

Why I Joined CHLP Fellowship

ನಾನು ಮೂಲಕ ಗುಲ್ಬರ್ಗಾ ಜಿಲ್ಲೆಗೆ ಸೇರಿದ್ದು ಅದು ಕರ್ನಾಟಕದ ಹಿಂದುಳಿದ & ದುರ್ಬಲ ವ್ಯವಸ್ಥೆ ಇರುವ ಜಿಲ್ಲೆಯಾಗಿದ್ದು, ಹಲವು ಸಮಸ್ಯೆ ತಾಣವಾಗಿದ್ದು, ಇಲ್ಲಿನ ಆರೋಗ್ಯದ ಬಗ್ಗೆ ಇರುವಂತಹ ಜನರಲ್ಲಿರುವ ಮನೋಭಾವನೆಯನ್ನು ತಿಳಿದುಕೊಂಡು ಸಮುದಾಯ ಮತ್ತು ಸಮುದಾಯದ ಆರೋಗ್ಯವನ್ನು ಉತ್ತಮ ಪಡಿಸುವುದು ನನ್ನ ಮೂಲ ಉದ್ದೇಶವಾಗಿದೆ.

ನನಗೆ ಮೊದಲಿಂದಲೂ ಶಿಕ್ಷಣ ಕ್ಷೇತ್ರದಲ್ಲಿ ಆಸಕ್ತಿ ಇದ್ದ ಕಾರಣ ನನ್ನ ಮನಸ್ಸು ಹಲವಾರು ವಿಷಯಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳುವುದರ ಜೊತೆಗೆ ನನ್ನಲ್ಲಿ ಹಲವಾರು ಬದಲಾವಣೆಗೆ ಕಾರಣವಾಯಿತು ಆ ಬದಲಾವಣೆಗಳಿಂದ ನನ್ನಲ್ಲಿ ಇರುವಂತಹ ಜನರ ಬಗ್ಗೆ ಕಾಳಜಿ ಮತ್ತು ಜನರಲ್ಲಿರುವ ಹಲವಾರು ತೊಂದರೆಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳುವುದು ಜೊತೆಗೆ ನನ್ನನ್ನು ಸಮಾಜ ಸೇವೆಯತ್ತ ನಡೆಯುವಂತೆ ಮಾಡಿತ್ತು.

ಇಲ್ಲಿ ಬರುವ ಮುಂಚೆ ನನಗೆ ಸಮುದಾಯ ಅಥವಾ ಸಮುದಾಯ ಆರೋಗ್ಯ ಮತ್ತು ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಪಾಲನೆ ಇದು ಯಾವುದರ ಬಗ್ಗೆಯೂ ನನಗೆ ಅಷ್ಟು ತಿಳಿದಿರಲಿಲ್ಲ.

ಸಮುದಾಯ ಆರೋಗ್ಯ ಏನು ಮಾಡುತ್ತದೆ ಯಾವ ರೀತಿಯಿಂದ ಕಾರ್ಯ ನಿರ್ವಹಿಸುತ್ತದೆ ಮತ್ತು ಯಾವ ಅಂಶಗಳನ್ನು ಹೊಂದಿರುತ್ತದೆ, ಅದರಲ್ಲಿರುವ ತೊಂದರೆಗಳನ್ನು ತಿಳಿದುಕೊಂಡು ಯಾವ ರೀತಿಯಿಂದ ಪರಿಹರಿಸಬಹುದು ಮತ್ತು ಸಮುದಾಯ ಆರೋಗ್ಯದಲ್ಲಿ ಜನರ ಪಾತ್ರ ಏನಾಗಿರುತ್ತದೆ ಎಂದು ತಿಳಿದುಕೊಳ್ಳಲು ನನ್ನಲ್ಲಿ ಆಸಕ್ತಿಯಿದ್ದ ಕಾರಣ ಸಮುದಾಯ ಆರೋಗ್ಯ ಕಲಿಕೆಯ ಕಾರ್ಯದಲ್ಲಿ ತೊಡಗಿಸಿಕೊಂಡೆ.

Learning Objectives

ನಾನು ಪರಿಸರ ಬಗ್ಗೆ ಆಸಕ್ತಿಯಿದ್ದ ಕಾರಣ ಪರಿಸರ ವಿಜ್ಞಾನದಲ್ಲಿ ಸ್ನಾತಕೋತ್ತರ ಪದವಿಯನ್ನು ಪಡೆದುಕೊಂಡ ಕಾರಣ ನನಗೆ ಪರಿಸರಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟ ಕಾರ್ಯಗಳನ್ನು ಮಾಡಲು ನನಗೆ ಖುಷಿಕೊಡುತ್ತಿತ್ತು.

- ಪರಿಸರಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟ ವಿಷಯಗಳನ್ನು ತಿಳಿದುಕೊಂಡು ಅವುಗಳನ್ನು ಸರಿಪಡಿಸುವುದು.
- ಸಾವಯವ ಕೃಷಿ ಮತ್ತು ಸಮತೋಲನತೆಯ ಅಭಿವೃದ್ಧಿಯನ್ನು ತಿಳಿದುಕೊಳ್ಳುವುದು.
- ಸಮುದಾಯ ಮತ್ತು ಸಮುದಾಯ ಆರೋಗ್ಯದ ಸಮಸ್ಯೆಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳುವುದು.
- ಸಂಶೋಧನಾ ಕ್ಷೇತ್ರದಲ್ಲಿ ನನ್ನನ್ನು ಆಳವಾಗಿ ತೊಡಗಿಸಿಕೊಳ್ಳುವುದು.

Introduction

ಆರೋಗ್ಯದ ಬಗ್ಗೆ ನನ್ನ ದೃಷ್ಟಿಕೋನ

ಈ ಮೊದಲು ಅಂದರೆ ಸಮುದಾಯ ಆರೋಗ್ಯ ಕಲಿಕೆಯ ಕಾರ್ಯಕ್ರಮವನ್ನು ಸೇರುವ ಮೊದಲು ನನಗೆ ಯಾವುದೇ ರೀತಿಯಾದ ಮತ್ತು ಆರೋಗ್ಯ ಮಾಹಿತಿಗಳ ಬಗ್ಗೆ ತಿಳಿದಿರಲಿಲ್ಲ, ಆರೋಗ್ಯ ಅಂದರೆ

ಆಸ್ಪತ್ರೆಯದಾರಿತ ಚಿಕಿತ್ಸೆ ಪದ್ಧತಿ ಒರೆತು ಯಾವುದೇ ಮುನ್ಸೂಚನೆ ಕ್ರಮಗಳನ್ನು ಅನುಸರಿಸುವುದು ತಿಳಿದಿರಲಿಲ್ಲ.

ಸಮುದಾಯ ಆರೋಗ್ಯ ಕೋಶದ Community Health Learning Program ಬಂದು ಸೇರಿಕೊಂಡ ಮೇಲೆ ಆರೋಗ್ಯವು ಎಲ್ಲರ ಹಕ್ಕು, ಅದನ್ನು ವೈದ್ಯಕೀಯ ದೃಷ್ಟಿಕೋನದಿಂದ ನೋಡುವುದು ಅದು ನಮ್ಮ ಕಲ್ಪನೆ, ಒಬ್ಬ ಸಮಾಜ ಸೇವಕನ್ನು ಕೂಡಾ ಆರೋಗ್ಯದ ಮಾಹಿತಿಯನ್ನು ತಿಳಿದುಕೊಂಡು ತನ್ನಲ್ಲಿ ಮತ್ತು ಇತರರಲ್ಲಿ ಬದಲಾವಣೆಗಳನ್ನು ಮಾಡಬಹುದಾಗಿದೆ.

ಆರೋಗ್ಯವನ್ನು ಹಲವಾರು ವೈದ್ಯಕೀಯ ದೃಷ್ಟಿಕೋನದಿಂದ ನೋಡದೇ ಹಲವಾರು ದೃಷ್ಟಿಕೋನದಿಂದ ಅಳಿಬಹುದಾಗಿದೆ. ಉದಾ:- ಸಾಮಾಜಿಕವಾಗಿ, ಪರಿಸರಾತ್ಮಕವಾಗಿ, ಸಂಸ್ಕೃತಿಕವಾಗಿ, ಮೂಡನಂಬಿಕೆಗಳಿಂದಾಗಿ ಸರಿಯಾಗಿ ಮಾಹಿತಿಯನ್ನು ತಿಳಿದುಕೊಂಡಿರದೆ, ಆರೋಗ್ಯದ ಮೇಲೆ ಪ್ರಭಾವ ಬೀರುವ ಅಂಶಗಳಾಗಿವೆ.

ಸಮುದಾಯದ ಆರೋಗ್ಯದ ಬಗ್ಗೆ ನನ್ನ ದೃಷ್ಟಿಕೋನ

ಸಮುದಾಯದ ಆರೋಗ್ಯದಲ್ಲಿ ಜನರ ಪಾತ್ರವೇನು, ಮತ್ತು ಪ್ರತಿ ಸಮುದಾಯ ತನ್ನದೇ ಆದ ಆಚಾರ, ವಿಚಾರ, ಸಂಸ್ಕೃತಿ, ಹಿನ್ನೆತೆಯನ್ನು ಹೊಂದಿರುತ್ತದೆ. ಆರೋಗ್ಯಕರ ಸಮುದಾಯವನ್ನು ಸೃಷ್ಟಿಸಲು ಹಲವಾರು ಅಂಶಗಳು ಒಳಗೊಂಡಿರುತ್ತದೆ. ಅದರಲ್ಲಿ ಮುಖ್ಯವಾಗಿ ಜನರ ಜೀವನ ಶೈಲಿ, ಕುಡಿಯುವ ನೀರು, ಪರಿಸರ, ತರಬೇತಿಗಳು, ವಸತಿ, ಮಾನಸಿಕ ಆರೋಗ್ಯ, ಧೂಮಪಾನ ಮತ್ತು ತಂಬಾಕು ಸೇವೆಯಿಂದಾಗುವ ದುಷ್ಪರಿಣಾಮಗಳು, ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಚಿಕಿತ್ಸೆ, ಜನಸಂಖ್ಯೆ, ಹವಾಮಾನ ಬದಲಾವಣೆ, ಅನಪೇಕ್ಷಿತ ಗರ್ಭಧಾರಣೆ, ಬಾಲ್ಯ ವಿವಾಹ, ಹೆಣ್ಣು ಭ್ರೂಣ ಹತ್ಯೆ ಜೀವ ಪದ್ಧತಿ ಬಗ್ಗೆ ಸಂಪೂರ್ಣವಾಗಿ ಮಾಹಿತಿಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳಲು ತರಗತಿಗಳು ಸಹಾಯವಾಯಿತು.

ಆಲ್ಟಾ ಆಟಾ ಹೊಂದಿರುವ ಆರೋಗ್ಯ ಅಂಶಗಳಾದ ಸಮತೆ, ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಅರಿವು, ಸಾಮಾಜಿಕ ಮತ್ತು ಆರ್ಥಿಕ ಧಾರಕಗಳು, ಆರೋಗ್ಯ ಒಂದು ಮಾನವ ಹಕ್ಕು. ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯದ ಪಾಲನೆ ಈ ಎಲ್ಲಾ ಅಂಶಗಳನ್ನು ಸರವಾಗಿ ತಿಳಿದುಕೊಳ್ಳಲು ಸಹಾಯಕವಾಗಿರುತ್ತದೆ.

Learning from collective Sessions

ನಾನು ಸಾಮೂಹಿಕ ಕಲಿಕಾ ಅವಧಿಯಲ್ಲಿ ನಡೆದ ತರಗತಿಗಳು ದಿನ ದಿನದಿಂದ ನಮ್ಮಲ್ಲಿ ಆಸಕ್ತಿಯನ್ನು ಹುಟ್ಟುವಂತೆ ಮಾಡುತ್ತಿದ್ದವು ಮಾನಸಿಕ ಆರೋಗ್ಯ, ಪರಿಸರ ಮತ್ತು ಸ್ವಚ್ಛತೆ, ಪರಿಸರ ಮಾಲಿನ್ಯ, ರಾಷ್ಟ್ರೀಯ ಗ್ರಾಮೀಣ ಆರೋಗ್ಯ ಅಭಿಯಾನ, ಪ್ರಸ್ತುತ ದಲ್ಲಿರುವ ಆರೋಗ್ಯದ ವ್ಯವಸ್ಥೆಯ ಮೇಲೆ ಜಾಗತಿಕರಣ, ಉದಾರೀಕರಣ, ಖಾಸಗೀಕರಣಗಳ ಪ್ರಭಾವ, ಧೂಮಪಾನ ಮತ್ತು ತಂಬಾಕು ಸೇವನೆ, ವೈದ್ಯಕೀಯ ಆಧಾರಿತ ಮತ್ತು ಸಾಮಾಜಿಕ ಆಧಾರಿತ ವ್ಯವಸ್ಥೆಯನ್ನು ಮತ್ತು ಅಸ್ವಸ್ಥೆಯ ಕಾರ್ಯವೈಖರಿಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳಲು ಸಹಾಯವಾಯಿತು.

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ಕಲಿಕೆಯಲ್ಲಿ ಮತ್ತು ಹಲವಾರು ವಿಷಯಗಳ ಚರ್ಚೆ ನಡೆಯುತ್ತಿದ್ದವು ಅವರಲ್ಲಿ ಎಲ್ಲರೂ ಭಾಗವಹಿಸುವಿಕೆ ಮುಖ್ಯವಾಗಿತ್ತು ಅಲ್ಲದೇ ಎಲ್ಲರೂ ಬೇರೆ ಬೇರೆ ರಾಜ್ಯಗಳಿಂದ ಅವರದೇ ಆದ

ಸಂಸ್ಕೃತಿಯನ್ನು ಹೊಂದಿದ್ದರು, ಅಲ್ಲದೇ ಎಲ್ಲರೂ ಒಂದೊಂದು ವಿಷಯದಲ್ಲಿ ಪರಿಣತಿಯನ್ನು ಹೊಂದಿದ್ದರು.

ಸಾಮೂಹಿಕ ಕಲಿಯುವ ಅವಧಿಯ ಹಲವಾರು ವಿಷಯಗಳು ಚರ್ಚೆಯಾಗುತ್ತಿದ್ದವು ಆದ್ದರಿಂದ ಹಲವಾರು ವಿಷಯಗಳನ್ನು ತಿಳಿಯುವಂತೆ ಮಾಡಿತು.

ಅವುಗಳಲ್ಲಿ ಮುಖ್ಯವಾಗಿ, ಆಶಾ ಸಮಾಜಸೇವಕಿಯರ ಪಾತ್ರ, ವಯಸ್ಕರ ಸಮಸ್ಯೆಗಳು, ಪೌಷ್ಟಿಕಾಂಶದ ಕೊರತೆ, ಹಲವಾರು ವಿಷಯಗಳು ತಿಳಿದುಕೊಳ್ಳುವ ಸಹಾಯವಾಗಿತ್ತು.

ಸಾಮೂಹಿಕ ಕಲಿಕೆಯ ಅವಧಿಯಲ್ಲಿ ವಿಶೇಷವಾದ ದೃಶ್ಯವಳಿಗಳ ನೈಜ ಚಿತ್ರಣ

ದೃಶ್ಯವಳಿಗಳ ನೈಜ ಚಿತ್ರಣಗಳ ಕಲಿಕೆಯು ಹಲವಾರು ಸಮಸ್ಯೆಗಳ ಸಂಗಮವಾಗಿತ್ತು ಅವುಗಳಲ್ಲಿ ಮುಖ್ಯವಾಗಿ ಮೂಡನಂಬಿಕೆಗಳ, ಆಚಾರ, ವಿಚಾರ, ಶಾಸ್ತ್ರ, ಸಂಪ್ರದಾಯ, ಎಂಬ ಹಲವಾರು ವಿಷಯಗಳಿಂದ ಹೆಣ್ಣಿನ ಮೇಲಾಗುವ ದೌರ್ಜನ್ಯ ಮತ್ತು ನಮ್ಮ ಸುತ್ತಮುತ್ತಲಿನ ಕತ್ತಲಿನ ಭಾಗವಾಗಿತ್ತು ಎಂದು ಹೇಳಬಹುದು.

“ರಾಮಕ್ಕ ಕಥೆಯಿಂದ” ಒಂದು ಊರಿಗೆ ಆಸ್ಪತ್ರೆಯ ಎಷ್ಟು ಮುಖ್ಯ ಬಡವರಿಗೆ ಯಾವ ರೀತಿಯ ಚಿಕಿತ್ಸಾ ಪದ್ಧತಿಯು ದೊರೆಯುತ್ತಿದೆ ಎಂದು ತಿಳಿದುಬಂದ ಸಂಗತಿಯಾಗಿತ್ತು.

Universal Health Coverage

ಈ ಒಂದು ದೃಶ್ಯವಳಿಯು ಹಲವಾರು ದೇಶಗಳ ಆರೋಗ್ಯದ ಯೋಜನೆಗಳು, ಖರ್ಚು ವೆಚ್ಚಗಳ, ಜನರ ಜೀವನ ಆರೋಗ್ಯಗಳ ತಿಳಿದುಕೊಳ್ಳಲಾಯಿತು.

ಲಾಲಪ್ಪನ ಕಥೆ

ಒಬ್ಬ ವ್ಯಕ್ತಿಯು ತನ್ನ ಜೀವನದಲ್ಲಿ ಆದ ಕೆಲವೊಂದು ಘಟನೆಗಳಿಂದ ತನ್ನ ಮನಸ್ಸಿನಲ್ಲಾಗುವ ಬದಲಾವಣೆಗಳು ಜೀವನದಲ್ಲಿ ಹಲವಾರು ತಿರುವುಗಳನ್ನು ಪಡೆದುಕೊಳ್ಳುತ್ತವೆ. ಅದರಿಂದ ಯಾವ ರೀತಿಯಾಗಿ ಹೊರಬಂದು ಸಮಾಜಕ್ಕೆ ಮಾದರಿಯಾದ ವಿಷಯವು ನಿಜಕ್ಕೂ ಕುತೂಹಲಕಾರಿಯಾಗಿತ್ತು.

ಮಾನ್‌ಸೂನ್ ಗೇಮ್

ಮಾನ್‌ಸೂನ್ ಗೇಮ್ ಈ ಒಂದು ಆಟವು ಕಲಿಯುವ ಭಾಗವಾಗಿದ್ದು, ರೈತರ ಜೀವನದಲ್ಲಿ ವಿಧಿಯು ಯಾವ ರೀತಿಯ ವರ್ತನೆ ತೋರುತ್ತದೆ ಆದ್ದರಿಂದ ಈ ರೈತನ ಜೀವನ ಸಮಸ್ಯೆಗಳು, ಅನುಕೂಲತೆಗಳು, ಅನಾನುಕೂಲತೆಗಳು ಎಂಬ ಅಂಶವು ಆಟದ ಮುಖ್ಯ ಸಂದೇಶವಾಗಿತ್ತು.

ಡಾ|| ರಾಜರಾಮ್‌ರವರ ಸೃಜನಶೀಲತೆ ಕಲಿಕೆ

ರಾಜರಾಮ್ ರವರ ಸೃಜನಶೀಲತೆ ಕಲಿಯುವ ಎಲ್ಲರಲ್ಲಿರುವ ಪ್ರತಿಭೆಯನ್ನು ಹೊರಹಾಕುವ ವೇದಿಕೆಯಾಗಿ ಪರಿವರ್ತನೆಯಾಯಿತು ಎಂದು ಹೇಳಬಹುದು ನಮ್ಮಲ್ಲಿ ಹಲವಾರು ರೀತಿಯ ಪ್ರತಿಭೆಯನ್ನು, ನಾವು ಎಲ್ಲರೂ ಎದುರು ಪ್ರದರ್ಶಿಸುವಲ್ಲಿ ಹಿಂಜರಿಕೆ, ನಮ್ಮನ್ನು ನೋಡಿ ಯಾರಾದರೂ ನಗುತ್ತಾರೆ ನನಗೆ

ಮಾಡುವುದಕ್ಕೆ ಆಗುತ್ತದೆಯೇ ಇಲ್ಲವೋ ಇಂಥಾ ಹಲವಾರು ಪ್ರಶ್ನೆಗಳಿಗೆ ಉತ್ತರಗಳು ತಿಳಿಯುವಂತಾಯಿತು.

ಇಂತಹ ಹಲವಾರು ದೃಶ್ಯಾವಳಿಗಳು ನನ್ನನ್ನು ಬೇರೆ ಬೇರೆ ವಿಷಯಗಳನ್ನು ಪುಸ್ತಕಗಳನ್ನು ಓದುವ ಅಭ್ಯಾಸ ರೂಪಿಸಿಕೊಳ್ಳುವಂತೆ ಮಾಡಿತ್ತು.

Learning from Filed Visits

ಕ್ಷೇತ್ರ ಭೇಟಿಗಳಿಂದ ಹಲವಾರು ಸಮಸ್ಯೆಗಳ ನೈಜ ಚಿತ್ರಣಗಳು ನಮ್ಮ ಮನಸ್ಸನ್ನು ಕಲಕುವಂತೆ ಮಾಡಿತ್ತು. ಈ ಒಂದು ಕಲಿಕೆಯ ಅವಧಿಯಲ್ಲಿ ಹಲವಾರು ಕ್ಷೇತ್ರಗಳಿಗೆ ಭೇಟಿ ನೀಡಿದಾಗ ನಮ್ಮಲ್ಲಿ ಏನೂ ಕೆಲವೊಂದು ಭಾರೀ ಮೌನ ಆವರಿಸುವಂತೆ ಮತ್ತು ಕೆಲವೊಂದು ಕ್ಷೇತ್ರ ಭೇಟಿಗಳು ನಮ್ಮ ಬಡೆದು ಎಬ್ಬಿಸುವಂತೆ ಮಾಡುತ್ತಿದ್ದವು, ಅವುಗಳಲ್ಲಿ ಮುಖ್ಯವಾಗಿ...

1. Green Foundation, Bangalore.

ಈ ಕ್ಷೇತ್ರ ಭೇಟಿಯಲ್ಲಿ ಸ್ವಯಂ ಸಂಘದಿಂದ ಕೃಷಿಯಲ್ಲಿ ಹಲವಾರು ಬಲದಾವಣೆಗಳು ಬಂದಿದ್ದು, ಸಾವಯವ ಕೃಷಿ, ಮಣ್ಣಿನ ಫವತತ್ವ, ರಾಸಾಯನಿಕ ಗೊಬ್ಬರಗಳಿಂದಾಗುವ ನಷ್ಟಗಳು, ಸಮತೋಲನೆಯ ಅಭಿವೃದ್ಧಿಗಳ ಅಂಶಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳಲಾಯಿತು.

2. Basic Needs India

ಎಲ್ಲರಿಗೂ ತಿಳಿದಿರುವಂತೆ ಬಿ.ಎನ್.ಐ ಮಾನಸಿಕ ಆರೋಗ್ಯದ ಬಗ್ಗೆ, ಕೆಲಸ ಮಾಡುತ್ತಾ ಸಮುದಾಯದಲ್ಲಿ ತೊಡಗಿಸಿಕೊಂಡಿದೆ. ಬಿ.ಎನ್.ಐ ನಮ್ಮನ್ನು ನೇರವಾಗಿ ಮಾನಸಿಕ ಅಸ್ಥಿರ ವ್ಯಕ್ತಿಯಲ್ಲಿ ಆಗುವ ತಾತ್ಕಾಲಿಕ ಬದಲಾವಣೆಗಳು, ಜೀವನ ಶೈಲಿ, ಸಮಸ್ಯೆಗಳು, ಸಮಾಜದಲ್ಲಿ ಅವರು ಯಾವ ರೀತಿಯ ಹಿಂಸೆಗೆ ಒಳಗಾಗುತ್ತಿದ್ದಾರೆ.

ಆ ವ್ಯಕ್ತಿಯನ್ನು ಯಾವ ರೀತಿಯಿಂದ ನೋಡಿಕೊಳ್ಳಬೇಕು, ಕುಟುಂಬದವರು ಯಾವ ರೀತಿಯಿಂದ ಸಮಾಜದಲ್ಲಿ ಅವರ ಸ್ಥಿತಿಗತಿಗಳು ಇರುತ್ತದೆ ಎಂದು ತಿಳಿದ ಸಂಗತಿಗಳಾಗಿದ್ದವು.

3. FRLHT, Bangalore.

FRLHT ಯು ಒಂದು ವಿಶೇಷ ಕ್ಷೇತ್ರ ಭೇಟಿ ಎಂದು ಹೇಳಬಹುದು. ಸಂಸ್ಕೃತಿಯಿಂದ ವೈದ್ಯ ಶಾಸ್ತ್ರ ಹುಟ್ಟಿದ್ದು ಹಲವಾರು ಔಷಧಿಕರಣದ ಗುಣವುಳ್ಳ ಎಷ್ಟು ಗಿಡಮೂಲಿಕೆಗಳು ನಮ್ಮ ಪರಿಸರ ನಮಗೆ ವರವಾಗಿದೆ, ಈ ಪರಂಪಾರಿಕ ವೈದ್ಯಶಾಸ್ತ್ರಗಳಾದ, ಆಯುರ್ವೇದ, ಯೋಗ ಯುನಾನಿ, ಹೋಮಿಯೋಪತಿ ಚಿಕಿತ್ಸೆ ಪದ್ಧತಿಗಳು ಬೇರೆ ಬೇರೆಯಾಗಿದ್ದು ಎಲ್ಲರ ಮೂಲ ಆರೋಗ್ಯ ಸುಧಾರಣೆ ಒಂದೇ ಅಂಶವಾಗಿತ್ತು.

4. Association of People with Disability

ಈ ಒಂದು ಕ್ಷೇತ್ರ ಅವಧಿಯು ಅಂಗವಿಕಲತೆ ಒಂದು ಶಾಪವೋ! ವರವೋ! ಎಂಬ ವಿಚಾರವನ್ನು ತಿಳಿಯುವಂತೆ ಮಾಡಿತು, ಅಂಗವಿಕಲತೆಯು ಸಮಸ್ಯೆ ಎಂದು ಕೊಂಡರೆ ಅಂದು ಕೊನೆಯವರೆಗೂ ಸಮಸ್ಯೆಯಾಗಿ ಉಳಿದು ಹೋಗುವುದು ಇಂತಹ ಅಂಗವಿಕಲತೆಯನ್ನು ಮೆಟ್ಟಿ ಹಲವಾರು ಸಾಧನೆಗಳು ಮಾಡಬಹುದು, ಹಾಗೂ ಇನ್ನೊಬ್ಬ ಅಂಗವಿಕಲರಿಗೆ ಅಂದು ಮಾರ್ಗದರ್ಶನವಾಗುವುದು ಎಂದು ತಿಳಿದುಕೊಳ್ಳಲಾಯಿತು.

5. ಸೇಹ್ಲಾಧನ (People Living with HIV/AIDS)

ಸೇಹ್ಲಾಧನ ನನ್ನ ಪ್ರಕಾರ ಇಂದು ಒಂದು ವಿಭಿನ್ನ ಭೇಟಿ, ಎಂದು ಹೇಳಬಹುದು ಏಕೆಂದರೆ ನಾನು ಒಬ್ಬ ಹೆಚ್.ಐ.ವಿ ಇದ್ದ ವ್ಯಕ್ತಿಯನ್ನಾಗಲಿ ಗಮನಿಸರಲಿಲ್ಲ, ಸೇಹ್ಲಾಧನ ಸಂಸ್ಥೆಯು ಹಲವಾರು ಹೆಚ್.ಐ.ವಿಯುಳ್ಳ ರೋಗಿಗಳ ಸ್ಪಂದಿಸುವ ಕಾರ್ಯದಲ್ಲಿ ತೊಡಗಿದ್ದು ಹಲವಾರು ಹೆಚ್.ಐ.ವಿಯುಳ್ಳ ಮಕ್ಕಳನ್ನು ನೋಡಿದಾಗ ಯಾವ ಪಾಪಮಾಡದೇ ಭೂಮಿಗೆ ಬಂದ ಮಕ್ಕಳಿಗೆ ಮನೆ ಎಂದು ಹೇಳಬಹುದು.

6. ಕರುಣಾಲಯ ವಯಸ್ಕರ ಮನೆ

ಕರುಣಾಲಯಕ್ಕೆ ಒಂದು ದಿನದ ಭೇಟಿ ಮಾಡಿದಾಗ ನಾನು ಇಲ್ಲಿಯವರೆಗೂ ಎಷ್ಟು ಅನಾಥ ಮಕ್ಕಳ ಬಗ್ಗೆ ಕೇಳಿದ್ದು ಸಾಮಾನ್ಯವಾಗಿತ್ತು, ಆದರೆ ಈ ಕ್ಷೇತ್ರ ಭೇಟಿಯಲ್ಲಿ ಎಷ್ಟು ತಂದೆ ತಾಯಿಗಳು ಮಕ್ಕಳಿದ್ದು, ಅನಾಥರಾಗಿದ್ದಾರೆ ಈ ದೃಶ್ಯ ನನ್ನನ್ನು ವಯಸ್ಕರ ಆರೋಗ್ಯದ ಆರ್ಥಿಕ ಮತ್ತು ಸಾಮಾಜಿಕ ಸಮಸ್ಯೆಗಳು ತಿಳಿದುಕೊಳ್ಳುವಂತೆ ಪ್ರೇರಣೆ ನೀಡಿತ್ತು.

ಕೊನೆಯದಾಗಿ ಇಂತಹ ಹಲವಾರು ಕ್ಷೇತ್ರ ಭೇಟಿಗಳು ನಮ್ಮಲ್ಲಿ ಅಂದರೆ ನಮ್ಮ ಸಮಾಜದಲ್ಲಿರುವ ಸಾಮಾಜಿಕ ತೊಂದರೆಗಳು ಕಡೆಗೆ ಗಮನಹರಿಸುವಂತೆ ಮಾಡಿತ್ತು, ನಮ್ಮನ್ನು ಆ ಮಾರ್ಗದರ್ಶನ ನಡೆಯುವಂತೆ ಮಾರ್ಗದರ್ಶನ ನೀಡಿತ್ತು.

Field Placement in Sarvodaya in Gulbarga District

ಸರ್ವೋದಯ ಎಂಬ ಸಂಸ್ಥೆಯು ಗುಲ್ಬರ್ಗಾ ಜಿಲ್ಲೆಯ ಅಳಂದ ತಾಲ್ಲೂಕಿನಲ್ಲಿ ಕಾರ್ಯ ನಿರ್ವಹಿಸುತ್ತಿದ್ದು ಹಲವಾರು ಸಾಮಾಜಿಕ ಸಮಸ್ಯೆಗಳಿಗೆ ಸ್ಪಂದಿಸುವಲ್ಲಿ ಯಶಸ್ವಿಯಾಗಿದೆ. ಈ ಒಂದು ಸಂಸ್ಥೆಯ ಮಕ್ಕಳ ಶಿಕ್ಷಣ, ಪೌಷ್ಟಿಕಾಂಶದ ಕೊರತೆ, ತಾಯಿಂದರ ಸಮಸ್ಯೆಗಳಿಗೆ ಸ್ಪಂದಿಸುವಾ ಸಭೆ, ಪರಿಸರ ಸ್ವಚ್ಛತೆಯ ಬಗ್ಗೆ ಮಕ್ಕಳನ್ನು ಇತರ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ತೊಡಗಿಸಿಕೊಂಡು ಕೆಲಸ ಮಾಡುತ್ತಿದೆ, ಸಿಸ್ಟರ್ ಟೀನಾ ಅವರು ಸಮುದಾಯ ತಳಹದಿಯ ಸಮಸ್ಯೆಗಳಿಗೆ ಸ್ಪಂದಿಸುವಾ ಅವರು ಕೆಲಸ ನಿಜಕ್ಕೂ ಹೆಮ್ಮೆಯ ವಿಷಯವಾಗಿದೆ.

ನಾನು ಸರ್ವೋದಯ ಎಂಬ ಸಂಸ್ಥೆಯು ಕ್ಷೇತ್ರ ಅಧ್ಯಯನಕ್ಕಾಗಿ ಹೋದಾಗ ಹಲವಾರು ರೀತಿಯಿಂದ ಸಮುದಾಯದ ಚಲನ ವಲನಗಳ ಸಂಪೂರ್ಣ ಮಾಹಿತಿ ತಿಳಿದುಕೊಳ್ಳುವಲ್ಲಿ ಸಹಾಯಕವಾಯಿತು, ಅದರಲ್ಲಿ ಲಿಂಗತಾರತ್ಯಮ, ಗ್ರಾಮೀಣ ಜೀವನ ಶೈಲಿ, ಅವರಲ್ಲಿರುವ ಮೂಡನಂಬಿಕೆಗಳ ನಿಗೂಢತೆ, ರೈತರ ಜೀವನದಲ್ಲಾಗುವ ಏರುಪೇರುಗಳು ಈಹಲವಾರು ಸಾಮಾಜಿಕ ಕಾರಣಗಳಿಂದ ಸಮುದಾಯದ ಆರೋಗ್ಯವನ್ನು ನಿರ್ಧರಿಸುವ ನಿರ್ಧಾರಕಗಳ ಬಗ್ಗೆ ಬಂದು ಪಕ್ಷಿನೋಟ ನನ್ನದಾಗಿತ್ತು.

ಮಂತ್ರಿ ಮಂಡಲದ ಮೂಲಕ ಮಕ್ಕಳ ಗುಂಪುಗಳ ಮಾಡಿ ಹಲವಾರು ಸಾಮಾಜಿಕ ಸಮಸ್ಯೆಗಳಿಗೆ ಸ್ಪಂದಿಸುವುದು ಸಿಸ್ಟರ್ ಟೀನಾರವರ ಮುಖ್ಯ ಉದ್ದೇಶವಾಗಿತ್ತು.ಅದು ಅಲ್ಲದೆ ಈ ಮಂತ್ರ ಮಂಡಲವನ್ನು ಉಪಯೋಗಿಸಿಕೊಂಡು ಬಾಲಕಾರ್ಮಿಕ ಮತ್ತು ಜೀತ ಪದ್ಧತಿ ತೆಗೆದುಹಾಕುವುದಾಗಿತ್ತು.

ಈ ಒಂದು ಗ್ರಾಮವು ಹಲವಾರು ಸಮಸ್ಯೆಗಳಿಂದ ಕೂಡಿದ್ದು ಅದರಲ್ಲಿ ಕುಡಿಯುವ ನೀರಿನ ಸಮಸ್ಯೆ, ಶೌಚಾಲಯ, ವಿದ್ಯುತ್, ರಸ್ತೆಗಳ ಮತ್ತು ಸಾರ್ವಜನಿಕ ವಾಹನಗಳ ಈ ಎಲ್ಲಾ ಸಮಸ್ಯೆಗಳ ನಡುವಲ್ಲಿ ಬದುಕು ಸಾಗಿಸುವಾ ಜೀವನ ಅವರದಾಗಿತ್ತು.

ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯ

ನನ್ನ ಅಧ್ಯಯನದ ವಿಷಯವಾದ ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯದ ಬಗ್ಗೆಯೂ ಹಲವಾರು ವಿಷಯಗಳನ್ನು ಇಲ್ಲಿ ತಿಳಿದುಕೊಳ್ಳಲಾಯಿತು. ಬಸವೇಶ್ವರ ಮತ್ತು ಸರ್ಕಾರಿ ಆಸ್ಪತ್ರೆಗಳಿಗೆ ಭೇಟಿ ನೀಡಿದಾಗ ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯವು ನಿರ್ವಹಣೆವು ಸರಿಯಾಗಿ ನಡೆಯದೇ ಇರುವುದು ತಿಳಿದುಬಂತು, ಗುಲ್ಬರ್ಗಾ ಜಿಲ್ಲೆಯಲ್ಲಿ ಹಲವಾರು ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಿಗೆ ಭೇಟಿ ನೀಡಿದಾಗ ನಾನು ತರಗತಿಗಳಲ್ಲಿ ತಿಳಿದುಕೊಂಡು ಹಲವಾರು ವಿಷಯಗಳ ಬಗ್ಗೆ ವೈದ್ಯರ ಜೊತೆಗೆ ಚರ್ಚೆ ಮಾಡಲು ಸಹಾಯಕವಾಯಿತು.

Healthcare WasteManagement Workshop in Gulbarga

ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯದ ಕಾರ್ಯಾಗಾರದಲ್ಲಿ ನಾನು ಭಾಗವಹಿಸಲು ಮುಖ್ಯ ಕಾರಣ ನನ್ನ ಆಸಕ್ತಿ ಮತ್ತು ಡಾ||ರಾಮಕೃಷ್ಣ ಗೌಡ ಎಂದು ಹೇಳಬಹುದು.

ಈ ಒಂದು ತರಬೇತಿಯ ಶಿಬಿರದಲ್ಲಿ ಹಲವಾರು ವ್ಯಕ್ತಿಗಳ ಮತ್ತು ಸಂಸ್ಥೆಗಳ ಪರಿಚಯವಾಯಿತು.ಅದು ಅಲ್ಲದೇ ಆರೋಗ್ಯ ಪಾಲನಾ ನಿರ್ವಹಣೆಯಿಂದಾಗುವ ಪರಿಸರ ಮಾಲಿನ್ಯ, ಸಮುದಾಯದಲ್ಲಿ ಯಾವ ರೀತಿಯಿಂದಾಗಿ ಹಾನಿಕಾರವಾಗಿದೆ ಅದು ಯಾರು ಯಾರಿಗೆ ಯಾವುದರಾ ಮೂಲಕಾ ಹೇಗೆ ಹರಡುತ್ತದೆ.ಪಾದರಸದ ನಿರ್ವಹಣೆ, ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯ ನಿರ್ವಹಣೆ ಮಾಡುವ ಮುಖ್ಯ ಉದ್ದೇಶಗಳು, ತಿಳಿದುಕೊಳ್ಳಲಾಯಿತು.

ಆಶಾ

ಸಮುದಾಯದಲ್ಲಿ ಒಬ್ಬ ನಿರ್ವಹಣೆ ಮನೋಭಾವನೆಯುಳ್ಳ ಹೆಣ್ಣಿನ ಸಹಾಯ ಮಾಡುವ ಸೇವಕಿಯರ ಬಗ್ಗೆ ವಿವರವಾದ ತಿಳಿದುಕೊಳ್ಳಲಾಯಿತು.ಅವರು ಹಲವಾರು ಜವಬ್ದಾರಿಗಳಿದ್ದರು, ಸಮುದಾಯದಲ್ಲಿ ಏಲಿಗೆಗಾಗಿ ಕಾರ್ಯ ನಿರ್ವಹಿಸುವ ವ್ಯಕ್ತಿಗಳಾಗಿದ್ದು, ಸಮುದಾಯ ಸುಧಾರಣೆಯಲ್ಲಿ ಅವರ ಪಾತ್ರ ಮುಖ್ಯವೆಂದು ತಿಳಿದುಕೊಳ್ಳಲು ಸಹಾಯವಾಯಿತು.

ಉಪಸಂಹಾರ

ಈ ಒಂದು ಕ್ಷೇತ್ರ ಅವಧಿಯಲ್ಲಿ ಗ್ರಾಮೀಣ ಜೀವನ ನೈಜ ದೃಶ್ಯಗಳು ನನ್ನ ಮನಸ್ಸಲ್ಲಿ ಸೆರೆಹಿಡುವಂತೆ ಮಾಡಿತ್ತು, ಸಮುದಾಯ, ಸಮುದಾಯ ಆರೋಗ್ಯ, ಆಶಾ ಸಮಾಜಸೇವಕಿ, ಪ್ರಾಥಮಿಕ ಆರೋಗ್ಯ ಕೇಂದ್ರ , ಅಂಗನವಾಡಿ ಕೇಂದ್ರ, ಮಕ್ಕಳ ಶಿಕ್ಷಣ ಕೊಠಡೆ, ವಯಸ್ಕರ ಜೀವನಶೈಲಿ,

ಮಾನಸಿಕ ಆರೋಗ್ಯ, ಈ ಎಲ್ಲಾ ತರಗತಿಗಳಲ್ಲಿ ತಿಳಿದುಕೊಂಡು ಬಂದ ನಂತರ ಕ್ಷೇತ್ರ ಭೇಟಿಗಳಲ್ಲಿ ನಮಗೆ ಸಹಾಯವಾಯಿತು.

ಸಮುದಾಯ ಎಂದರೆ ಏನು, ಸಮುದಾಯದಲ್ಲಿರುವ ಸಮಸ್ಯೆಗಳು, ಅವುಗಳ _ ಜನರು ಹೇಗೆ ಸೃಂದಿಸುತ್ತಾರೆ ಹಾಗೂ ಸಿಸ್ಟರ್ ಟೀನಾರವರ ಸಮುದಾಯದೊಂದಿಗೆ ಇರುವ ಸಂಬಂಧವನ್ನು ನನ್ನನ್ನು ಸಮುದಾಯ ಕಡೆಗೆ ಸೆಳೆಯುವಂತೆ ಮಾಡಿತು.

Second Placement visit in Bangalore

ಈ ಒಂದು ಕ್ಷೇತ್ರ ಅಧ್ಯಯನದಲ್ಲಿ ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟಂತೆ ಕೆಲಸ ಮಾಡಲಾಯಿತು.ಎರಡನೇ ಕ್ಷೇತ್ರ ಅವಧಿಯಲ್ಲಿ ನನ್ನ ಕಲಿಕೆ ಅತ್ಯುತ್ತಮವಾಗಿ ಸಾಗಿತ್ತು.

ಡಾ|| ಪೃಥ್ವಿಶರವರನ್ನು ಭೇಟಿ ಮಾಡಿದ ನಂತರ ನನ್ನ ಸಂಶೋಧನಾ ಅಧ್ಯಯನಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ಪ್ರಶೋತ್ತರಗಳನ್ನು ತಯಾರಿಸಿಕೊಂಡು ಅಧ್ಯಯನ ಪ್ರಾರಂಭಿಸಿದೆ ಅದು ಆದ ನಂತರ ಆನೇಕಲ್ ಕ್ಷೇತ್ರದಲ್ಲಿ ಬರುವ ಸಾರ್ವಜನಿಕ ಮತ್ತು ಖಾಸಗಿ ಆಸ್ಪತ್ರೆಗಳಿಗೆ ಭೇಟಿ ನೀಡಿ ಆರೋಗ್ಯ ತಾಜ್ಯ ನಿರ್ವಹಣೆಯ ಬಗ್ಗೆ ಸಂಪೂರ್ಣ ತಿಳಿದುಕೊಳ್ಳಲಾಯಿತು.

ಈ ಒಂದು ಕ್ಷೇತ್ರ ಅಧ್ಯಯನದಲ್ಲಿ ನಾನು ಹಲವಾರು ಆರೋಗ್ಯ ಪಾಲನಾ ಕೆಲಸಗಾರರೊಂದಿಗೆ ಚರ್ಚಿಸಿ ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯದ ಮಾಹಿತಿಯನ್ನು ಸಂಗ್ರಹಣೆ ಮಾಡಿಕೊಂಡು ಅದನ್ನು ಕಂಪ್ಯೂಟರ್‌ನಲ್ಲಿ ದಾಖಲೆ ಮಾಡಿಕೊಂಡು ಅದನ್ನು ಪರಿಶೀಲನೆ ಮಾಡಲಾಯಿತು.

ಈ ಒಂದು ಅವಧಿಯಲ್ಲಿ ಹಲವಾರು ಸರ್ಕಾರಿ ಮತ್ತು ಖಾಸಗಿ ಕಛೇರಿಗಳಿಗೆ ಭೇಟಿ ನೀಡಲಾಯಿತು.

- Taluk Family and Social Welfare office Anekal, Bangalore (U).
- District Plan Management Office, Bangalore.
- District Family and Social Welfare Office, Bangalore
- Dr.Pruthiush, M.S.R Medical Hospital, Bangalore.
- Anekal Taluk PHC's and Private Hospital.
- Karumalaya Old Aged Home, Bangalore.
- Snehadhan (Living with HIV/AIDS).
- Institute of Ayurveda and integrative medicine low-cost copper device for Microbial purification of drinking water in household a field visit.

1. FRU Hospital Anekal Taluk

ಈ ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯಕ್ಕೆ ವಿಷಯಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ಈ ಆಸ್ಪತ್ರೆಗೆ ಭೇಟಿನೀಡಿದಾಗ ಮತ್ತು ಅಲ್ಲಿ ಇರುವ ಕೆಲಸಗಾರರೊಂದಿಗೆ ಮಾತನಾಡಿದಾಗ ಆರೋಗ್ಯ ಪಾಲನಾ ತ್ಯಾಜ್ಯ ನಿರ್ವಹಣೆಯ ಬಗ್ಗೆ ಸರಿಯಾದ ಮಾಹಿತಿ ನೀಡುವುದರ ಜೊತೆಗೆ ಒಳ್ಳೆಯ ನಿರ್ವಹಣೆ ಮಾಡುವುದು ತಿಳಿದುಬಂತು.

2. District Health Care District Nodal Officer

District Health Care District Nodel Officer ಭಾಗ್ಯವಂತಿಯವರನ್ನು ಭೇಟಿಮಾಡಿದಾಗ ನನ್ನ ಸಂಶೋಧನಾ ಅಧ್ಯಯನ ಬಗ್ಗೆ ಅವರಿಗೆ ತಿಳಿಸಿದಾಗ ನನ್ನ ಅಧ್ಯಯನಕ್ಕೆ ಅನುಕೂಲವಾವುವಂತೆ ಆನೇಕಲ್ ತಾಲ್ಲೂಕಿನಲ್ಲಿರುವಾ, ಆಸ್ಪತ್ರೆಗಳ ದಾಖಲಾತಿ ನೀಡಿದ್ದರು ಇದ್ದರಿಂದ ನನ್ನ ಸಂಶೋಧನಾ ಕಾರ್ಯಕ್ಕೆ ಸುಲಭವಾಯಿತು.

3. Taluk Family and Social Welfare Office, Anekal.

ಈ ಒಂದು ಕಛೇರಿಗೆ ಭೇಟಿ ನೀಡಿದ ಉದ್ದೇಶ ನನ್ನ ಸಂಶೋಧನಾ ಅಧ್ಯಯನದ ಅನುಮತಿ ಪಡೆದುಕೊಳ್ಳುವುದಾಗಿತ್ತು.

ಡಾ. ಸನೀಲ್ ಕುಮಾರ್ Taluk Family and Social Welfare Officer ಆಗಿದ್ದು ನನ್ನ ಸಂಶೋಧನಾ ಅಧ್ಯಯನದ ಅನುಮತಿಯ ಭೇಟಿ ನೀಡಿದಾಗ ನನ್ನ ಸಂಶೋಧನೆಯ ಬಗ್ಗೆ ತಿಳಿದುಕೊಂಡು ಐದು ದಿನಗಳ ಮೇಲೆ ಅನುಮತಿ ನೀಡಿದ್ದರು ನನಗೆ ತಿಳಿದಂತೆ ಹಲವಾರು ಸಮಸ್ಯೆ, ಸರಿಯಾಗಿ ವರ್ತನೆ ಮಾಡದಿರುವುದು ಕಂಡು ಬೇಸರವಾಯಿತು.

4. District Family and Social Welfare Office

ಈ ಒಂದು ಭೇಟಿಯು ಕೂಡಾ ನನ್ನ ಸಂಶೋಧನೆ ಅಧ್ಯಯನಕ್ಕೆ ಅನುಮತಿಯನ್ನು ಪಡೆದುಕೊಳ್ಳುವುದಾಗಿತ್ತು, ನನಗೆ ಅನುಮತಿಯನ್ನು ನೀಡಲು ತುಂಬಾ ತಡವಾಯಿತು. ನಾನು ಐದರಿಂದ-ಆರು ಬಾರಿ ಈ ಕಛೇರಿಗೆ ಭೇಟಿ ಅನುಮತಿ ಪಡೆದುಕೊಳ್ಳಲು ಯಶಸ್ವಿಯಾದೆ.

5. Snehadhan (People Living with HIV/AIDS)

ಸೇಹ್ಲಾಧನ(People Living with HIV/AIDS) ಈ ಒಂದು ಸಂಸ್ಥೆಗೆ ಭೇಟಿನೀಡಿದಾಗ, ಹೆಚ್.ಐ.ವಿ ರೋಗಿಯ ಆರೋಗ್ಯ ಸ್ಥಿತಿ, ಅವನಲ್ಲಿ ಆಗುವ ಮಾನಸಿಕ ಬದಲಾವಣೆ ಅವರ ಜೀವನ ಶೈಲಿಗಳ ಬಗ್ಗೆ ಅವರೊಂದಿಗೆ ಮಾತನಾಡುವುದರ ಮೂಲಕ ತಿಳಿದುಕೊಳ್ಳಲಾಯಿತು. ಈ ಮೊದಲು ನಾನು ಹೆಚ್,ಐ.ವಿಯ ರೋಗಿಯನ್ನು ನೋಡಿರಲಿಲ್ಲ, ಈ ಒಂದು ಸಂಗತಿ ನನ್ನ ಮನಸ್ಸಿನಲ್ಲಿ ನೋವಿನ ಮನೆ ಮಾಡಲು ಕಾರಣವಾಯಿತು.

ಈ ಕ್ಷೇತ್ರ ಅವಧಿಯಲ್ಲಿ ನನಗೆ ತಿಳಿಯದಂತೆ ಹಲವಾರು ಕಲಿಕೆಗಳು, ನನ್ನನ್ನು ಮುಟ್ಟುವಂತೆ ಮಾಡಿತ್ತು, ಜನಗಳ ಬೆರೆತು ಮಾತನಾಡುವುದು ಅವರ ನೋವಿನ ಸ್ಪಂದಿಸುವುದು ಒಂದು ವಿಷಯವನ್ನು, ಹಲವಾರು ದೃಷ್ಟಿಕೋನದಿಂದ ನೋಡುವುದು, ಮಾನಸಿಕ ರೋಗಿಗಳು ಏರು ಪೇರುಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳಲು ಸಹಾಯಕವಾಯಿತು.

ಉಪಸಂಹಾರ

ಎರಡನೇ ಕ್ಷೇತ್ರ ಅವಧಿಗಳಲ್ಲಿ ನಾನು ಸಂಶೋಧನೆಯ ವಿಷಯದಲ್ಲಿ ಆಳವಾಗಿ ತಿಳಿದುಕೊಳ್ಳಲು ಸಹಾಯಕವಾಯಿತು ಹಾಗೂ ನನ್ನನ್ನೆಲ್ಲರೂ ಹಿಂಜರಿಕೆ ದೂರವಾಗುವಂತೆ, ಆರೋಗ್ಯವನ್ನು ಒಂದೇ ದೃಷ್ಟಿಕೋನ ನೋಡದೇ ಹಲವಾರು ದೃಷ್ಟಿಕೋನದಿಂದ ನೋಡುವಂತೆ

ಮಾಡಿತ್ತು ಹಾಗೂ ಜನರೊಂದಿಗೆ ಬೆರೆಯುವ ಮನೋಭಾವನ್ನು ಹೆಚ್ಚಿಸಿತ್ತು, ಡಾ||ಯುವರಾಜ, ಡಾ||ಪ್ರೊಫೆಸ್ಸರ್ ಅವರ ಮಾರ್ಗದರ್ಶನದಲ್ಲಿ ಹಲವಾರು ಹೊಸ ಹೊಸ ವಿಷಯಗಳ, ತಿಳಿದುಕೊಳ್ಳಲು ಸಹಾಯವಾಗಿತ್ತು, ಆಗ ಅವರು ಕೂಡಾ ನನ್ನನ್ನು ಒಬ್ಬ ವಿದ್ಯಾರ್ಥಿಯನ್ನಾಗಿ ನೋಡದೆ ಸರಿಸಮಾನವಾಗಿ ನೋಡಿ, ನನ್ನನ್ನು ಹಲವಾರು ವಿಷಯಗಳಲ್ಲಿ ತೊಡಗಿಸಿಕೊಳ್ಳುವಂತೆ ಮಾರ್ಗದರ್ಶನ ನೀಡುತ್ತಿದ್ದರು.

ಈ ಸಂಶೋಧನೆಯ ಅಧ್ಯಯನದಲ್ಲಿ ಸಾಬೂ ಸರ್ ತರಗತಿಗಳು ನನಗೆ ಬಹಳ ಸಹಾಯಕವಾಗಿತ್ತು. ಸಂಶೋಧನೆ ವಿಷಯವು ನಿಜಕ್ಕೂ ಒಂದು ಉತ್ತಮವಾದ ಜ್ಞಾನವನ್ನು ಒದಗಿಸುವುದರಲ್ಲಿ ಯಶ್ವಸಿಯಾಯಿತು. ಹಾಗೂ ಈ ಒಂದು ಸಂಶೋಧನಾ ಅಧ್ಯಯನವನ್ನು ಮುಗಿಸುವಂತೆ ಡಾ||ಪ್ರೊಫೆಸ್ಸರ್‌ರವರು ಮಾರ್ಗದರ್ಶನ ನೀಡಿದ್ದರು ಆ ಒಂದು ಮಾರ್ಗದರ್ಶನದ ಫಲವಾಗಿ ನನ್ನ ಒಂದು ಸಂಶೋಧನಾ ಅಧ್ಯಯನವನ್ನು Indian Society of Helath Care Waste Management ಎಂಬ ಮುದ್ರಿಕೆಯಲ್ಲಿ ಮುದ್ರಿಸಲಾಯಿತು.

Field Placement in Gurukula Botanical Sanctuary in Kerala

The Gurukula Botanical Sanctuary and Garden in Peria, in the Wayanad district of Kerala. To reach it, you have to travel along an unpaved road from Peria for a couple of kilometers through a jungle. The moment you enter the Gurukula you experience the tranquility of nature. There are evergreen forests on all sides. You can see numerous types of butterflies and birds, like the winged parakeet and Mountain Imperial Pigeon. There is the Niligiri Langur, the sambar deer and the necked mongoose. It is home to nearly 3,000 species of plants from the Western Ghats and is rich in fauna and flora. But there is a whiff of danger too. There are more than 20 varieties of snakes, of which seven are very poisonous.

In GBS, there is organic farming, animal husbandry, and alternate energy mechanisms, rain water harvesting vegetable garden. They have a programme called, **'School in the Forest'** where schoolchildren and adults live and work in the sanctuary. A five-month programme costs Rs 50,000, which includes food, accommodation, instruction and travel.

Wolfgang Theuerkauf is a German, who came here 40 years ago, fell in love with the place and stayed on. "His travels to different parts of the world, his came to India and ended up in the Western Ghats, he says "He bought a patch of land and started the Gurukula in 1981. As this area was encircled by forests, no one was willing to look after it, so. I decided to do so. In 1981 he received Indian nationality and married a Malayali, Leelama, who is from Periya.

Suprabha Seshan, a Tamilian, has been assisting Theuerkauf for the past 20 years. Now, as Director of the sanctuary, Suprabha gives classes on the conservation of forests.

Their work has received international recognition. The International Union for the Conservation of Nature has labeled the Gurukulam as one of the 25 centers of bio-diversity in the world.

In 2006 it won the 'Whitley' award, the biggest environment award from Great Britain for the most effective conservation efforts around the world. So a German living in India is doing his best to preserve eco systems in one corner of this vast country.

The Sanctuary is a patch of 50 acres of forest land of which some 40 acres are left largely alone for natural succession. About 5 acres is meticulously tended and doubles as a showcase for visitors to visit, explore, interrogate and comprehend. The Gurukula tends its forests on the principles of restoration ecology with careful, conscious human interference. From the mosses, liverworts, ferns, orchids, lichens to the massive angiosperms, each one is documented, catalogued, tended and known by nature, place, origin, age and stage.

A small group of six individuals live and work at the sanctuary and are collectively responsible for the place. It has grown into an informal centre for botanical research, forest department's collaborative centre for conservation efforts and a space for children to gleam into the mysteries of what constitutes the living earth.

Objectives of GBS

The GBS aim is to conserve the nature and preserve the disappearing flora and fauna. They grow the plants seen everywhere to make people aware that these are the plants they neglect also they grow fishes.

Objectives of School in the Forest

GBS educational programme 'The School in the Forest' is now 12 years old. It works with schools, individuals and NGOs at local, regional, national and international levels.

The concern is to bring about a shift in attitude and alliance within human society with respect to the natural world.

GBS encourage long and intensive exposure to the tropical forest environment, to open up different sensibilities and dimensions in children.

They are urging a collective reflection of environmental and global issues in order to bring about effective and meaningful action.

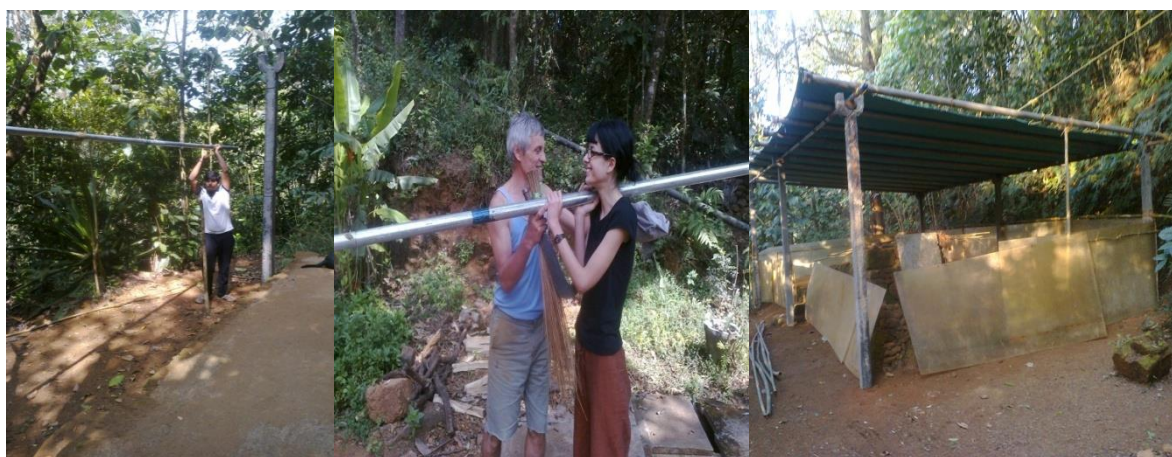
They suggest that the severance between humanity and nature has complex roots. A far deeper awareness is needed to address this.

“My experience in school in the forest”

On December 26th morning I left for wayanad and reaching Gurukula Botanical Sanctuary (GBS) I stay couple days in GBS guest house.

School in the forest was unexpected wonderful Opportunity when I first went to GBS I’ve no specific ideas about School in the forest I was concerned with to understanding about nature conservation, Climate of wayanad, Cultural of tribal people, later when I interact with the people GBS I slowly understood the School in the forest program along with objectives and specific ideas agreed to its rules and regulation.

Construction house in the forest



This is a new experience for me. It is the first time are I and lorenzo construction house. It is a totally different exposure. Shelter and food are basic needs for human beings wherever you go, whatever you do these are very important.

House took four to five days to complete. I had carried to down from the sanctuary. This activity was. some time boring and sometimes I’m thinking where I have come, what I’m doing, what my interest, and I’m not clear my ic objectives.

Setting up tent



I also tent a on preparing my own. Daily I was asking about setting up of tent to loranzo, finally one day I got to do it. I did not sleep even one day in the tent because I scared about elephants.

Work on Sanitation

Sanitation is very important work because it indicates of clean environment and their reason. Alternative sanitation constructed In the forest a. While working on sanitation I remembered Mr. Prahlad IMwho is working on water and sanitation. One of the unexpected activities that I enjoyed

Shopping weekly once in Mananthavady

I went for shopping in Mananthavady with Subbi, Loranzo, Isa, we purchased materials and things for school in the forest.

Coffee picking



Coffee harvesting was another activity in which I was interested and daily I was involved in picking up coffee from 10 to 11.30 am.

Path clearing in forest

Path clearing is also a part of the program while working on path clearing; I did not know how to use the spade initially but slowly I understood the method and developed using a spade.

Cooking also part of program



Another experience was of cooking, and I learned to cook, how much quantity is required for four persons, daily menu and all members cooked nicely and it was a helpful to understand each other.

Forest walk



I wake up in the between morning 6.30 and 7 am I used to go for forest walk daily for 1 hour between 7 and 8. In the walk I observe many things are which a very different experience was for me. There are many different variety of species of plants, different shaped leaves, colorful butterflies, different types of bird's, spiders, mosses, Ferns, orchids, and also learnt relation between plant to one other, some time I saw snakes, and insects. It created a complete different world around me, sometimes I forget myself while enjoying nature.

River walk



River walk is another enjoyable activity in the forest

Visiting Garden with Suma



I went to around garden with suma, who is specialist in plants, suma explained about elephant leaves(Begonia family) Orchids, impatiens plant, first plant on earth, herbivorous, carnivores, plants, trees, scrubs, wood trees, woodless trees, exotic trees, re plantation and rare plants, she is suggested me read to biological plant book.

Yoga and physical exercise

Loranzo was teaching us yoga daily in the morning. Some physical activity, like running, roof climbing and so on.

Working in site



In the forest I selected my own site for identification of plants, in my site I collected different types of flowers, leaves, grass, and seeds then went to the library to discuss with Suprabha Seshan.



The site I selected near to water spring it is rich in plants I collected so many things I discuss taxonomy of about roots, leaf, flowers structure, ecology, habitat etc...

About Loranzo

Loranzo is a one of my best friend, teacher, a good person and a hard worker; he inspired me a lot, thank you, Loranzo.

Some of the trip we had in this program were Visit of Maradam farm School and herbal park Tiruvnamalai in Tamilnadu, Solitude Organic cafe.

My Leanings

This program in I learnt many thing like discovering the nature, Simple living, Work experience, my personal skills are developed, Discovered the other culture and language, the beauty of the tribal people, the beauty of physical hard work, challenges of wild life, Interactions with people of different nationality, Feeling of humanity as one, idea developed on organic farming.



Paper presentation in Lucknow, UP.

13th Annual Conference of Indian Society of Hospital Waste Management Lucknow, Uttar Pradesh.

Loranzo And Poul

Suprabha, Pradeep, Nadeem

Bhim, Govinda, Lorazo

A Study on the status of health care waste management of Infection Control practices in health care settings of Anekal Talk, Bangalore Urban District.

ಈ ಒಂದು ಅವಕಾಶವು ನನ್ನನ್ನು ತಿಳಿದುಕೊಳ್ಳುವಂತೆ ಹಲವಾರು ಜವಬ್ದಾರಿಗಳ ಭಾರವನ್ನು ಒರುವಂತೆ ಮಾಡಿತ್ತು. ಅಲ್ಲದೆ ಹಲವಾರು ವಿಷಯಗಳು ಮತ್ತು ವ್ಯಕ್ತಿಗಳ ಪರಿಚಯಕ್ಕೆ ಕಾರಣವಾಯಿತು ಎಂದು ಹೇಳಬಹುದು.

ಈ ಒಂದು Presentation ಮಾಡಲು ಹಲವಾರು ವ್ಯಕ್ತಿಗಳ ಮಾರ್ಗದರ್ಶನ ಮುಖ್ಯವಾಗಿತ್ತು. ಅವರಲ್ಲಿ ಮುಖ್ಯವಾಗಿ ಡಾ||ಪ್ರೊ. ಡಾ||ಯುವರಾಜ, ಡಾ||ಆದಿತ್ಯ, ಡಾ||ರಾಹುಲ್ ಇವರ ಒಂದು ಸಹಾಯದಿಂದ ನಾನು ಈ ಒಂದು Presentation ನೀಡಲು ಸಹಾಯಕವಾಗಿತ್ತು.

Reading books in CHC library

- ✓ Down to earth
- ✓ National health policy
- ✓ Biomedical waste and the law
- ✓ Naimarlya & Aryogya (kannada)
- ✓ Hosatu (Kannada)
- ✓ Environmental impact assessment
- ✓ Essential Of Public Healthcare
- ✓ Compulsory Liencin for Public Health
- ✓ Bio medical waste law
- ✓ Rapidex English course
- ✓ Hospital waste management and Monitoring
- ✓ Safe management of healthcare management information & learning from community
- ✓ Pesticides in India
- ✓ Setting environment standards
- ✓ CHLP Reports
- ✓ Community Health Monitoring Plan
- ✓ Chinese Acupuncture
- ✓ Elements of NHP
- ✓ Health for All
- ✓ Report on national Health policy Work shop
- ✓ Health and national manual
- ✓ Public health nutrition
- ✓ Research for development

- ✓ Methods for community development
- ✓ Participation research and evolution
- ✓ Community development
- ✓ How to measure and evaluation
- ✓ Community monitoring planning
- ✓ NRHM in the eleventh five years plan
- ✓ Primary health care
- ✓ Yoga foe diabetes
- ✓ Ayurveda
- ✓ Homeopathy
- ✓ Science and technology
- ✓ Ten steps towards organic farming
- ✓ Green tropism
- ✓ Ministry of Wayanad

Abstract

A study on the status of health care waste management and infection control practices in health care settings of Anekal Taluk, Bangalore Urban district

Introduction

Health care waste (HCW) is a potential source of infectious diseases and may also root to environmental pollution. This hazardous impact on human and environment can be minimised by implementation and execution of standard systematic Health Care Waste Management (HCWM) procedure. The study was accomplished to observe and describe HCWM and infection control (IC) practices in health care settings (HCS).

Materials and Method

A cross sectional study was conducted in Anekal taluk, Bangalore Urban district of Karnataka state by visiting 37 HCS during August and September, 2013. Data was collected using a standard check list for HCWM and IC related practices (segregation, storage, collection, transportation and disposal). Descriptive analysis was done using Microsoft Excel and SPSS version 20.

Result

Sharp waste containment was satisfactory in 51.4% and sharp waste disinfection/treatment in 45.9% (n=17) of HCS. Infected plastic waste was being disinfected 48.6% (n=18) HCS. Appropriate final disposal of sharp waste was carried out in 89.2% (n=33), infected plastic waste in 64.9% (n=24) and soiled waste in 83.8% (n=31) HCS. Sharp waste disfigurement was done at 75.7% (n=28) HCS and infected plastic waste disfigurement in 56.8% (n=20) HCS.

Conclusion

The study on the status of HCWM and IC practices illustrates that all the guidelines are not being followed at all the HCS and there is a need to strengthen the HCWM for better enforcement of guidelines to ensure the human health and environmental protection.

Keywords: Healthcare, Waste Management, Waste Disposal, Segregation, Containment, Disinfection

Introduction

Health care sector is one of the fastest growing sectors in India especially in the urban areas with an estimated growth rate of 12% per annum¹. With increasing number of health care settings (HCS) the health care waste generated is also increasing. An estimated 0.33 million tonnes of hospital waste is generated annually in India; the average waste generated per bed per day ranges between 0.5kg and 2 kg². WHO estimates that between 75% and 90% of hospital waste generated is non-hazardous and the remaining 10-25% is hazardous waste which has potential to affect human health³.

Healthcare waste is a source of environmental pollution and infectious diseases, and is made up of toxic chemicals, infective materials, plastic waste, sharps and general waste for which appropriate disposal is essential. Health care waste is dependable source for infectious diseases like gastroenteric infections, respiratory infections, ocular infections, tetanus, skin infections, HIV/AIDS and hepatitis³. Health care waste presents a threat not only to patients and their visitors but also to health care workers⁴. Appropriate management of these wastes is important to protect human and environmental

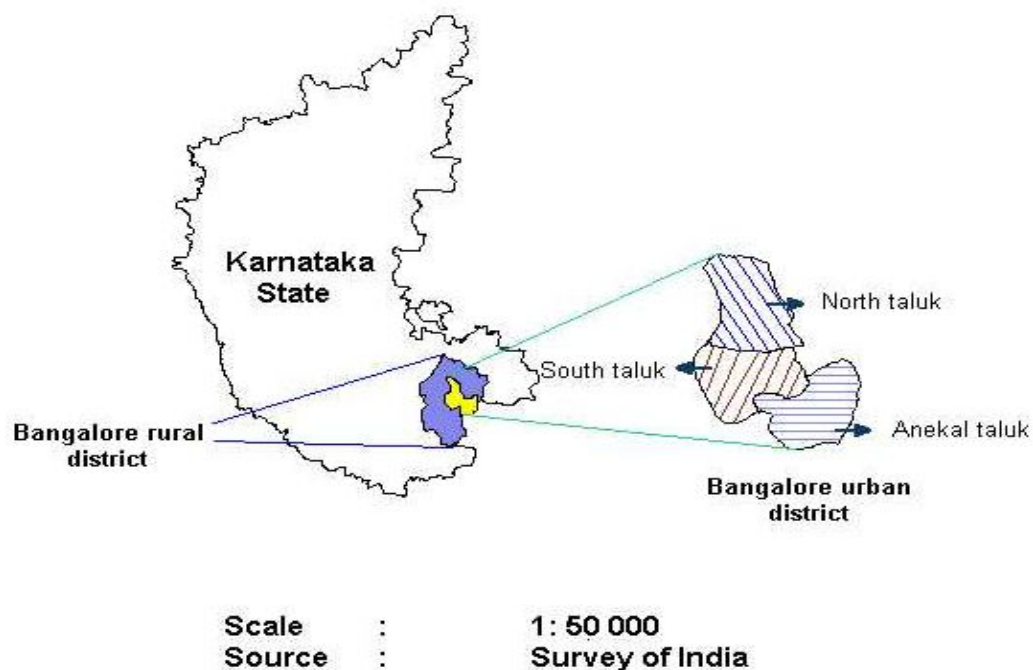
health and is a responsibility of all health care workers and facilities.³ Guidelines have been established for segregation, containment, colour coding, transportation and final disposal of healthcare waste. Studies conducted in different parts of the country have shown poor adherence to biomedical waste management rules prescribed by the Ministry of Environment and Forests as per the Bio-Medical Waste (Management and Handling) Rules, 1998^{5,6,7}.

In this context the present study was conducted to observe and assess healthcare waste management (HCWM) and infection control (IC) practices in HCS located in Anekal taluk of Bangalore urban district which has seen a recent spurt in urbanisation and increase in number of healthcare centres.

Materials and Method

Study Area: HCS located in Anekal taluk of Bangalore urban district which has seen a recent spurt in urbanisation and increase in number of healthcare centres.

Fig 1: Study area: Bangalore District



http://wgbis.ces.iisc.ernet.in/energy/water/paper/wetland_restoration/studyarea.htm

Study Design: A descriptive cross sectional was conducted to assess the existing health care waste management practices in 37 HCS including Primary

Health Centres (PHC), First Referral Unit (FRU), private hospitals, nursing homes, clinics, diagnostic centres.

Study Period: The study was conducted between August and September 2013 in Anekal taluk of Bangalore urban district

Sampling: A total of PHC-09, FRU-01, Clinics-13, Private hospital-11, Diagnostic centres-2, were selected through convenient sampling.

Study Population: Population for the study comprised of health workers (Doctors, Nurses, lab technicians, ward boys, ayah and helpers).

Inclusion criteria: Health care facilities with consent and permission were included in study. Within each centre, staff members (indicated above) who knew Kannada or English and willing to participate were included in the study.

Data collection: Data was collected using a modified version of a previously tested checklist which covers the HCWM topics of segregation, containment, colour coding, disfigurement, transportation, final dispose of waste and, availability of guidelines and infrastructure for waste disposal, personal protective measures/equipment (PPE) and vaccination status of at-risk workers.

Analysis: Data was entered in SPSS version 20. Basic analysis was performed using Microsoft Excel and the results were stratified and compared.

Results

The final sample for analysis conducted out of total 37 HCS in the study, Table 1 shows information of the various centres surveyed. Of the surveyed centres, 43.2% had in-patient services besides OPD services (56.25% were private hospitals and 31.25% were PHC's). FRU had the most number of beds per centre, in-patient admissions, out-patient visits, followed by private hospitals. (Table 1)

Table 1: Details about healthcare settings surveyed

Type of HCS	Only OPD		OPD+IP		Avg. Beds	Avg. admission/month	Avg. deliveries/month	Avg. OP visits
	N	%	n	%				
PHC (n=9)	4	44.4	5	55.6	4.8	14	12.7	805.6
FRU (n=1)	0	0	1	100	100	80	140	22500

Clinics (n=14)	13	92.9	1	7.1	0.4	0	0	698.6
Diagnostic centres (n=2)	2	100	0	0	0	0	0	0
Private Hospital (n=11)	2	18.2	9	81.8	24.5	36.4	17.4	1790.9
Total (n=37)	21	56.8	16	43.2	11.3	16.4	12	1600.8

Avg.- Average, OPD- Outpatient Department, IPD- Inpatient Department

Sharp management practices were observed and assessed at HCS surveyed. Colour coded dustbins were present only at 66.7% of PHC's, 7.1% of clinics, 50% of diagnostic centres and 54.5% of private hospitals surveyed. While appropriate sharp waste segregation was being done only at 77.8% of PHC's and 78.6% of clinics, all diagnostic centres and private hospitals were following appropriate segregation. Containment of sharp waste was being carried out only at 66.7% of PHC's, 35.7% of clinics, 50% of diagnostic centres and 66.7% of private hospitals included in the study. Sharp waste disfigurement was being done at majority or all of the different types of HCS surveyed except for in clinics. Other than clinics, majority of the other HCS undertook safe transportation of sharp wastes. Appropriate sharp waste disposal was being carried out at majority of the HCS surveyed. (Table 2)

Table 2: Sharp waste management practices being followed at healthcare settings surveyed

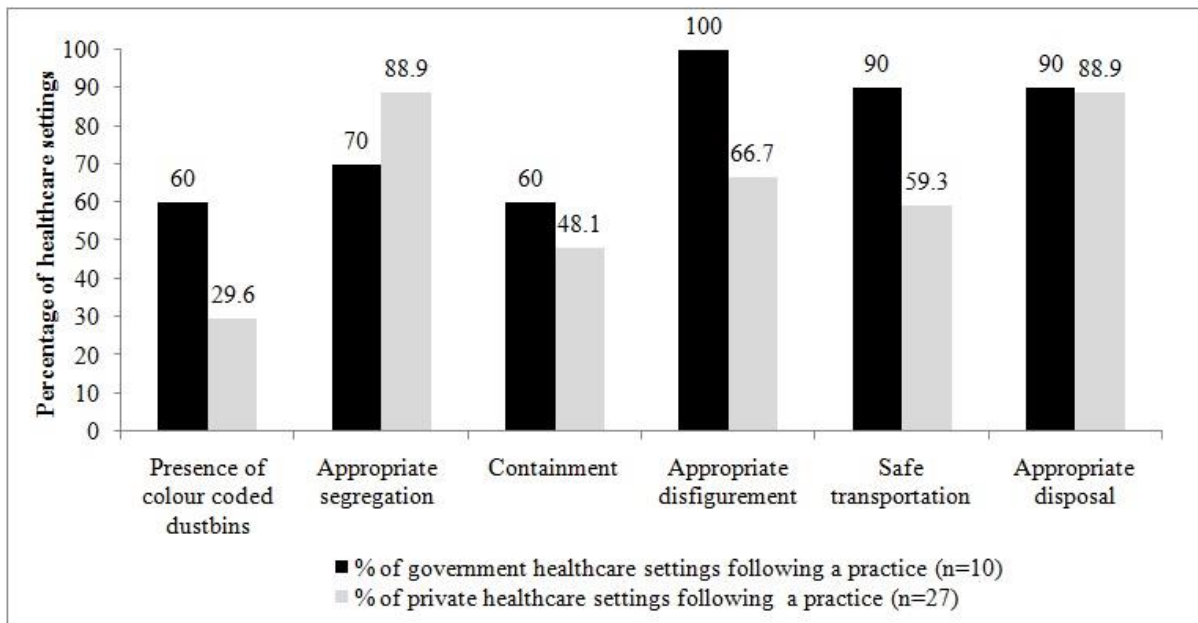
Type of HCS	Presence of colour coded dustbins		Appropriate segregation		Containment		Appropriate disfigurement		Safe transportation		Appropriate disposal	
	N	%	N	%	N	%	N	%	N	%	N	%
PHC (n=9)	6	66.7	7	77.8	6	66.7	9	100	8	88.9	8	88.9
FRU (n=1)	0	0	0	0	0	0	1	100	1	100	1	100
Clinics (n=14)	1	7.1	11	78.6	5	35.7	6	42.9	6	42.9	11	78.6
Diagno	1	50	2	100	1	50	2	100	2	100.0	2	100

stic centres (n=2)												
Private Hospital (n=11)	6	54.5	11	100	7	63.6	10	90.9	8	72.7	11	100

N=Number of centres adhering to guidelines

Comparing government and private HCS with regards to sharp waste management shows that for all sharp waste management practices except appropriate segregation, government HCS were performing better than private HCS. (Figure 1)

Figure 1: Comparison of sharp waste management practices between government and private healthcare settings surveyed



Infected plastic waste management practices were studied at HCS surveyed. Colour coded dustbins for disposal of infected plastic waste were present only at 55.6% PHC's, 14.3% of clinics, 50% of diagnostic centres, and 45.5% of private hospitals and at the single FRU surveyed. Except for clinics appropriate segregation of infected plastic waste was being carried out at all other HCS. While only at 77.8% PHC's, 35.7% clinics, 54.5% private disfigurement of infected plastic waste was being carried, at the FRU and all diagnostic centres such practice was being followed. Disinfection of infected plastic waste was being carried out at 55.6% PHC's, 35.7% clinics, 63.6% private clinics, the FRU and none of the diagnostic centres respectively. With

regards to appropriate disposal of infected plastic waste it was being done at 77.8% PHC's, 50% clinics, 63.6% private hospitals, the FRU and all the diagnostic centres. (Table 3)

Table 3: Infected plastic waste management practices being followed at healthcare settings surveyed

Type of HCS	Presence of colour coded dustbins		Appropriate segregation		Containment		Appropriate disinfection		Infected Plastics Disinfection		Safe transportation		Appropriate disposal	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
PHC (n=9)	5	55.6	9	100	7	77.8	7	77.8	5	55.6	5	55.6	7	77.8
FRU (n=1)	1	100	1	100	1	100	1	100	1	100	1	100	1	100
Clinics (n=14)	2	14.3	11	78.6	5	35.7	5	35.7	5	35.7	6	42.9	7	50
Diagnostic centres (n=2)	1	50	2	100	1	50	2	100	0	0	1	50	2	100
Private Hospital (n=11)	5	45.5	11	100	6	54.5	6	54.5	7	63.6	6	54.5	7	63.6

N=Number of settings adhering to guidelines

While comparing government and private HCS with regards to their infected plastic waste disposal it is seen that the former have better waste management practices than the latter in terms of proportion of HCS following a practice. (Figure 2)

Figure 2: Comparison of infected plastic waste management practices between government and private healthcare settings surveyed

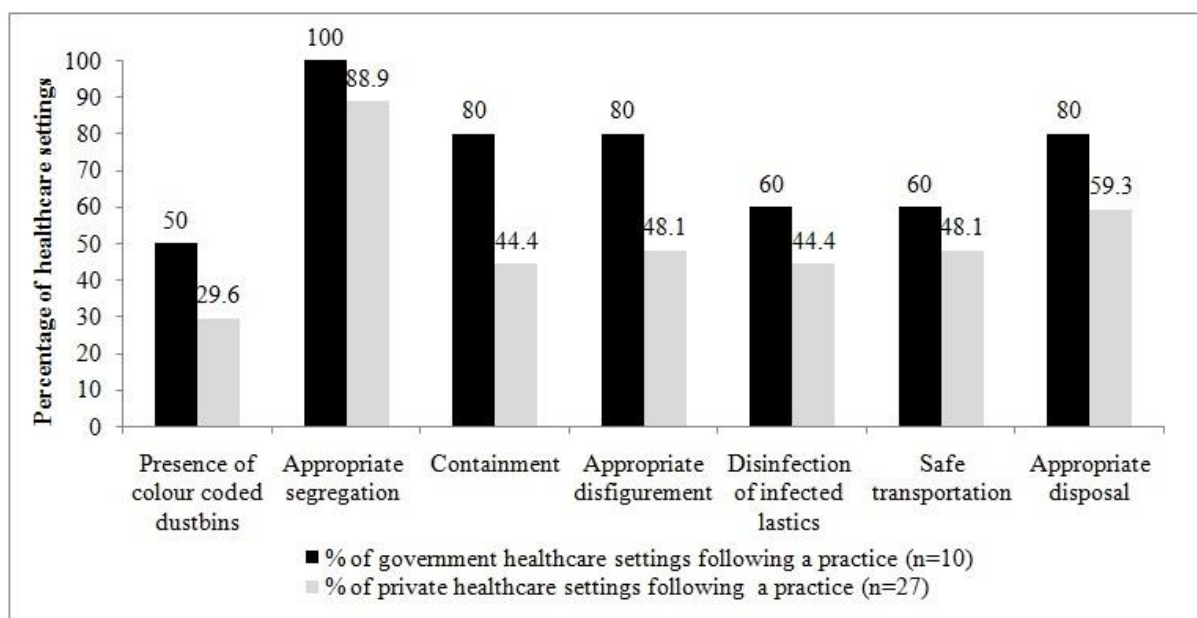


Table 4 provides information on the facilities available and methods used for disposal of healthcare wastes at various settings. Incinerator was not available at any of the HCS surveyed. Autoclave, burial pit and sharp pit were being used present all the PHC's. In contrary to guidelines two PHC's reported that plastic waste was being burnt. Autoclave was present at 21.4% of the clinics and 45.5% of the private hospitals. The FRU, clinics, private hospitals and diagnostics centres out sourced their HCWM to a private agency for final disposal and hence had no need for burial and sharp pit.

Table 4: Facilities available and methods used for final disposal of healthcare waste in the healthcare settings surveyed

Type of HCS	Burning		Autoclave		Burial Pit		Waste Sharps Pit	
	Yes	%	Yes	%	Yes	%	Yes	%
PHC (n=9)	2	22.2	9	100	9	100	9	100
FRU (n=1)	0	0	1	100	0	0	0	0
Clinics (n=14)	0	0	3	21.4	0	0	0	0
Diagnostic centres (n=2)	0	0	0	0	0	0	0	0
Private Hospital (n=11)	0	0	5	45.5	0	0	0	0

Expect for one private hospital there was satisfactory usage of gloves by ward boy at other HCS with ward boys. With regards to vaccination status of ward boy except for private hospital rest of the HCS with ward boys had vaccinated them. Of the HCS with ayah's on roll not at all PHC's and private hospitals there was satisfactory usage of gloves and except for ayah's in PHC in all other HCS they were vaccinated. In all HCS with helpers there was satisfactory usage of gloves by them and also all of them were vaccinated. (Table 5)

Table 5: Occupational safety measures for healthcare workers at healthcare settings surveyed

Type of HCS	Gloves usage Ward Boy		Vaccination status of Ward Boy		Gloves usage Ayah		Vaccination status of Ayah		Gloves usage Helper		Vaccination Status of Helper	
	CWB	Satisfactory usage (%)	CWB	Vaccinated (%)	CWA	Satisfactory usage (%)	CWA	Vaccinated (%)	CWH	Satisfactory usage (%)	CWH	Vaccinated (%)
PHC (n=9)	5	100	5	100	4	75	4	75	1	100	1	100
FRU (n=1)	1	100	1	100	1	100	1	100	1	100	1	100
Clinics (n=14)	2	100	2	100	1	0	1	100	1	100	1	100
Diagnostic centres (n=2)	1	100	1	100	0	0	0	0	0	100	0	100
Private Hospital	5	80	5	80	3	67	3	100	3	100	3	100

(n=11)											
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CWWB = Centres with ward boys, CWA = Centres with ayah CWH = Centres with helpers

District Nodal Officer for healthcare waste management has visited all the HCS surveyed for purpose of monitoring. Majority of the HCS had obtained authorization from Karnataka Pollution Control Board for healthcare waste generation and consequent management. There was lack of system for recording of illness/ injuries/ accidents resulting from healthcare waste handling limited to healthcare workers in majority of the HCS. Similarly there was lack of a monitoring mechanism for healthcare waste management system in majority of the HCS. Staff training was also found to be lacking in majority of the HCS. Accident register was available only at two PHC's and the FRU. While the FRU had all the required monitoring and regulatory systems in place, the diagnostic centers were seen to be lacking in all such systems expect for obtaining authorization from Karnataka Pollution Control Board. (Table 6)

Table 6: Compliance with monitoring and regulatory systems for healthcare waste management at healthcare settings surveyed

Type of HCS	Authorization from Pollution Control Board obtained		System of recording of illness/ injuries/ accidents		Monitoring of waste management system		Training/ retraining to the staff provided		Accident register	
	Yes	%	Yes	%	Yes	%	Yes	%	Yes	%
PHC (n=9)	8	88.9	4	44.4	5	55.6	4	44.4	2	22.2
FRU (n=1)	1	100	1	100	1	100	1	100	1	100
Clinics (n=14)	13	92.9	1	7.1	1	7.1	4	28.6	0	0
Diagnostic centres (n=2)	2	100	0	0	0	0	0	0	0	0
Private Hospital (n=11)	10	90.9	4	36.4	3	27.3	3	27.3	1	9.1

Discussion

The present study was aimed at assessing the practice of Health Care Waste Management indicates that HCWM guidelines were not being adhered at all HCS. The situation in government HCS being better compared to private HCS as per this study. Two health centers studied were burning plastic wastes, a source of dioxins which have adverse health effects⁸. The importance of segregation is to separate infectious and non infectious waste and to avoid potential hazards which may occur as a result of mixing the waste produced. Similar to the present study, studies conducted in Lucknow, Uttar Pradesh; Pulwama, Jammu and Kashmir have shown that colour coding for containment of wastes was not being practiced at HCS which led to poor segregation practices; however a study conducted in rural India have shown that the HCS was following colour coding of wastes^{6,7,9}. Similar to our findings, a study conducted in Pune, Maharashtra showed that segregation of sharps and infected plastic waste was being adhered in majority of HCS^{6,10}.

Disfigurement of sharps which is important in order to prevent injuries and also to prevent transmission of communicable diseases like Hepatitis B, HIV/AIDS, is not being followed at some HCS according to the present study and also studies conducted in Pune, Kathmandu and Nepal^{10,11}. Similar to the findings of the present study health care workers in Pune were provided with personal protective equipment and were in practice; however, a study conducted in Agra showed poor usage of personal protective equipment^{10,12}. Thus it can be seen that all the HCS are not adhere to HCWM guidelines. The strengths of the study is that both government and private HCS including diagnostics centres of Anekal taluk were included and tested study tool was used for data collection. However, due to time constraint, only few hospitals could be visited. Due to inability to obtain permission from some of the private HCS for this study, the sample size was reduced furthermore.

Conclusion:

The study conducted in HCS located in Anekal taluk of Bangalore urban district shows that, most of the HCS are following HCWM rules prescribed by the Ministry of Environments and Forests, Government of India. There is a need to address on some of the issues like following the colour coded bins, disfigurement, disinfection and safe transportation in private HCS compare to public HCS. Enabling the knowledge and practicing skills among healthcare personnel's at HCS may lead for positive outcome. There is a need to tackle these issues with hand holding trainings, capacity building to practice and

disseminate knowledge about HCWM. Continues monitoring and evaluation could help to sustain the HCWM and practice at all levels of HCS.

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PRESIDENT'S MESSAGE



The UN Basel Convention has identified health care waste as the second most hazardous waste after radioactive waste. There are not very many countries which have made significant contributions in this field. India is one of them, especially in south East Asia. India was the first country to have legislation on bio-medical waste in 1998. The Indian Society of Hospital Waste Management (ISHWM) was formed soon after, in the year 2000. Air Marshal (retd) L K Verma as founder President ISHWM nurtured it for long time and made sincere efforts to bring it to a centre stage. Today, ISHWM has distinguished membership spread across the country. The ISHWM and its members have been on Board of National and International agencies, namely, Government of India, WHO, UNDP, UNIDO and others. ISHWM contributed in the planning and development of IGNOU's six month duration Certificate Programme in Health Care Waste Management (CHCWM) through distance learning.

It is heartening to note that WHO, SEARO has recently signed an Agreement for Performance of Work (APW) with ISHWM to undertake a multicentric research study "On Linkage between Hospital Associated Infections and Health Care Waste". Further, as many of you are aware that the 2nd Edition of the WHO HQ Geneva's famous Blue Book "Safe Management of Waste from Health Care Activities", January 2013 has been published. It is like a global Bible on HCWM. The President ISHWM has authored Chapter 13 in the Blue Book. <http://www.healthcarewaste.org>.

I would recommend that you should download it and read at your convenience.

The ISHWM has a great repository of experts and talent across in HCWM the country. The last ISHWMCON 2012 at Yenepoya Medical University, Mangalore was a great success. I am grateful to KGMU, Lucknow to take a laudable initiative to host ISHWMCON 2013. I am also grateful to WHO, SEARO specially Mrs Payden to support our conferences and take initiative to invite delegates from number of SEA countries.

I am sure the delegates and students will be immensely benefited by way of rich scientific deliberations, presentations and interactions during this conference and through this coveted Journal which will be ejournal from this issue.

Wish you all Merry X-Mas and Happy New Year.

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EDITORS PAGE



Esteemed readers and members of ISHWM!

It brings immense pleasure to the editorial board to bring out this issue of the Journal of ISHWM (Vol 12 No1 September 2013).

Interesting experiential articles are the highlight of current issue.

Situation of Health Care Waste Management in Primary Health Care setting portrayed in three articles – from Chikkaballapur District, Anekal Taluk, Udupi Taluk in Karnataka is probably representative of picture in Primary Health care system in Karnataka and rest of India. It is good to see research articles from Government Health system. Proposal to consider pasteurization of water is an attempt towards innovation by Dr Ramesh of Karnataka Pollution Control Board. Dr Arpana traces chronicles of mercury. There are articles on mercury and plastic management from MS Ramaiah Dental College and Bangalore Medical College. Dr Ramakrishna Goud takes us through grey areas of health care waste management. Dr S Kumar, President, Medical Education, Gokula Education Foundation, Bangalore makes silent contribution through inspiring quotations across the Journal. From this issue, the Journal of ISHWM will be an e- Journal and will be hosted in website from second week of Dec 2013. The editorial board seeks support of all readers to help in designing, developing, updating an email directory of all ISHWM members and readers who subscribe to the Journal. The editorial board invites research articles, useful information on trainings, conferences, resource materials and educational materials, documentation of innovations made from across the South East Asia Region. Please help us develop the Journal, further.

Indeed it has been a tough job to bring out the journal on time. The Governing Council of ISHWM and Faculty and Post graduate students of the Dept. of Community Medicine, and friends of Health Care Waste Management Cell, MS Ramaiah Medical College have extended their support to make it possible to bring out this issue, as in the past.

We thank the readers for their continued support and participation through the forum created by ISHWM.

Merry Christmas and Happy New Year! With warm regards

Dr Sreekantaiah Pruthvish

Hon Chief Editor, Journal of Indian Society of Hospital Waste management

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ORIGINAL ARTICLE

A STUDY ON THE STATUS OF HEALTH CARE WASTE MANAGEMENT AND INFECTION CONTROL PRACTICES IN HEALTHCARE SETTINGS OF ANEKAL TALUK, BANGALORE URBAN DISTRICT

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INTRODUCTION: *Health care waste (HCW) is a potential source of infectious diseases and may also root to environmental pollution. This hazardous impact on human and environment can be minimized by implementation and execution of standard systematic Health Care Waste Management (HCWM) procedure. The study was accomplished to observe and describe HCWM and infection control (IC) practices in health care settings (HCS).*

MATERIALS AND METHOD: *A cross sectional study was conducted in Anekaltaluk, Bangalore Urban district of Karnataka state by visiting 37 HCS during August and September, 2013. Data was collected using a standard check list for HCWM and IC related practices (segregation, storage, collection, transportation and disposal). Descriptive analysis was done using Microsoft Excel and SPSS version 20.*

RESULT: *Sharp waste containment was satisfactory in 51.4% and sharp waste disinfection/treatment in 45.9% (n=17) of HCS. Infected plastic waste was being disinfected 48.6% (n=18) HCS. Appropriate final disposal of sharp waste was carried out in 89.2% (n=33), infected plastic waste in 64.9% (n=24) and soiled waste in 83.8% (n=31) HCS. Sharp waste disfigurement was done at*

75.7% (n=28) HCS and infected plastic waste disfigurement in 56.8% (n=20) HCS.

CONCLUSION: The study on the status of HCWM and IC practices illustrates that all the guidelines are not being followed at all the HCS and there is a need to strengthen the HCWM for better enforcement of guidelines to ensure the human health and environmental protection.

Keywords: Healthcare, Waste Management, Waste Disposal, Segregation, Containment, Disinfection

INTRODUCTION

Health care sector is one of the fastest growing sectors in India especially in the urban areas with an estimated growth rate of 12% per annum¹. With increasing number of health care settings (HCS) the health care waste generated is also increasing. An estimated 0.33 million tonnes of hospital waste is generated annually in India; the average waste generated per bed per day ranges between 0.5kg and 2 kg². WHO estimates that between 75% and 90% of hospital waste generated is non-hazardous and the remaining 10-25% is hazardous waste which has potential to affect human health³.

Healthcare waste is a source of environmental pollution and infectious diseases, and is made up of toxic chemicals, infective materials, plastic waste, sharps and general waste for which appropriate disposal is essential. Health care

waste is dependable source for infectious diseases like gastroenteric infections, respiratory infections, ocular infections, tetanus, skin infections, HIV/AIDS and hepatitis³. Health care waste presents a threat not only to patients and their visitors but also to health care workers⁴. Appropriate management of these wastes is important to protect human and environmental health and is a responsibility of all health care workers and facilities.³ Guidelines have been established for segregation, containment, colour coding, transportation and final disposal of healthcare waste. Studies conducted in different parts of the country have shown poor adherence to biomedical waste management rules prescribed by the Ministry of Environment and Forests as per the Bio-Medical Waste (Management and Handling) Rules, 1998^{5,6,7}.

In this context the present study was conducted to observe and assess

healthcare waste management (HCWM) and infection control (IC) practices in HCS located in Anekal taluk of Bangalore urban district which has seen a recent spurt in urbanisation and increase in number of healthcare centres.

MATERIALS AND METHODS

Study Design: A descriptive cross sectional was conducted to assess the existing health care waste management practices in 37 HCS including Primary Health Centres (PHC), First Referral Unit (FRU), private hospitals, nursing homes, clinics, diagnostic centres.

Study Period and Population: The study was conducted between August and September 2013 in Anekal taluk of Bangalore urban district. Population for the study comprised of health workers (Doctors, Nurses, lab technicians, ward boys, ayah and helpers).

Sampling: A total of PHC-09, FRU-01, Clinics-13, Private hospital-11, Diagnostic centres-2, were selected through convenient sampling.

Inclusion criteria: Health care facilities with consent and permission were included. Within each centre, staff members who

knew Kannada or English and willing to participate.

Data collection and analysis: Data was collected using a modified version of a previously tested checklist which covers the HCWM topics of segregation, containment, colour coding, disfigurement, transportation, final dispose of waste and, availability of guidelines and infrastructure for waste disposal, personal protective measures/equipment (PPE) and vaccination status of at-risk workers. Data was entered in SPSS version 20. Basic analysis was performed using Microsoft Excel and the results were stratified and compared.

RESULTS

The final sample for analysis conducted out of total 37 HCS in the study, Table 1 shows information of the various centres surveyed. Of the surveyed centres, 43.2% had in-patient services besides OPD services (56.25% were private hospitals and 31.25% were PHC's). FRU had the most number of beds per centre, in-patient admissions, out-patient visits, followed by private hospitals. (Table 1)

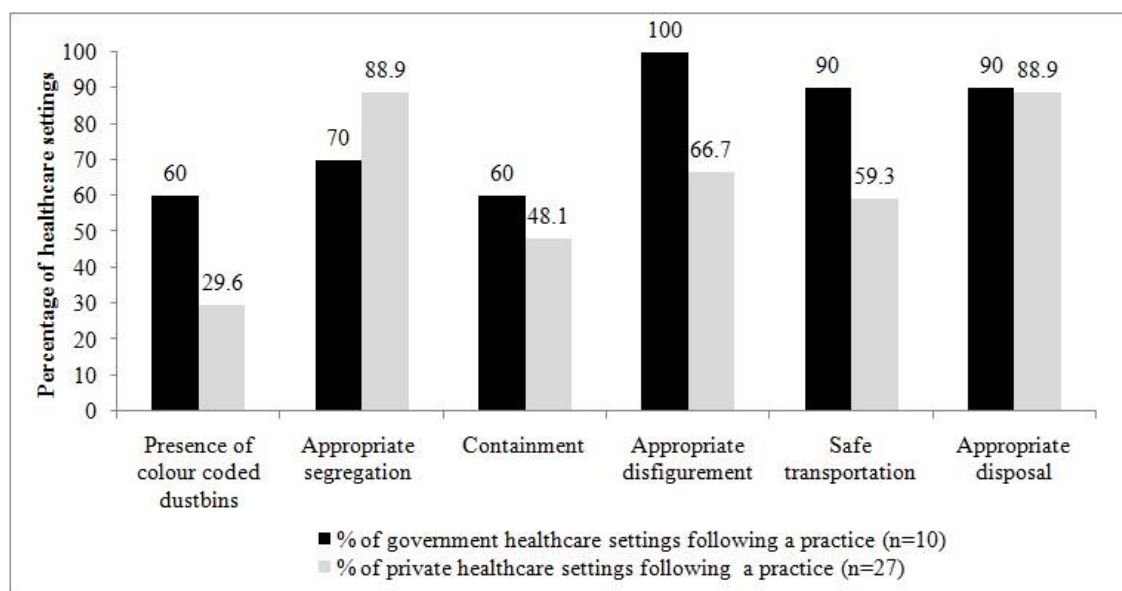
Table 3: Details about healthcare settings surveyed

Type of HCS	Only OPD N	OPD+IP %	OPD+IP n	OPD+IP %	Avg. Beds	Avg. admission/	Avg. deliveries/	Avg. OP
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PHC (n=9)	6	66.7	7	77.	6	66.	9	100	8	88.9	8	88.9
FRU (n=1)	0	0	0	0	0	0	1	100	1	100	1	100
Clinics (n=14)	1	7.1	11	78.	5	35.	6	42.	6	42.9	1	78.6
Diagno stic centres (n=2)	1	50	2	100	1	50	2	100	2	100.	2	100
Private Hospit al (n=11)	6	54.5	11	100	7	63.	10	90.	8	72.7	1	100
						6		9			1	

N=Number of centres adhering to guidelines

Figure 1: Sharp waste management practices in government and private settings



Comparing government and private HCS with regards to sharp waste management shows that for all sharp waste management practices except appropriate segregation, government

HCS were performing better than private HCS. (Figure 1)

Infected plastic waste management practices were studied at HCS surveyed. Colour coded dustbins for disposal of infected plastic waste

were present only at 55.6% PHC's, 14.3% of clinics, 50% of diagnostic centres, 45.5% of private hospitals and at the single FRU surveyed. Except for clinics appropriate segregation of infected plastic waste was being carried out at all other HCS. While only at 77.8% PHC's, 35.7% clinics, 54.5% private disfigurement of infected plastic waste was being carried, at the FRU and all diagnostic centres such

practice was being followed. Disinfection of infected plastic waste was being carried out at 55.6% PHC's, 35.7% clinics, 63.6% private clinics, the FRU and none of the diagnostic centres respectively. With regards to appropriate disposal of infected plastic waste it was being done at 77.8% PHC's, 50% clinics, 63.6% private hospitals, the FRU and all the diagnostic centres. (Table 3)

Table 3: Infected plastic waste management practices being followed at healthcare settings surveyed

Type of HCS	Presence of colour coded dustbins		Appropriate segregation		Containment		Appropriate disfigurement		Infected Plastics Disinfection		Safe transportation		Appropriate disposal	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
PHC (n=9)	5	55.6	9	100	7	77.8	7	77.8	5	55.6	5	55.6	7	77.8
FRU (n=1)	1	100	1	100	1	100	1	100	1	100	1	100	1	100
Clinics (n=14)	2	14.3	11	78.6	5	35.7	5	35.7	5	35.7	6	42.9	7	50
Diagnostic centres (n=2)	1	50	2	100	1	50	2	100	0	0	1	50	2	100
Private Hospital (n=11)	5	45.5	11	100	6	54.5	6	54.5	7	63.6	6	54.5	7	63.6

N=Number of settings adhering to guidelines

Private Hospital (n=11)	0	0	5	45.5	0	0	0	0
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Table 5: Occupational safety measures for healthcare workers at healthcare settings

Type of HCS	Gloves usage Ward Boy		Vaccination status of Ward Boy		Gloves usage Ayah		Vaccination status of Ayah		Gloves usage Helper		Vaccination Status of Helper	
	C	Satisfactory usage (%)	C	Vaccinated (%)	C	Satisfactory usage (%)	C	Vaccinated (%)	C	Satisfactory usage (%)	C	Vaccinated (%)
PHC (n=9)	5	100	5	100	4	75	4	75	1	100	1	100
FRU (n=1)	1	100	1	100	1	100	1	100	1	100	1	100
Clinics (n=14)	2	100	2	100	1	0	1	100	1	100	1	100
Diagnostic centres (n=2)	1	100	1	100	0	0	0	0	0	0	0	0
Private Hospital (n=11)	5	80	5	80	3	67	3	100	3	100	3	100

CWWB = Centres with ward boys, CWA = Centres with ayah CWH = Centres with helpers

Table 6: Compliance with monitoring and regulatory systems for healthcare waste management at healthcare settings surveyed

Type of HCS	Authorisation from Pollution Control Board obtained		System of recording of illness/ injuries/ accidents		Monitoring of waste management system		Training/ retraining to the staff provided		Accident register	
	Yes	%	Yes	%	Yes	%	Yes	%	Yes	%
PHC (n=9)	8	88.9	4	44.4	5	55.6	4	44.4	2	22.2
FRU (n=1)	1	100	1	100	1	100	1	100	1	100
Clinics (n=14)	13	92.9	1	7.1	1	7.1	4	28.6	0	0
Diagnostic centres (n=2)	2	100	0	0	0	0	0	0	0	0
Private Hospital (n=11)	10	90.9	4	36.4	3	27.3	3	27.3	1	9.1

Expect for one private hospital there was satisfactory usage of gloves by ward boy at other HCS with ward boys. With regards to vaccination status of ward boy except for private hospital rest of the HCS with ward boys had vaccinated them. Of the HCS with ayah's on roll not at all PHC's and private hospitals there was satisfactory usage of gloves and except for ayah's in PHC in all other HCS they were vaccinated. In all HCS

with helpers there was satisfactory usage of gloves by them and also all of them were vaccinated. (Table 5) District Nodal Officer for healthcare waste management has visited all the HCS surveyed for purpose of monitoring. Majority of the HCS had obtained authorisation from Karnataka Pollution Control Board for healthcare waste generation and consequent management. There was lack of system for recording of illness/ injuries/ accidents resulting

from healthcare waste handling limited to healthcare workers in majority of the HCS.

Similarly there was lack of a monitoring mechanism for healthcare waste management system in majority of the HCS. Staff training was also found to be lacking in majority of the HCS. Accident register was available only at two PHC's and the FRU. While the FRU had all the required monitoring and regulatory systems in place, the diagnostic centres were seen to be lacking in all such systems expect for obtaining authorisation from Karnataka Pollution Control Board. (Table 6)

DISCUSSION

The present study was aimed at assessing the practice of Health Care Waste Management indicates that HCWM guidelines were not being adhered at all HCS. The situation in government HCS being better compared to private HCS as per this study. Two health centres studied were burning plastic wastes, a source of dioxins which have adverse health effects⁸. The importance of segregation is to separate infectious and non infectious waste and to avoid potential hazards which may occur as a result of mixing the waste

produced. Similar to the present study, studies conducted in Lucknow, Uttar Pradesh; Pulwama, Jammu and Kashmir have shown that colour coding for containment of wastes was not being practiced at HCS which led to poor segregation practices; however a study conducted in rural India have shown that the HCS was following colour coding of wastes^{6,7,9}. Similar to our findings, a study conducted in Pune, Maharashtra showed that segregation of sharps and infected plastic waste was being adhered in majority of HCS^{6,10}.

Disfigurement of sharps which is important in order to prevent injuries and also to prevent transmission of communicable diseases like Hepatitis B, HIV/AIDS, is not being followed at some HCS according to the present study and also studies conducted in Pune, Kathmandu and Nepal^{10,11}. Similar to the findings of the present study health care workers in Pune were provided with personal protective equipment and were in practice; however, a study conducted in Agra showed poor usage of personal protective equipment^{10,12}. Thus it can be seen that all the HCS are not adhere to HCWM guidelines. The strengths of the study is that both

government and private HCS including diagnostics centres of Anekतालुक were included and tested study tool was used for data collection. However, due to time constraint, only few hospitals could be visited. Due to inability to obtain permission from some of the private HCS for this study, the sample size was reduced furthermore.

CONCLUSION:

The study conducted in HCS located in Anekतालुक of Bangalore urban district shows that, most of the HCS are following HCWM rules prescribed by the Ministry of Environments and Forests, Government of India. There is a need to address on some of the issues like following the colour coded bins, disfigurement, disinfection and safe transportation in private HCS compare to public HCS. Enabling the knowledge and practicing skills among healthcare personnel's at HCS may lead for positive outcome. There is a need to tackle these issues with hand holding trainings, capacity building to practice and disseminate knowledge about HCWM. Continues monitoring and evaluation could help to sustain the HCWM and practice at all levels of HCS.

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“You will never reach your destination if you
Stop and throw stones at Every dog that barks”

--Winston Churchill

