogya Aandolana Karnataka) trainings. The first question that I had been asking is what is health? The responses could be grouped into two categories like,

- The definition based- A WHO definition which appears holistic,
- Socio-ecological relation ship of humans –Relating to pure drinking water, good nutrition, better living place, enhanced relation ship with community.

The above two categories of answers were from the same group, it depends on how you interact and put it across so that you reach the depth of peoples understanding. Even after giving answers to above people still feel that health is determined by doctors. The following are the reasons I fell are associated with it.

- The doctors are trained to identify disease and treat it with appropriate medicines.
- Traditionally it is a belief that medical profession is not merely an occupation of highly learned and skilled technicians, but also an affirmation of strong and inseparable moral commitment. (1)

Thinking in above directions the path of health is scattered interwoven with difficulties. It depends on the perceptions as health is perceived in different ways by different communities. The Biomedical concept views health as absence of disease, the ecological concept which views as a dynamic equilibrium between man and his environment, the psychological concept believes health as influence of social, cultural, psychological, economic and political factors and the holistic concept which synthesizes all the above concept.

Health in broad sense dose not mean absence of disease or provision of diagnostics curative and preventive services. The health implies to perfect functioning of body and mind, often referred to as positive health. Therefore health in this context is defined as the ability of an individual or social group to modify himself or itself continually, in the face of changing conditions of life.

Defining health in board terms:

- Health is a condition embedded within the individuals to carry out activities to sustain and lead a normal life.
- Health is a resource for everyday life not an objective of leaving- WHO
- There is a universal understanding of health and the struggle is to enhance the understanding by universal definition and scale to measure.
- Health is a common theme of all the cultures and the necessity/ compulsion of being healthy is to achieve what is set as the goals of life.
- Health is maintained through food, hygiene, surroundings and proper conduct with people surrounding him (Understanding humans as social animals).
- The focus is to avoid the means or methods which can or could become an obstacle to the activities carried out routinely (Termed as disease).
- Health is the centre of all the activities and all the progresses of mankind can be directly or indirectly related to it. Eg; All developments in science and technology are for betterment of human life or to protect it.

WHO clarifies the sate of health as "The extent to which an individual or a group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities" (4). Health is determined by the personal, social, cultural, economic and environmental factors that influence the health status of individuals or populations. (5)

Now understanding health in broad terms can health care professionals ignore the problems arising out of above problems? Following the biomedical model for health and applying it seeking cellular level intervention to the facts of SEPCE causation has its own limitations. Putting forward the theory that disease is only due to dysfunction of bodily parts and correcting it through medical/surgical interventions added with aspects of mental well being as means of being healthy ignoring the concept of well-being is in practice. Iam sorry to say this is not the way to understand health. But a claim to sell health as a means to cure the perceived disease, understood through narrow technological means is on everybody's priority.

Health by itself is full of changing concepts, adding new dimensions, factors determining it, responsibilities at various levels and indicators to measure it. Limiting health to just mere biological, technological and mental dimensions as a solution to health problems is not the solution to health care. This leads to a question of understanding the motive of health care services which are ever spreading and overwhelming through private establishments. Its not only the establishment but the claim that are being made in the pretext of health. Overall no student of health will accept the promotion of limited understanding.

At National Bioethics Conference held at Bangalore in December 2007, discussions were around technology, trails, access etc keeping ethics as a theme. Better medicine and technology can't be a solution to health problems until they are

- Appropriate
- Comprehensive
- Adequate
- Available
- Accessible
- Affordable
- Feasible

Above all these things are to be supplemented with minimal living standards, which include adequate water, electricity, nutrition and possession of the basic resources. If health was to be taken care through medicine the question I would like to ask myself and other health professional "weather medicine is only a source/ resource for cure to treatable disease?"

Health care is also as old as mankind. Health to a large extent is shaped by medical, social economic and political influences. Building health on the basis of any one of these components will be a unidirectional and cannot be claimed as holistic. The question on how these components are a part of health needs to be answered.

Describing health as social economical cultural and political wellbeing is to be based on what happens to an individual and communities and how the components like

- society,
- finance,
- services and

- policies

shape health. The simple way is to relate above components to life of an individual, let me start of with my own experiences and then relate it to community.

Relating individual and Communities

I graduated in February 2005, like every other graduate, I also had to find ways to earn and survive. I need to earn through a job, survive /coexist with my friends and family depend on the services offered through government and private setups for my basic needs of food water and shelter. The availability and access of such services are dependent on the policies of government. While affordability and feasibility is dependent on my individual capacity, which relates my earning and what influences me to avail such services.

Taking health as a resource for a sustainable living, my access to basic human needs is important for *"socially and economically productive life"(6)* this again is shaped by government policies debated and approved through the elected representatives of people.

For an individual born in a country he has some basic human liberties to lead a life and achieve what he sets for himself as a goal for life of people. The article 25 (1) of the universal declaration of human rights states that *"every one has the right to a standard of living adequate for the health and wellbeing of himself and his family"* the objective is to recognise that an individual has sufficient and necessary means to right to life, liberty and security. (7)

"The concept of a right relates to the freedom from interference by other individuals or the government. Individual rights refer to the liberties of each individual to pursue life and goals without interference from other individuals or the government. Examples of individual rights include the right to life, liberty and the pursuit of happiness as stated in the constitution of India".

A community is a group of people with common interests and values. Community is characterized by "wholeness incorporating diversity" and may include people of different ages, ethnicities, educational backgrounds and incomes. Individuals may be members of two or more communities; for example, one of geographic residence and another of employment.

Community responsibilities are an individual's duties or obligations to the community and include cooperation, respect and participation. The concept goes beyond thinking and acting as individuals to common beliefs about shared interests and life. A basic community responsibility is to participate in the process which define the services which are being made available to them". (8)

Looking at things from a balloonist view health can be represented as a combination of medical, social, economical and political concepts. These concepts have to

interact with each other adding new dimensions. However health can also be envisaged from different dimensions, one realizes that, they function and interact with each other at various levels and have their own natures and have to be treated with integration.

The social component:

This relates to understanding of health status through,

- Social inequities in health through class and caste barriers
- Availability and accessibility to basic human needs,
- Deprivation of resource
- Gender barriers to access, availability and utilization of health services
- Conflict and violence etc.

These are also called the broader social determinates of health which have been studied and popularised to promote a better health for communities. An understanding of health from this concept is to understand the basic barriers for service outreach and achieving the goal for a health for all, which in true sense means reduction of poverty and better environment for achieving a positive state of health.

The economic component:

John W. Lynch traces the development of research on income distribution and health to the most recent epidemiologic studies from the USA that show how income inequality is related to age- adjusted mortality within the 50 States. (r = -0.62, p = 0.0001) even after accounting for absolute levels of income. (9) at the same time other study reveals

- Income inequality has generally been associated with differences in health
- A psychosocial interpretation of health inequalities, in terms of perceptions of relative disadvantage and the psychological consequences of inequality, raises several conceptual and empirical problems
- Income inequality is accompanied by many differences in conditions of life at the individual and population levels, which may adversely influence health
- Interpretation of links between income inequality and health must begin with the structural causes of inequalities, and not just focus on perceptions of that inequality
- Reducing health inequalities and improving public health in the 21st century requires strategic investment in neo-material conditions via more equitable distribution of public and private resources. (10)

The Political Component:

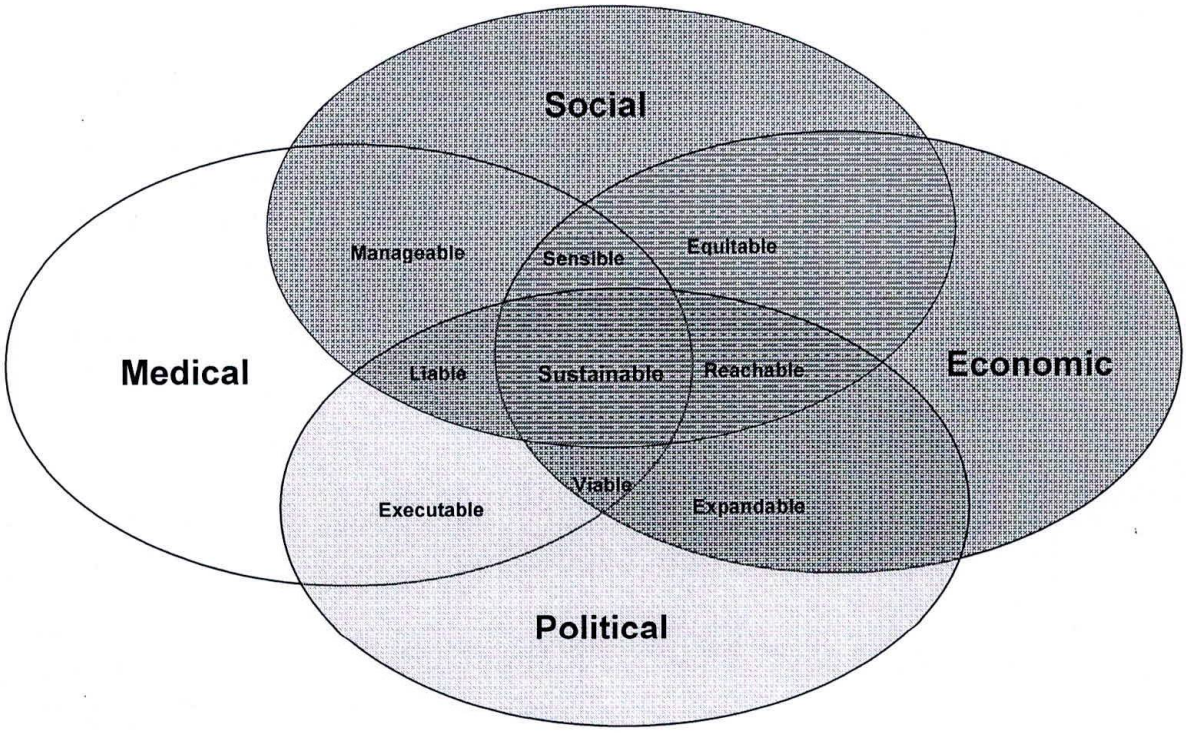
A programme and existing structures on health are shaped and reformed through the policies. Translation of appropriate research findings to policy is projected as a need for reforming health sector. In this context the definition of the term appropriate plays an important role, the term appropriate should comprehensively include basic principles of primary health care. Policies should be drawn to understand that social and political reforms as a base to understand the health care needs of population

"Health research that contributes to large-scale socio-political change may require more methodological pluralism and greater focus on key institutional structures. Case studies reviewed suggest that dissemination is enhanced if researchers involve managers and policy-makers in the development of the framework for and focus of research and if investigators assume a responsibility for seeing their research translated into policy. Clear research findings are not always a passport to policy, but researchers can reframe the way health policy issues are seen, and collaboration with policy-makers initially can enhance implementation" (11)

The medical component:

This refers to community outreach, through programmes and existing health care delivery systems. The delivery is measured in terms of targets and coverage but importance has to be given for humanness in services and measuring the deliverables. The Component of funding which creates financial dependencies must be oriented towards empowerment and self sustainability which in true sense promote freedom. Empowerment seems to be commonly word but there is no accepted definition of this term. The understanding empowerment as an impact and searching means and ways to measure empowerment in terms of health is very important. A study on attitude of patient towards services and doctors need to be identified to promote better access and utilization of health services. (12)

Understanding the inter phase of various dimensions



Health on Interpahse of various components

Source: This modified Model taken from http://en.wikipedia.org/wiki/sustainable development

This is based on my limited understanding of above components, and the assessing the positive sides on inter-phase keeping health as a central theme, this is just a concept for the vindication of above issues in terms of health. The impression is to understand health which can be sustainable, trying to project other possibilities of componential integration in fractions.

Health can be sustainable on proper inter-phase/ inter-linkage, of all four components. By sustenance I mean, to keep in a condition of good efficiency, or use. (13)

On combination of political, economic, and medical components, health becomes Capable of occurring or being done. i.e. Viable (14)

On combination of social, economic, and medical components, health progresses towards showing good sense or sound judgment i.e., sensible (15)

On combination of social and economic components health will be characterised by fairness, (fair to all parties as dictated by reason and conscience) i.e. equity (16)

Health can succeed in accomplishing goals, in combination with medical and social factors. i.e. manageable(17)

Health can stretch or hold out if combined with social, economic and political power. i.e it can be made more reachable. (18)

Health can increase in extent, size, volume and scope, if combined with economic and political factors. i.e. it becomes expandable. (19)

Accomplishing something, as an assigned task is possible when medicinal and political factors come together. i.e. to say executable. (20)

Legal obligation or responsibility can be added to health on the combination of medical, social and political factors. (21)

Understanding responsibilities for health

It has been established that health is right and also responsibility. It becomes important to distinguish between social responsibilities and personal responsibility. Thinking of protecting health and improve it becomes more important to treat the underlying cause of the disease and also legal responsibilities of the government.

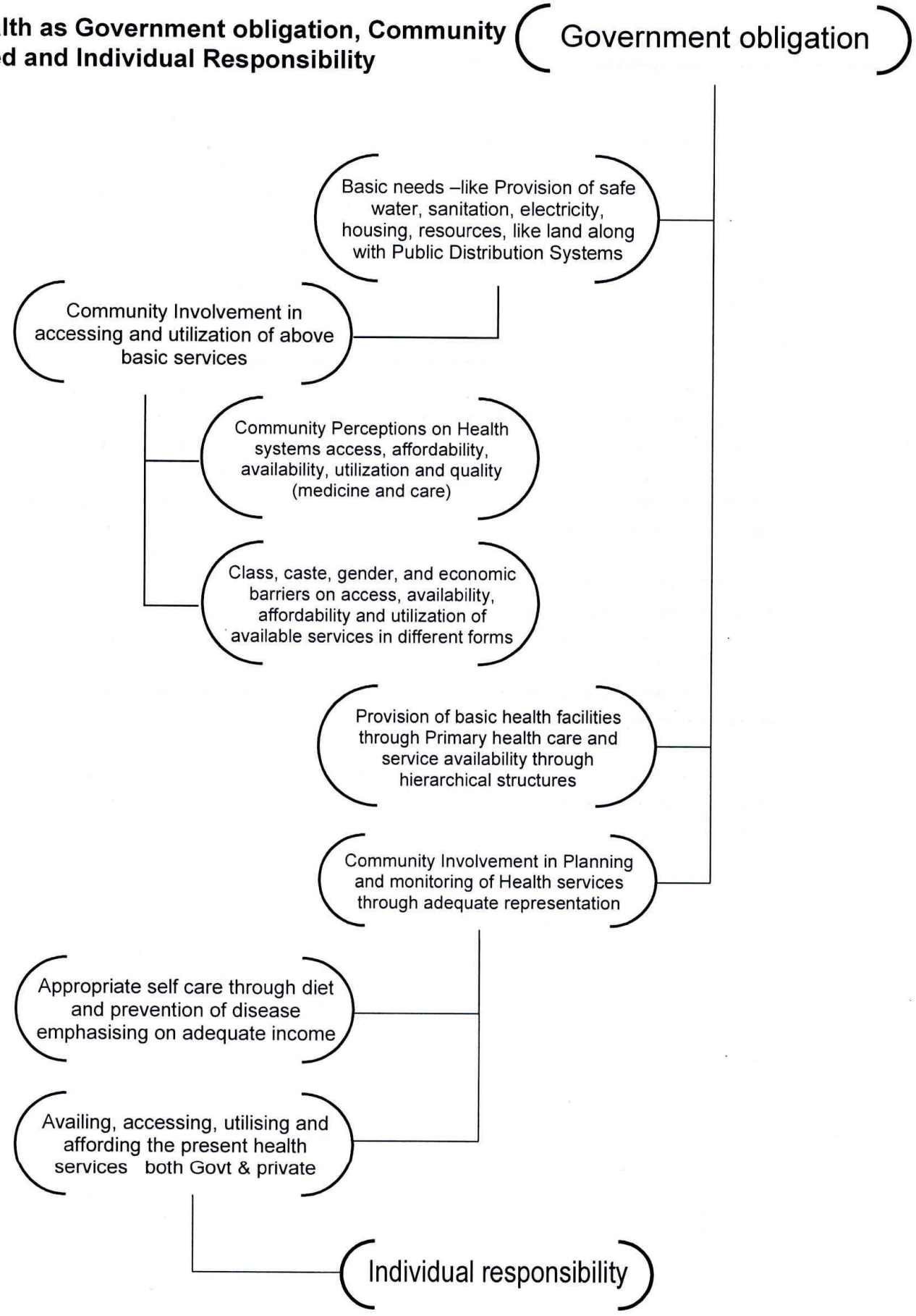
The preamble to WHO constitution also affirms that, one of the fundamental rights of every human being to enjoy "the highest attainable standard of health". The concept of right to health has generated so many questions viz. right to medical care, right to responsibility for health, right to food, right to healthy environment, right to procreate

(artificial insemination, family planning, sterilization, legal abortion), rights of the diseased person right to die (suicide, hunger strike, discontinuation of life support measures') etc. many of these are debatable and it is left to lawyers , ethicists and physicians to formulate a general outline of what's acceptable in the human society.

Right to health has been held by Supreme Court as integral to the right to life guaranteed by article 21 of constitution. The constitution of India provides that health is a social responsibility, and can be found in the directive principles of state policy. Health to a large extent left to states. The main legislative entry relating to public health is state list entry 6 which reads as '' public health and sanitation; hospitals and dispensaries''. Entry 29 ''prevention of extension from one state to other of infectious or contagious diseases or pests affecting men animal or pests,'' takes care of interstate element in public health. Entry 30 covers the vital statistics including the birth and death. As regards to the duty of state in matter of public health, the Supreme Court has held that "attending to public heath is one fourth of high priority, perhaps the one at the top" (22)

A community has its own societal mechanism or ways in which the relationship is structured and they would have developed systems which would have enabled them to efficiently deal with the health problems they face. Therefore it must be presumed that people naturally enjoy a sate of positive health. In addition to this the element of equity should be considered. The equity should in terms of highest possible level of health by all
people, and it is the obligation of the state to act and ensure the same access to people, even if that involves prohibiting certain people from accessing certain facilities.

Health as Government obligation, Community Need and Individual Responsibility



India has adapted the Declaration of Alma Atta and is committed to the concept of "*health for all*" and to that of positive health. The valuation and description of the systems of protection used by the state/ organizations and also the study of means implemented by the individual under the frame work of the system demands the undertaking on a large scale. The term "*Health Legislation*" is used to identify the standard that defines legal frame work on these issues.

Health in one hand is a highly personal responsibility and on the other hand a major public concern, thus it involves the joint effort of the individual, the community and the state to protect and promote health. At an individual level; health is often taken as granted and its value is not understood until it's lost. The existing laws govern the implementation of health care at different levels and its maintenance. The meaning of personal responsibility for health is to be understood from a historical context and as a cultural perspective. A frame work on standard of living and quality of life is to be considered for the better implementation and maintenance of existing system.

Combining all the above It I have put together my perspective on health as a collective responsibility of Government, community and individual. This is just an idea and does not involve the exact identification of roles and responsibilities, criteria for involvement/ intervention etc. These are huge questions which are in search of answers, contextual or universal, which are to be based on the evidence gathered in particular context.

In the end Ideas my be exceptional but requires frame work for implementation, given a chance I wish to study the context of health based on perception of communities, and prioritization of needs and explain it.

Reviving the knowledge and documentation on Herbal medicine practices of Health workers at Jagrutha Mahila Samghatana, Potanal, Raichur.

1. The Background

1.1. This protocol is a result of the group discussion with the health workers of Jagrutha Mahila Samghatana Potanal Raichur, during my visit to Potanal, Raichur, on 31 March- 3 April 2008.

1.2 The participant's in the discussions, were women representatives of JMS (Jagrutha Mahila Samghatana) an NGO working on the "Social and Political empowerment of Dalith women", Herbal practice on local health care needs and few selected disease is one of the off shoot of the Ngo Activities. The health workers have received training on the utilization of herbs as a resource for health care needs, and have been successful in implementing the training into practice since last four years.

1.3. There are 14 health workers; the women run a clinic which on every Thursday where in they interact with people and prescribe treatment according to the condition approached. There are case studies on Paralysis and numerous cases of vitiligo/lukoderma; overall it is envisaged to have a primary health care using the local available resource in the surrounding areas, so as to cater for the local needs of the population.

1.4. The recommendations and conceptualised work plan envisaged in this protocol is in line with giving them a frame work which will enhance the practice.

1.5. We as a group shared our background, experiences and our own perspectives on the use of herbal medicine. The outcome was to have a framework for safeguarding and enhancing the present knowledge.

1.6. The idea is to work on the existing herbal practices and have documentation base which will enhance the present understanding and learn on how knowledge on the use of herbs can contribute at a primary level. At the same time see how these processes relate to "Social and Political empowerment of Dalith women" at a later stage.

1.7. We looked at three major areas –

- Documentation of existing practices and herbal repository. Documentation will include the literature survey for the formulations that are being utilised, from various Ayurveda texts, which will serve as basic criteria on safety and efficacy of the formulation in use. Details are to be worked out.

- Formation of a repository which will be basically herbarium sheets- so as to enhance the knowledge on the identification of herbs and its habitat.
- Training on the compiled data so that they understand the methods and perspectives with its value.

1.8. I felt that first step would be to learn the method of using herbs for health care. The intent is to strengthen the existing practice.

2. The rationale

2.1 **Traditional knowledge on herbs** generally refers to the long-standing herbal practices for certain diseases at a personal or community level. This knowledge has been transferred orally from one generation to the other. Some of the health practices are expressed through songs.

2.2. Traditional knowledge in herbal medicines generated through years of observation and monitoring is specific to different regional locations and is being carried out generations after generation through verbal communication, some of the characteristics associated with herbal/traditional medicine's are

- Based on belief and empirical evidence of, cure safety and efficacy, and the quality of drugs often not well known. V/S scientific proof and clearly demonstrated cure, efficacy and safety and quality.
- High accessibility to individuals and community.
- High acceptance based on understanding by communities in both rural and urban settings.
- High affordability as it is locally available and cheap.
- Reputation and credibility spread on mouth to mouth basis from individual and community experience.
- Perception not specified or restricted and can be provided by any body at any level including house holds. (23)

2.3. This form of knowledge is not recognised as science as it is combined with beliefs values and practices. This form of knowledge is generally based on the community interest for survival e.g. the various practices like modification of diet as per season to meet the nutritional demands.

2.4. Traditional knowledge on herbs is generally embedded with spirituality, destiny, and cosmic influences. Misappropriation / misuse of knowledge are considered to be offensive. Much of the emphasis is being laid down on custodianship and guidelines for useage of knowledge.

2.5. Herbal medicines have been utilised since age old times, efforts to rationalise the use of herbal medicines the legislative/ regulatory control, together with the quality control (both raw materials and finished) are still to be exercised in domestic level. The issues around the utilization of herbs for health care are;

Who will provide the medicines? How will these be obtained and where will they be stored?

2.6. Interestingly, much of the scientific literature for TM/CAM uses methodologies comparable to those used to support many modern surgical procedures: individual case reports and patient series, with no control or even comparison group. (24)

2.7. Herbal medicine is a form of therapy that uses plants or plant extracts to treat illness, and is an important part of keeping/ maintaining health. There fore herbs have been utilized in variety of ways for the benefit of mankind. Indian subcontinent represents one of the greatest empires of ethno-botanical wealth, well-recorded and well practiced knowledge of traditional herbal medicine. The basic requirements include,

- Well-documented traditional use,
- Single plant medicines with standard treatment guidelines
- Safety and efficacy.

Scientifically documenting the use of herbal medicine will project herbal medicine in a proper perspective and help in sustained use of health care.

2.8. "Clearly, a part of informed self-care is knowing one's own limits and guidelines should include not only for what to do, but for when to seek help" (25). Therefore it can be projected that use of herbal medicine with proper knowledge on safety efficacy and guidance for use can be an effective tool towards the implementation of herbs in health care.

3.1. An overview of the health workers situation at Potanal

3.1. A. Community Health worker:

"There is no single accepted definition of a community health worker or of any of the other titles commonly applied to lay health providers. We define community health workers broadly as community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs".(26)

The essential part of this work is to help identify the community health workers need and help them identify their own needs and implement their own solutions. There is limited documentation on the number, use, and scope of utilization of herbal medicines initiated at Potanal.

3.1. A. 1. Contributions of health workers:

The contributions of health workers can be assessed based on the existing set of objectives (Objectives of health workers initiation) and the tools of assessment which are;

3.1. A. 1. a. Increasing access to health care:

As Dalith women they are translating the herbal health/disease practices to community benefit through outreach on specific disease curative services. The need is to evaluate such practices in comparison with village health services. (Appendix-1) This will help in the assessing the health care option provided by health workers and also expand the outreach. Eg. The use of calotropis gigantica for head ache by the health workers.

3.1. A. 1. b. Reducing the cost of health care.

In concept the community health workers will help in reducing the cost of health care. At Potanal herbal medicine initiative is not only a process for social empowerment through voluntarism but also a source of supporting lively hood. However these services have potential cost reduction factors in comparison with other health services and also reduce the unnecessary dependence on health services. (Appendix-2)

3.1. A. 1. c. Social contribution

In addition to their role as health workers the JMS women also take up other social issues like promoting the network of Self help group (SHG) which encourage the

promotion of social wellbeing and aiming to meet basic needs of human life which are quite a challenge in itself for the marginalised groups. (Appendix-3)

JMS carries out its activities at four different areas the above assessment will cover 4 villages (NSEW) of four focal centers. The Survey will cover opinions from different communities of the village (a set of 6 from each village).

3.2. Expanding the knowledge and utilization of herbal practices for health workers

The benefit of herbal health practices for the poor and marginalised has not been prioritised due to lack of universalised standard definition and conceptualization of such practices through health workers and legal barriers for such an initiative. Defining the problem may help to a certain extent but there need for a consensus for such definition from an operational/utilization point of view?

The concern on quality of care imposed by professionalism and also the legitimacy of such practices through the health providers (health workers) the availability affordability and accessibility to resources need to be answered. The training provided on the above issues and accreditation of such process will determine the legitimacy of such practices.

"Legislation against unlicensed practice, cross-practice (practice using medications, treatments in which one is not trained) exists. However, it would seem legislators and health ministries must again address the ethical question of licensing, certification and other regulatory measures regarding medical practitioners in order to ensure the safety of the patient in search of health care". (27)

The evaluation, experience sharing, continued training and establishing the referral systems are the need for sustainability of such initiatives, which helps in developing accountability and information sharing with the community.

3.2. A. Recommendations for expanding the knowledge and utilization of herbal practices for health workers.

The existing practice at Potanal provides an opportunity to understand and experience the utilization of herbal medicine at a community level. The recommendations provided are in directions to acknowledge the existence along with insights to provide an evidence base for such practices.

3.2. A. 1. Technical assistance for information sharing.

There is a limited documentation of herbal medicine practice at Potanal. As an initial step there is a need to sort information numbers of various conditions treated with a specific remedy. The intent is to identify the local responsiveness of the health

workers to the health care needs which the community seek out in correlation with the assessment of Appendices 1-3.

3.2. A. 2. Assessment of existing knowledge.

The assessment of knowledge will be based on the documentation of health worker in increasing access to health care, reducing the cost of health care and social contribution. The purpose is to clearly define / envisage the role of health workers in above context with an assessment of their knowledge in terms of health and disease. The focus is to get do some basic research involving the community health workers.

3.2. A. 3. Training on health and disease.

As an essential part training on health and prioritised disease condition emphasising on practical application of obtained knowledge is required. This can provide an advocacy basis for legitimization more over it presents with opportunities to foster and establish the herbal practices.

3.2. A. 4. Maintain the Quality of medicine.

This process is to have an assurance on the basic question pertaining to herbal medicine viz. how the herb is collected. How are the medicines prepared from the collected herbs? How are they being stored and dispensed?. Quality in itself is huge, the idea is to engage quality in terms of procurement, cleanliness, preparation and storage in compliance with classical Ayurveda text references.

3.2. A. 5. Community level Initiative

The term community level initiative refers to initiation of herbal intervention through health workers for common ailments. The intervention will be based on simple formulation involving a maximum of 3 herbs, priority will be given to use of single herbs. At the same time the emphasis will also be given to establishment of referral systems. At the same time it is also necessary to give an understanding of limitations of herbal medicines, building on the existing strength.

The community level planning, task allocation and implementation of herbal intervention for health care will be based on the assessment carried out during the first phase of the programme. Such initiative is already in place, the intent is to establish the centralised data collection systems which will serve as a data base to review and report the coverage and utility on herbal practices for health care.

3.2. A. 5.1. Basis of recommendations for community level initiative.

Based on the earlier recommendations for herbal health practices it is necessary to prioritise the entry points to such an initiative. In broad terms it can be mentioned as primary health care initiative, as the health workers of the organization are also

involved in the social empowerment of Dalith women. However the aspects of primary health care can be termed as componential as the focus is only on social empowerment and support of lively hood through other initiatives. Therefore the focus should be to initiate the comprehensive model stressing on the community level initiative. The efforts are required to incorporate the social interest in prevention of disease and utilization of locally available herbs for such interests.

The interest should not be limited in terms of herbal intervention for disease prevention and promotion of health, but also screening and control of diseases, through epidemiological inputs.

There are numerous disease care centres (both government and non government including private) which are in place, therefore it becomes necessary to participate in processes and programmes of the existing structures and also utilise the available services rather than creating an alternative.

In creating an approach towards utilization of local herbal resources for disease prevention and promotion of health, the knowledge base in the form of Ayurveda should be demystified and incorporated. The out reach should be designed incorporating life style theory for disease causation along with environmental dimension. This approach may sound like individual focus, the argument is, it provides behavioural changes in form of better life style with adequate sensitivity to surrounding environment. This will supposedly have a minimal impact on health.

In planning any initiative one should be clear about the outcomes and its impact on people which is dependent on sustainability of inputs. Incorporating the above duality it can be proposed that herbal interventions for health should also envisage the true paradigm of health which includes (in line with dominant paradigm. ie., Medical intervention as health) the direct and indirect effects of disease causation broadly termed as S.E.P.C.E.

Since it is still in the initial stage the focus will be to initiate herbal interventions on common ailments, stressing on reduction of symptoms with in 48 hrs of intervention on establishment of referral systems for further disease management.

The objective is to have an out reach through simple cost effective, safe and efficacious interventions through health worker so as to cater the health care needs of the community. Once the systems are established next step is information sharing among the community about the specific practices and will be phased out to community to establish and sustain it.

3.3. Summing up

'The community health workers have an important role to play in the' efficient functioning of health care systems. They encourage 'preventive and primary care, and accommodate previously underserved populations'. Supporting and

strengthening existing programs, and broad dissemination of the capabilities to community health workers are needed to expand their 'recognition' as 'integral members of the health care work force'. (26)

Social and political reforms

At Potanal I see Women organising themselves to challenge the oppression by the upper cast and every activity they do is for their betterment which intern helps to get a social status on a longer run there by commanding respect for themselves and denouncing the exploitation.

At the same time the Activities of NJMO reflect much of a political reforms where in they say we are socially backward group which needs a revival in assuring the availability of basic human services and ask for system change ie. More related to political change

Overall these two group do both the things I see more of a social orientation with women of Potanal and political orientation with women of NJMO, it may be too a unfair conclusion but its out of gut feeling.

The evidence in the form of my interaction with JMS women and Communities on a deep analysis has led me towards understanding the social forms

These processes are interdependent and cannot be separated from each other in the context of development of marginalised. There has to be both the reforms, which run parallel so that the basic human needs can be fulfilled,

Recognising social reforms

The argument put forth in Annihilation of cast, that without social efficiency, no permanent progress in the other fields of activity was possible; The struggle put forth by Raja Ram Mohan Roy, Bal Gangadharnath Tialk and Others to reform the society of its evil customs should not me limited to a class or caste if such reforms are brought to marginalised and resource less communities they will have a better life which in turn contributes to a health and prosperous nation.

Here the social reforms for marginalised means a better equal opportunity and a social status considering them equal as human being and not to distinguish on caste as upper and lower caste allowing them to access all resources. **"Basic requirement is to treat them as human beings".**

Recognising Political reforms

The Idea of Government through democracy which is representative in our country is to provide people with basic amenities of life. Every citizen pays tax directly and

indirectly to the government, which asks for accountability forms them. Even the representatives of people are given honorarium for their services to the community.

This call in for more demand for basic needs of food shelter and employment. These structures may not hold good for people with resources as they have self sufficient means to survive and get along with life in a hassle free way. At the same time people with out resources who become heavily dependent on the services of the government suffer a lot it may affect people with comparatively less resources but the impact of such services availability and accessibility is not being emphasised and some times subjected to oppression.

Why do people go to streets and demonstrate against government. Its not because they are paid to do it, it happens as there is no other way to do it, and if you ask me that's the last option people have to make their voices recognised.

Its not all who participate in a demonstration but people who come and demand on streets become opponents and who simply do it with out any other thing become people with simplicity and should be supported.

Given this situation who is to take responsibility? Peoples representative, communities leaders who? Its just like asking who should be given the responsibility of health? As explained earlier it's a collective responsibility of all the people and should be made aware of role and responsibilities.

Health and Human Rights an approach for improving population health.

The views expressed are based on the reflections through participation and little reading. Here I have tried to understand why this new interest has approached.

Health as human right refers enforceable claims against the state.

Adding this frame work will actualize the principle of equity

For a socially disable/marginalized group it becomes important to possess the resources which will guarantee them of basic needs. It also means a stable life them, so they emphasize more on resources, in the form of better income, better house to live better etc.

But one should not forget that it's easy to demand but difficult to produce them. Health as a human right should reinforce the basic amenities of life and then create equitable access to health care by people.

The most important aspect is to consider the legal obligation of this framework. In A.S. Mittal vs.state of U.P. and Others SC/0004/1989

The Lions Club at a pottery Town at Khurja in Uttar Pradesh arranged and conducted, an "Eye-Camp" intended to extend facilities of expert Ophthalmic surgical services to the

residents of the town. This was a part of its social service programme, The Club invited Dr. R.M. Sahay of the Sahay Hospital, Jaipur and his team of doctors to offer the surgical services. 21st April, 1986, examined about 122 patients. One hundred and eight patients were operated upon, 88 of them for Cataract which, with the modern advances in Ophthalma Surgery, is considered a relatively minor and low-risk surgery.

The operated-eyes of the petients were irreversibly damaged, owing to a post- operative interaction of the Intra Ocular Cavities of the operated eyes. It is now undisputed that this terrible medical mishap was due to a common contaminating source. The suggestion in the Report of the enquiries that ensued is that, in all probability, the source of the infection, referred to as E coli infection of the intra ocular cavity, was the "normal saline" used of the eyes at the time of surgery.

Dr. Sahay admitted the unfortunate event which he called a "Mishap" : Senior Counsel appearing for the State of Uttar Pradesh, submitted that the State would approach the matter not with the spirit of a litigant in any adversary action but would look upon the proceedings as a participatory exploration for relief to the victims. He further submitted that the State would indeed, be willing to render help to the victims within the constraints of its resources. Relief of 12,500/- was offered to victims.

On the basis of law can one argue that a person's right to health is violated if that person health/ organ gets deteriorated? The court stressed on guidelines for operationalizing such things. The court also gives appropriate reasons to consider humanitarian grounds. Should on take this as an example for adhering to guidelines and following it with human ness.

Smt. Santara Had to wait till 2000 April to get relief (complaint filed in 1989) from the state for doctors negligence, are courts the place to decide personal agonizing and medical problems?

On one side person does not have sufficient resources herself to pay for the services on the contrary state claims that it does not have sufficient resources to pay for the necessary services.

Conclusion

- Recognizing health as a social and political issue can strengthen the Primary health care and adding in human rights will promote equity.
- Strengthening and utilizing the existing government services can potentially be an effective method of improving access to health care.
- Monitoring and reporting the process of health care services will strengthen the government.

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