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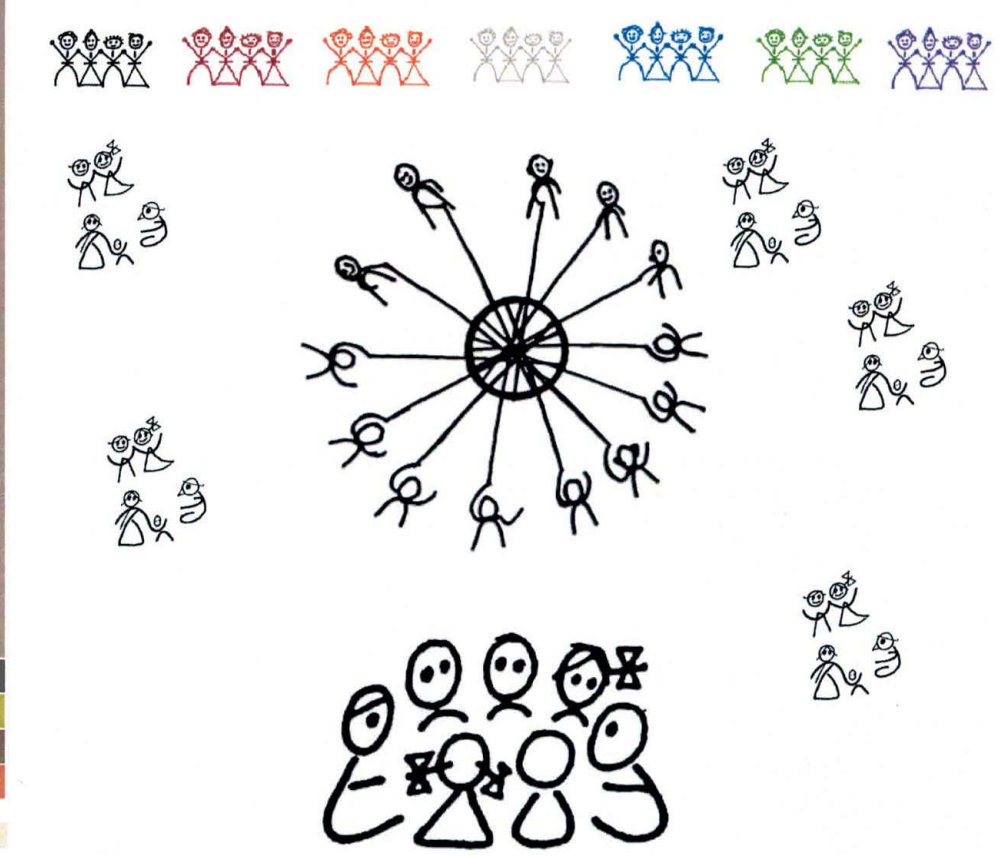
Community Health Learning Programme

A Report on the Community Health Learning Experience

AZAM KHAN



School of Public Health Equity and Action
(SOPHEA)

sochara
building community health

Society for Community Health Awareness Research and Action

COMMUNITY HEALTH LEARINIG PROGRAMME

(ANNUAL REPORT)

I would like to thank SISEC for ethical gave ethical permission with their valuable suggestions for such a small study.

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Learning been a reward indeed, it's a life time learning memorable experience. Without the guidance and help of all the stated persons, institutions and organizations, this would have never been completed in such a fruitful way.

- Azam Khan

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CONTENTS

Reason to join CHLP

After seven years in voluntary sector I worked on democratic rights of marginalized communities (Dalit, Minority, Child; Women) as a social advocate. I felt that health is an important issue for marginalized communities but I am not aware about it. Before joining the programme I understand the market forces decides the agenda for poor people and without understanding the issue I can not intervene in it. I decide to join the fellowship programme with goal of knowledge, experience and learning about Community health.

Learning objectives

1) To understand the health
2) To understand the health and development
3) To start a new journey of life.

Abbreviation

1) **ASHA:** Accredited Social Health Activist
2) **USHA:** Urban Social Health Activist
3) **ANM:** Auxiliary Nurse Midwife
4) **VHND:** Village Health and Nutrition Day
5) **HIV:** Human immunodeficiency Virus
6) **AIDS:** Acquired Immunodeficiency Syndrome
7) **BWWF:** Beedi Worker Welfare Fund

LEARNING FROM COLLECTIVE SESSIONS

It is one year Community Health Learning Programme (CHLP) and annual report is based on my learning experience, observation and reflection through collective sessions (in the classrooms and field visits) and visits. Programme equally divided in collective sessions and field work and it is a uniqueness of the programme which provides equal opportunity to experience community life and community health with health care system.

HEALTH

Before **Community Health Learning Programme,** I thought the presence of Doctor, Hospital, Medicine facilities is health but after the programme I knew that it all address the need of ill-being not well-being and now health for me is -Physical, mental and overall well being not absence of illness. Now a day we are facing many health problems due to various reasons and we realize it also. Health is important aspect of human life without healthy life one cannot imagine value of life. Presently in our society we are discussing the illness and its preventive measures while we have to concentrate on root. As per **WHO** definition, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."(From 7 April 1948.)

Every society have rich and diverse heritage of healthy life and in our society we call it AYUSH (Ayurved, Yoga, Unani, Siddha, Homepathy) which is in compact form. From last so many years we are continuously shifting to Bio-medic model and Govt. also support it on every level. To address health problems we have health system in India which is mainly based on Bio-Medicine and other remedies supplement it. But in our society people first apply traditional approach to prevent any illness or health problem and it is also economical and tested method to get healthy life.

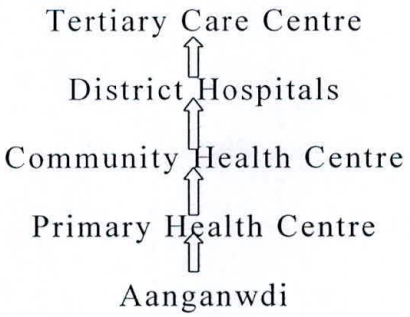
Public health

In our country Public Health address two major aspect of health: Health care system and health promotion and prevention. It is led under Govt. policies and schemes and the participation of people is very less. While health is an integrated matter and other factors are also important (Like: People, health Practitioners, Voluntary Organizations etc.). Basically our public health system support and promote bio-medic but now they provide space to others like: Unani, ayurveda also but the system treat other health practitioners not equally. our public health system face many problems and Trained human resources is one of a major problem so they provide space to others also but their (Others) medicines and other things are not in good condition.

Community Health

Community health is not a new thing for our society from ancient time when we lived in small groups or community we applied it. But after bio-medicine and imperial time it collapse and after independence our Govt. promote bio-medicine model and it spoiled others. Community health is a very simple and democratic model which is based on community knowledge, condition, accessibility, availability and community participation. Public health is based on top to bottom Approach and community health system is based on bottom to top approach and we can small reflection in our present health care system as Rogi Kalyan Samiti. Community health care system is harmonious and has Ayurveda, Unani, Sidha and Homeopathy. After NRHM or NHM we can say that Govt. realise that it is necessary for the people of country.

Public Health System in India (Structure)



Factor Affecting Health

In this Globalize period everybody is anxious about health and understands the value of healthy life. Health is not a self-dependent element in human life it is inter-dependent with others: Social, Economical, Political, Environmental, Cultural (SEPCE) and these factors decides healthy life in society.

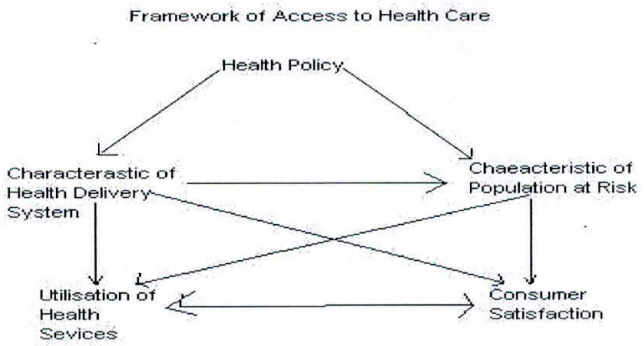
A_4's (Accessibility, Availability, Acceptability, Affordability,)

4 A is a most important aspect in utilisation of health care services through Rakku's Story we can understand it after so many years the condition is same. Most of the voluntary sector organisations work on awareness in society. These following factors affecting 4 A's:

1. Individual,
2. Household,
3. Community
4. Authorities,
5. Policies, Schemes and Law

Few organisations added two aspects in it: A (Appropriate) and Quality and now it are $\mathbf{A_5Q}$.

Frame Work of Access to Health Care



Social Determents of Health (SDH) and Social Vaccine

SOCIAL Determinants of health decides health of a person or community and we can classify it in three segments (Conceptual Framework):

1. I :Socio-Economic-Political
2. II :Structural Determinants(Income, Education, Class)
3. III :Intermediary Determinants(Social, Cultural; Psycho Environment)

Primarily we study social status, income-employment, education, gender, culture, women & child development, food security, social environment, psychological environment, water and sanitation and universal access to health care under SDH. We can tackle these issues by three steps:

1. To improve daily living conditions,
2. To tackle the equitable distribution of power, money and resources,

3. To measure and understand the problem and access the impact of action.

Drug Companies manufacture medicines and vaccines to prevent the diseases in human body and **Social Vaccines** prevent root cause of diseases in society on the basis of SEPEC. In developed countries they rid the disease by social programmes. It works on two levels:

1. Structural,
2. Vulnerability.

Drug companies are interested to earn more profit so they manufacture drugs and promote their drugs in the market. But if you want to cut you health expenditure you will invest in Social Vaccines because it provides you sustainable solution and resistance in society like: if you invest in Life Skill Education you can prevent domestic Violence, Alcoholism, and HIV (through Responsible Human Being). In comparison the cost or investment of social vaccine is not more than vaccine and it will change the scene health

Illness comes late but inequality comes early like: Discrimination and Dr.Karan Singh said, "Development is the best contraceptive".

Alma Ata

In 1978 an International Conference on Primary Health Care was organized in Alma-Ata at Kazakhstan and was attended by virtually all the member nations of the World Health Organization (WHO) and UNICEF. The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care (PHC) as the key to the attainment of the goal of **Health for All (HFA)**. Following are key points of the declaration:

- Health is a fundamental human right and health is a most important world-wide social goal which requires the action of many other social and economic sectors.
- existing gross inequality in the health status of the people, between developed and developing countries, within countries, is politically, socially, and economically unacceptable and therefore its common concern to all countries.
- People have a right and duty to participate individually and collectively in the planning and implementation of their health care.
- Primary health care is essential health care for human Life.
- Through full and better use of resources we will achieve Health for All (HFA) by the year 2000 in the world.

But after sometime both the main organisers of meeting WHO and UNICEF took their own way and poor countries trapped into World Bank an IMF's neo-liberal policies. But Alma Ata is a landmark declaration in the matter of health worldwide, it gave a dream and dreams give us hope and courage.

Gender and Health

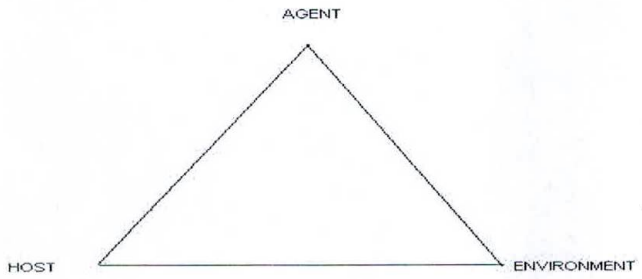
As per constitutional right every citizen have equal right and marginalized groups have special rights but our social structure is not so democratic and every Govt. welfare schemes utilization is affected by social structure or mind-set. In mainstream society women and children are most vulnerable the percentage of anemia is higher in women than men and it is a single example while we have so many health and social indicators which clearly exhibit the real story. Few years ago they address the women health issue under RCH-I and RCH-II now it's called RMNCHA+ (Reproductive Maternal Child Health). Our public system address Family Planning Issue which is mainly concentrated on women and distribute pills of iron to eradicate anemia while they are have many health problems due to current global economic trend, private health care services and lack of awareness. Govt.'s health care centers provide many family planning remedies but every year they fix targets of sterilization and many women lose their life in the premises of hospital in absence of proper treatment or negligence. Social status, undignified life decides health status of a person in the society.

To address the Indian women's issue eminent groups and other voluntary organizations formed "Indian Women's Health Charter 2007". Govt. initiated many Health Care Programmes but its long way to address health problem of Indian women.

Communicable disease (CD)

Communicable diseases spread from one person to another. It is spread by bacteria or virus or through any infectious fluid. Presently marginalized communities of third world countries suffered by it and prevalence are high. The most common communicable diseases found in India are as follows: Malaria, Typhoid, Hepatitis, Jaundice, Diarrhoeal Diseases, Amboise's, Cholera, Brucellosis, Hookworm Infection, Influenza, Filariasis, Tuberculosis, Chicken Pox; scabies. Every year many children died by pneumonia and Diarrhea and both are preventive but our system is interested to talk about disease(Morbidity) and death(Mortality) while every disease tells the story of **Social Determinants** and death shows the systemic approach.

Causation Framework of Disease is:



Non-communicable disease (NCD)

Non-communicable diseases (NCD) are not passed from person to person. They are typically of long duration and progress slowly. The most common NCD's include cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma), diabetes, Obesity, Anaemia, Headache, Depression, Anxiety, Epilepsy; hypertension.

NCD is based on web of **Causation and Association,** first it requires essential cause and after that it requires other factors.

Web of Causation and Association=>Multiple Factors=>interacts=>disease

Diseases have the following stages:

Mild =>Acute=>Severe=>Chronic=>Death

today NCD's are not the health problem but developmental challenge before human life, marginalised communities are the main victim of it and the marginalised section of society are in double risk or have **Double Burden**(CD+NCD) of disease.

HIV and Public Health Approach

In this developmental era HIV is a disease of fear, myth and stigma in society while it is simply a disease which diminishes immune system in human body. In practical a person with HIV –AIDS live happily within society by these ways:

- Accept Status,
- Abstinence,
- Maintain healthy life style.

Some groups' faith and bio-medic groups advocate it on the stated base: A (Abstinence), B (Be Faithful), C (Condom).

Dr. A.P.J Abdul Kalam mentioned the achievement of a HIV lady's life in his book and her struggles also. As per her experience she expressed in our collective session that a person need support system it is important to deal with any condition may be illness or other problem. As per my interaction with Doctors, Caretakers and others I have observed besides lack of awareness, medicinal facilities and poverty HIV Affected person face stigma, discrimination and High Risk.

Most of the bio-medic and faith base groups exercise slogan "Safe-Sex" but if you analyse the problem and it intensity, **Dr.Ravi Narayan's** opinion is appropriate "Responsible-Sex" is the best way to address on the basis of public health approach.

Waste and Waste Management

In our society we are rapidly generating waste from daily life, industrial and other activities from last fifteen years we are anxious about it. Waste is classified in these categories:

a) bio-degradable waste
b) non-biodegradable waste
    a. bio-medic waste
        i. Non-hazardous waste (79.90%)
        ii. Hazardous waste (10.25%)

For segregation of bio-medic waste institutions use yellow, red, blue, black poly bags as per waste.

    b. E-waste: E-waste is based on electronic items (Like Computer, Mobile, etc.)

In our society we are generating waste from Industries, Agriculture, and Domestic Usage. From Domestic use we produce Gray Water by washing; bath and Black water from toilets (26.7%).

Everywhere we are facing problem of waste from plastic and tetra packs and waste create these problems:

a) environmental,
b) health
c) wasting resource

We can manage our waste by these steps: Recycle, Reuse, Reduce(R-3), treatment, landfill and awareness. Landfill is least preferred way to manage waste but authorities practice it frequently.

waste is not fully waste without knowledge its waste while people who have knowledge to utilise it is resource or wealth for them but in our country waste is matter of local authorities (Municipal Corporation, Panchayat;

Cantonment etc.). In some areas people use toilet waste for Bio-gas generation and some people use poly-bags for other household articles. We have guidelines for Bio-medic waste management in our country. We can handle it by eco-sanitation management which is based on the principal of recycle.

Water-Sanitation

In the agrarian era sanitation is not a problem big before us but now in the globalise era or urban and industrial time it is a big question before us. Lack of clean water for drinking, cooking and washing, and the lack of sanitary waste disposal are to blame for many deaths a year, say experts. Now Safe drinking water and sanitary waste disposal is a big question before human life. Now poor sanitation and contaminated drinking water increase many diseases. In poor sanitation open deification is a one problem in it and Government of India announced "Swach Bharat" Campaign and toilet construction is one of a key element of the campaign. But it depend on community culture (Value, Behaviour, life style, attitude, Assumption) so the programme is on toilet construction not to change their practices.

Open deification is not a simple thing, it affects mental health also on the basis of gender and people face these problems:

1. animal attack,
2. teasing and harassment,
3. reduction in food intake,
4. menstruation course problem,
5. misunderstanding/suspicion,
6. domestic violence,
7. feeling of shame,
8. feeling of worthless,
9. worry,
10. low self-esteem,
11. mental-stress(Disable),
12. impact on mental health,
13. Suicidal Thoughts.

The disease burden is high in India, for obvious reasons like poor sanitation, lack of access to fresh water, poor hygiene, etc., which are common in the most developing countries.

Occupational health

Occupation and livelihood is a major part of our life working condition and environmental effect on the health of a person who involved in the occupation is occupation health. We can classify it on the basis of nature (Agriculture, Industry), region also. We can also study wages, gender, caste, and age in it.

DEFINITION((ILO / WHO 1950)): Occupational Health is the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations by preventing departures from health, controlling risks and the adaptation of work to people, and people to their jobs.

Presently people face many problems in their occupation in rural and urban area but these are major problems:

- minimum wages,
- land holding
- reliable source of Income,(in rural area :Seasonal)
- dignity
- Working environment and safety.

In India MNREGA is the only law which is directly address livelihood issue of rural people.

internationally and nationally experts agreed on that the working hours decides quality of productivity but now in the changing era of development Indian Govt. amending the laws against it.

Respect is important for every occupation but in our society we not respecting equally like: Housewife, manual scavenger, cobbler, farmers and other traditional skilled labour and stigmatise them with their caste and stigmatisation is dangerous for civilised society. The major concern of occupational health is to protest health of a worker (Informal and informal labour).people study fact and Impact, Impact and repercation in occupational health.

first of all Govt. Formed laws, policies in the interest of people and implemented it and after a period evaluate it and make necessary arrangement in the it but evaluation part is missing in our system or hard to do so. But now many organisation and groups are working in the interest of working class in the country.

Mental Health

As per definition mental health is state of well-being where every individual realize his or her own potential with sound mind and contribute to his or her community. The positive dimension of mental health is stressed in whose definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Present life style is very complex and as result without age and gender classification people suffered by mental illness and mental disorder. Our Govt. understands the condition and as result they formed mental health policy and incorporated in National Health Mission also but the condition of mental institution and the number of Psychological Experts and Service Providers is not satisfactory. **Effects** of mental illness

1. stigma
2. discrimination
3. denial of illness
4. harmful treatment
5. chaining and locking in the room
6. social boycott
7. denial of property rights
8. marriage and legal separation
9. family members not getting marriage alimony
10. Denial of right to treatment

It is not a new health problem in or society; some people refer traditional faith-based healing method. But it is right time to increase awareness about it.

Climate Change & Global Warming

The terms "global warming" and "climate change" are often used interchangeably in newspapers and television reporting, but they are really separate things. Globally people discuss its impact on earth and on the life of living being. B the five points we can try to understand it:

1 What is weather?
It is a short term condition of atmosphere.
2 What is climate?
Climate is an average of weather (30 days) and it depends on multiple factors like: rivers, sea, hills; geographical position.
3 What is climate change?
Change in average and variability of climate I called climate change. It depends on frequency, magnitude, geographical distribution and intensity.
4 What is Global Warming?
The rise in Global Temperature is called Global Warming due to this global average temperature increase and change the natural cycles like: water, sea level etc. The rise in global average temperature doesn't mean the temperature will increase by the same amount everywhere. It does not mean that everywhere in the world the average temperature increase on same level, just increase average temperature and it change the climate. Globally we are agreed upon the reasons of climate change are man-made increase greenhouse gases due to uncontrolled fossil fuel consumption.
5 Why everybody worry about climate change?

A). Sea Level increasing,
B). crops are affecting,
C).Bio-Diversity affected,
D).Diarrhoeal disease increased,
E).food production decrease.

Direct impacts of climate change are:

- water scarcity,

- conflict & Violence,
- disasters,
- displacement,
- Mental health affected.

Indirect impacts of climate change are:

- Water bone disease Increased,
- Malnutrition,
- Allergic
- Respiratory problems,
- Dangerous for small islands.

Causes of climate change are:

1 Deforestation
2 Industrialisation,
3 Warfare,
4 Excess fossil fuel consumption,

We can mitigate climate change by the New model which is based on Drivers(D),Pressures(P),State(S), Exposure(E), Effects(E) and Action at all level(A). Source: Drivers: Industrialisation, Energy consumption, Pressure: CO_2, CH_4; Green House Gases, State: Government, Exposures: flood, draught, temperature variation, extreme weather, effects: Direct and Indirect effects.

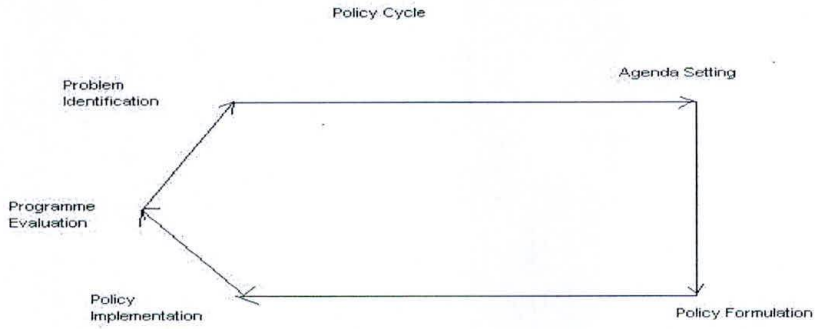
We can mitigate it by adoption (Accept results) and these preventive methods: Forestation, Appropriate Fossil fuel Consumption, Waste Management. Social Justice and Equity are the two major basic content of mitigation. On the name of development all the state Drivers and State actors working on it but without **Conversion, Equitable Distribution, and appropriate Consumption** it will not happen (Equitable and sustainable Development only possible through stated ways.

Policy Analysis

Policy analysis sessions conducted by **Dr.Justin Parkhurst**(London School of Hygiene & tropical Medicine) he described the policy making with various definition and examples like : "the authoritative allocation of values"-Easton 1953. "Albert Einstein said," there is only one constant in this universe and that constant is change". Policy process: change involves political struggle and struggle require power. Policy Analysis is focus on how, who, why and not what while Politics address: who, what, when, how and Science address only the good and bad impact of it. We can analyse Policy by following approaches:

1. Interest Focused Approach,
2. Institutional Approach,
3. Group-Network Approach(Stakeholder)
4. Idea Based Approach

Policy change process is based on Rational, incremental and dynamic. We can understand it by the diagram:



We can analyse policy by two ways: a).Content b), Process analysis. Content address objective, aim, assumption, value, distribution. We use policy analysis retrospectively and prospectively. Policy analysis is not an easy task it has many challenges like: analysis inherently subjective, all policy is unique in time and place (How to generalise) and data is sensitive & restricted difficult to capture due to complexity and dynamics. Policy analysis is necessary for improvement," Policy analysis matters because it helps us to act and move effectively".

In policy analysis agenda and stakeholder are two important content who influence the policy, stakeholder's role, organisation & network and power to influence it and agenda clarify distribution. Key actors of policy are state, market, consumer, community and civil society. Institutions set agenda and under agenda setting **Kingdon Theory** is based on the following streams:

1. problem stream,
2. policy stream,
3. political stream

To analyse policy under stated theory is easy and practical but we found many differences between National and Global policy making like:

1. decision making arena,
2. Different actors & stakeholders,
3. global agenda rapidly change,
4. weak governance and accountability lines for global level,
5. Others.

Stakeholders Power and influence decide agenda of policy and it is based on:

1. Who has power?
2. Who has influence?
3. What source of power – where does it come from?
4. What source of influence?

5. How is power exercised?
6. What is power?

As per Luke power is based on three dimensions:

1. power of decision making,
2. power of non-decision making,
3. Power as thought control-influence of desires.

Source of power are capital (Social, cultural, economic; symbolic power), right and entitlements. Before analysis defining issues and problems is necessary. Stakeholder's analysis is necessary in the process because they have interest. Under Prospective Policy Analysis these steps are necessary to plan policy change:

1. Position Strategy,
2. Power Strategy
3. Player Strategy,
4. Perception Strategy

In India policy decides who is BPL and APL and entitle to get benefits from welfare schemes, nowadays influential stakeholders got benefits (Like: Business Houses) on the cost of public money and policy makers present Placebo-Policies before public to keep public happy and hopeful, create space for elite to serve their interest. Sometime police analysis is political analysis.

Transactional Analysis

Dr.Eric Berne (1971) Transactional Analysis: interpersonal relations tool which explain the behavior of people and why they behave like this. You can observe a persons behavior by the vocabulary (Words), gesture (Actions) and attitude (Behavior).

Every human being behaves on three levels **(Ego states):**

1. Parent Ego State
2. Adult Ego State : always reasoning (Never combined by one emotional feeling)
3. Child Ego State: behave like child.

Suggestions:

- ❖ Do not stuck, use option in life
- ❖ You can measure your own energy (Ego) by ego gram.
- ❖ Script: a blue print of your life plan.

Ego-gram: By ego gram you can measure the stage of a person and these are major bar contents in it Child-Parental (CP), no-parental (NP), Adult (A), FC, RC, AC, LP

You can change you ego-gram by these: awareness, acceptance, decision to change (Decide); take steps to change.

Ideal Ego-gram need:

1. decrease CP,RC
2. increase A, LP, FC,NP

Four Life Positions: Life position is based on Strokes (Appreciation, acceptance),

1. I am not OK you are OK (0-25)
   (Inferiority complex)
   "get rid off me" position, "Withdrawal".
2. I am OK you are not OK (25-40)
   (Fundamentalism, Homicide),
   "Get rid off you" position.
3. I am not OK you are not OK
   criticize , Suicide , Homicide
4. I am OK you are OK
   (This is only a single healthy position)

Time sharing

24 hrs: 7 hrs sleep, 17 working hrs.

- 17 working hrs.
- 2.5 hrs. rituals
- 2 hrs, withdrawals (physic, psych)
- 3.5 hrs pastime (time spend without any profit motive)
- 4 hrs games (psychological)
- 3.5 hrs. activity
- 1.5 hrs intimacy

Games: psychological game is a series of an interaction relationship or transaction between one person to another person or may be group leading to a pay off.

Activity: any work without profit motive.

Intimacy: physical, psychological; spiritual

Psychopathology:

1 **Contamination(Most problematic) of ego-state**
   a) Single
   b) Double
2 Exclusion
3 Symbioses

A). **Single contamination:** by Parents or By Child

Parental: fundamentalism, fanatic, suspicion, oppression, dictatorship, invading, prejudice.

Fundamentalism: strong believes on false theories. Our society is a suppressive society who serves interest of imperious people. Main problem of all our problems in our world is contamination.

WHY PEOPLE PLAY GAMES?

To get psycho strokes (Appreciation, Recognition) and Psych-Script is a blue print of your life plan.

What to do in the Game?

A) Give Adult Transaction
B) No game will play from your adult transaction.
C) Change the subject.
D) Reject any role in a game.(Persecutor, Rescuer, Victim)

Degree of Games:

A) First Degree: It is a Temporary Stage.
B) Second Degree: It is a Revengeful Stage.

C) Third Degree: Killing

Dynamics of Stroke (Psycho): A Psychological stroke may be word, gesture or act of recognition, one person gives to another. Strokes can be ***Positive*** or ***Negative***, ***Conditional*** or ***Unconditional***, ***Genuine*** or ***Counterfeit*** from Parent, Adult and Child.

Psychological Hunger: Depends on Stroke to get recognition.

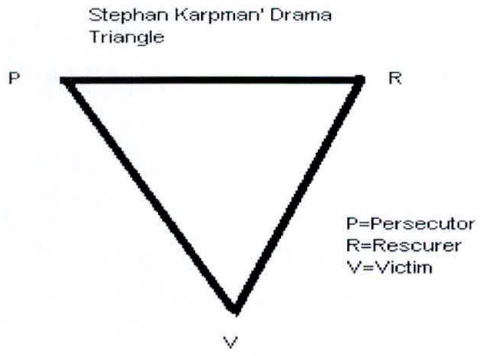
1) Getting positive stroke or at least negative stroke.
2) Favorite ego-state (Life Position)
3) To remain your favorite ego-state(7)
4) Favorite structure-gram.
5) Favorite game.

Conclusion:

1) Keep high your adult ego-state,
2) Reject any role in game that will keep me happy every time.
3) Be generous to give positive strokes on time.
4) These points give me success in my life.

Eric Bern's Games formula "G": C+G=R=>S=>X=>P (Construct, Gimmick, Response, Switch, Cross up, Payoff)

Stepan Karpman's easiest Formula called Drama Triangle is based on Persecutor, Rescuer; Victim likes this:



Systemic Thinking

In the Systemic Thinking first of all we should know the objectives of organisation nature of organisation and why people participate in the activities of a voluntary organisation?

Voluntary organisations objectives are good and based on pious hopes and based on need of community like: relief & welfare (Immediate), Community Development (5-10 Years); Sustainable System Development (10-20Years). Activities of NGO's are based on Felt Need, Projected Need and Analyse Need (Time & Effort).

Before starting a programme we should design trust building within community by your **skill and knowledge**, Create Dendrite because every human being's memory is combination of Emotion and information and construct trust. Soft system methodology model (Google +SSM) and a purposeful Activity Model (PAM) construct trust in the community and it will be right time to start wok with community.

Apply public goods theory it contains Easy-Difficult, Low-High joint use relation and all goods have following four Function and Four Questions:

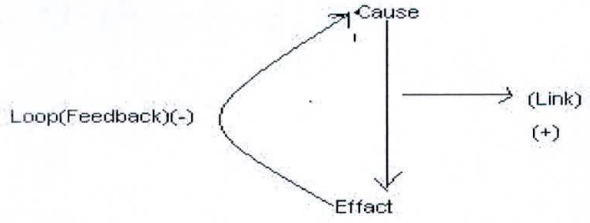
1. Provision Function Provisional Questions (in Beginning)
2. Production Function Production Question(Day to day Activity)
3. Consumption Function Consumption Question(How many)
4. Co-production Function Co-production Question (Participation)

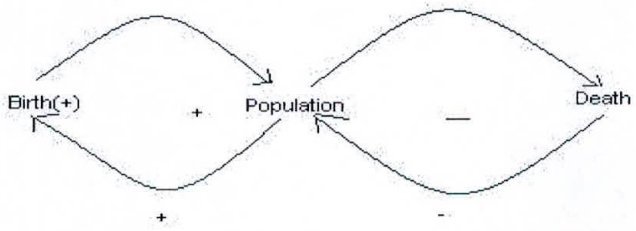
System thinking is based on Input and output, output change form of input or you can say input is unfinished and output is finished thing. System is based on specification without it can not exist and specification is based on Client, Actors, Transformation (Information of Input), Worldwide View,

owner; Environmental Constraints (CATWOE). Before intervention we plan activities and event (time) and the structure is:

1. List Problem(Need Assessment)
2. Priority Ownership(Money)
3. Public Goods Categorisation
4. Function
5. Flow Chart(System Design)

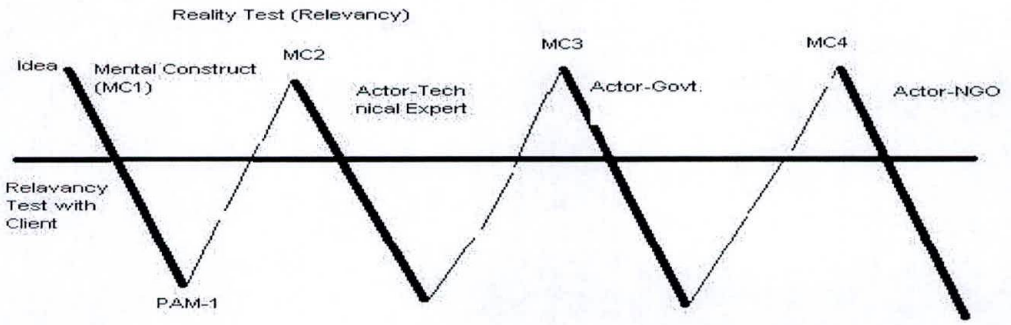
Every time System thinking is in circle and in loop our system control birth by Immunisation, Nutrition, Health System and Death by Health Care, Food, War, Disaster and you can say it in different words its combination of Cause and effect. We can understand it by the following diagram:





Cause and effects have adverse relation if cause if heavy than effect of intervention is light and if cause is light intervention of effect is heavy. Prioritisation, control and owner ship decide the success and sustainability of programme.

Technical adviser is an expert of CATWOE he will analyze Transformation (T) on the basis of Objective Current (T1), Objective Desired (T2); Specification (T3). In first phase we will prioritise the problem, choose Skill and knowledge, CATWOE; Reality Check:



We perform reality check with various actors (Govt, Community, and NGO) by flowcharting. Effectiveness, Efficiency; efficacy (E3) decides success of your plan and it will also show you approach towards problem.

Personality and Communication

Mr. Krishna Chakwarty conducted the class without notebook and pen and all the sessions are completely practical which was based on various exercise (Mirror, Use of Prop, self-sound creations etc.) and plays to perform. After two days training fellows developed a play and played it on Cleanliness and health with other issues. He explored the qualities and barriers in smooth communication in participatory mode with fellows.

Qualities of speaker are:

1. Eye Contact,
2. Confidence,
3. Gesture,
4. Addressing Everyone,
5. Facial Expression,
6. Voice Modulation,
7. Knowledge about Subject,
8. Careful Listener.

Barrier in Communication: Fear of Others Reactions
My learning's are: **Observe Listen, Humble and Patience.**

Communication is an important part of our life, our life is based on relationship and relationship is based on communication and without communication we are in great risk or in deep rouble. Most of the time in our life we communicate from non-verbal mode of communication. We have three types of communication: **Crucial, Important and Interesting.**

Barriers in communication are:

1. Language,
2. Acceptance,
3. Superstitions,
4. how to start communication with community / woman,
5. How to approach?
6. How to tackle emotions?

Answer: You should be a good listener.

Qualities in group communication are:

1. patience
2. listener,
3. time needed
4. Leadership (Democratic, Autocratic Dictator Etc.)

5. Empathy (Not Sympathy because most of the time sympathy is lip service)
6. partnership,
7. Inter-Personal-Communication(Trust or Close Communication)
8. Responsibility,
9. people's Participation,
10. Media

In Nero- Linguistic- Programme we follow these

Study=>identify=>Interact=>Repo =>Aware=>mobilise

If programming is perfect outcome will be fantastic and responsibilities have risk. If you want to achieve something change the meaning and after that it will be mission.

Our analyse anything on the basis of VAK (Visual, Auditory; Kinaesthetic) and it is called **Representational System.**

Visual (Seeing) : Colour, Light, Size,
Auditory (Hearing) : Tone, Volume
Kinaesthetic (Feeling) : Temperature, Pressure

Primary Representational System (PRS) Example:

I hear what you mean.
I see what you mean
I feel what you mean.

A community health worker influence community leaders by stated PRS Example.

1. Intra-personal communication is good like: Self Analysis, Prayers and Self Assessment.
2. Self-Disclosure is important but boring like: Preaching, Teaching and Boring.
3. Inter-personal communication like: I, Family, friends, relatives, co-workers, people.

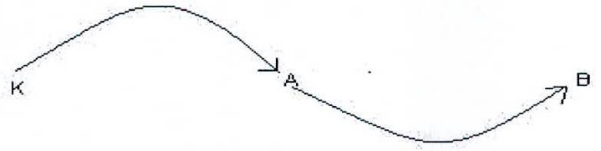
❖ If you use three words great, marvellous and excellent everyday to encourage five people you can get amazing results.

Every Communication has five levels:

1. **kliche** : Good Morning, Bye
2. **Information** : Facts.
3. **Opinion** : Point of view, trust building and leaders share opinion and risk.
4. **Experience** :SWOT(Strength, Weakness, Opportunity, Threat) SWOC(Strength, Weakness, Opportunity, Threat) SOFI(Strength, Opportunity, Fear, Impediment)
5. **Peak** : conversation reach any of the time.(Forget About it)

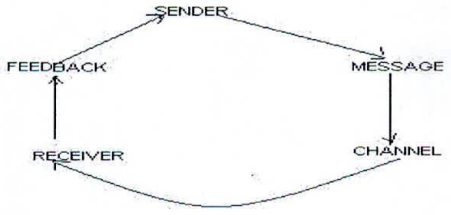
Generally communication is nothing it is knowledge sharing information and idea opinion between two people or among group of people. It is based on Knowledge, Attitude and Behaviour.

KNOWLDEGE , ATTITUDE AND BEHAVIOUR CONTROL GRAPH



Communication is a complex process and it has important elements of cycle:

COMMUNICATION -CYCLE



- Diluted and Halt Communication is Very Dangerous.

Problems in communication is based on

- **WIGO** (What is going on?)
- **WIS** (What is selected?)
- **WIMTU** (What its Mean to us?)

Three Dangerous things in communication are:

1. Deletion
2. Distortion
3. Generation D+D+G=DDG

5 senses

Outsource =====➔DDG=➔Mind =➔Constructed reality

Problem in Listening

1 Physical Tired
2 WIGO
3 Language
4 Distraction
5 Psychological
6 Speed (200 words wpm)
7 Unfamiliar with topic (Lack of interest)
8 Preconceive notion (Filters)
9 Sitting Arrangement

Two **Principals of Listening** are:

1 UPISE(Understand, Patience, interest, support, empathy)

2 SOLER(sit-straight, openness, Lean-forward, empathy, relax)

(Anthropological research observation is important to cater society.)

Left side of brain is logical and right side is creativity, under Nero linguistic Programming we have five rapport positions:

1. Content Rapport :Identifying Key Words,
2. Emotional Rapport :Short Form without lose of feeling,
3. Tone & Tempo Rapport :Positive conversation,
4. Posture Rapport :Mirror,
5. Breathing Rapport : intense (Lover, Mother and Child)

Under Communication we can access eye ball movements also. Psychological empowerment is the prerequisite for development. Interpersonal analysis is based on: goal, aim, mannerism, attitude, Reading, training programme; role model.

Creating Group is important, without group we are unproductive and we can create it by following steps:

1. creating group idea is better than individual
2. group idea or decision is better,
3. effect of group is great,
4. group decision is not a argument nor debate,
5. Group seeks conviction.

Ten Commandments for communication:

1. best possible solution,
2. avoid pre-conceived notion,
3. participate (Contribute your idea),
4. say what you really think(Honestly, no need to please)
5. be flexible(Consideration)
6. learn to listen,
7. do not start on a different track (Brief and to the point)
8. ask for clarification
9. have a grip over the discussion
10. Agree to disagree.

Your communication should be short, sharp and penetrating (SSP). Listening is not acceptance, rejection is not sin but without reason it is. We found these task Functions in group communication as:

1. Information Giver,
2. Opinion Giver,
3. Direction giver,
4. Summarisers,
5. Reality Tester,
6. Evaluator.

They all play important role in group with these role players communication spoiled. In a meeting these functions for maintenance:

1. Harmonizer
2. gate keeper
3. praise giver,
4. tension reliever,
5. empathetic listener,
6. Inter-personal problem solver.

In community effective communication is important and tool to address and engage with real issues.

Use of Rational Drugs

Medical Practitioners prescribed Drugs to patient to recover from illness but under the influence of pharmacy companies many Health Practitioners prescribed medicines irrationally (Combination) to patient which is not ethical. They prescribed medicine more than required, inappropriate medicines and combinations of medicines and its called doctor shopping. We understand the necessity of prescription to avoid Risk, Drug Resistance and poverty if they prescribe rationally.

Rational Drugs means which is based on effective, sufficient, adequate-duration, clinical condition and lowest cost. Due to irrational medicine prescription many people lost their life or trapped into poverty. If we use rational medicine we can avoid Minimise Health Expenditure, Drug Toxicity, Antibiotic Resistance, Side Effects.

In 2002 our Govt. initiated **National Pharmaceutical Policy – 2002(NPP);** it is based on following **objectives**:

- Ensure affordability of medicine,
- Encourage indigenous remedies(R&D)
- Encourage

It is a compact form of policy and addresses these:

1. Drug Price Control Order(DPCO)
2. Drug and Cosmetic Act,
3. NIPER(National institute of pharmacy education and research)Act

Under DPCO, National Pharmacy Pricing Authority regulates the pricing, Drug and cosmetic Act prohibit spurious medicines production and clinical trials and NIPER address educational part.

Public Health Movements and Community Action for Health (CAH)

In context of health Policies influence Drivers (Elite-Class, Companies, Govt., Consumers) and in India we have a very good History of Public health Committees (Sokhey, Bhore, Mudallar) and policies (National Health Policy2002, National Health Mission 2013) but the recommendation and implementation is very hard and our Govt. signed Alma-Ata Declaration with 125 countries but before that many Medical Practitioners and Others have

similar intension like "health for all". And they after alma-ata they thought that the implementation part is weak so we need movement to create people's pressure on system and they initiated **People's Health Movement (PHM)**, and India people called it "Jan-Swasthy-Abhiyan"(JSA), before PHM many groups (MFC, VHAI, CMAI, ACHAN) were exist but most the groups are Doctor Dominant and its major hurdle to address public health because people thought health is doctors issue.

They realise and analyse the problem and formed Public Health Movement nationally after that they aware, mobilise and gather the public and organised **World Health Assembly** where 75 countries 1500 representatives participated and they launched **People's Health Charter** in 50 Languages. It changed the scene of public health in India. After it Governments and other interest group (Drivers) realise the power of people besides election in a democratic country. JSA established the truth that we will win if we are united with people.

Community Action for Health (CAH) is based on Community Health Problem and its Community Based Solutions. Through CAH we can change anything and in these processes: Library, Resource Centre, Lecture, Study Circle and Cultural Activities are important tools t empower community towards health. It counter the idea of serving people, it establish idea of working with people - as per **Mr. Alan Leather (Action Village of India).**

- **Globalization and Health :**

Globalization is not a new thing for India from ancient times people from all over world come to India for business, education and spiritual learning. Due to After gulf war, split of Russia and Economic Recession world became uni-polar behind G7 Countries (Now G8). IMF, World Bank and Asian Development Bank dictated the terms of loan to the developing and underdeveloped countries before loan. And their terms are based on Liberalization, Privatization, Globalization (LPG) and the main source of these elements are World Trade Organization and GATT (General Agreement on Trade and Tariff) and most of the third world countries sign it.

From 1989 our country follows the world economic order under the leadership of IMF and World Bank and decrease expenditure on welfare and public services. Privatize the Public Sector companies into private sector company listed it into Stock Market and encourage privatization of services like: Education, Health, Public Services (transport, Water, etc.)Banking, Natural Resources on the name of **Neo-Liberalization Policies** or **Economic Reform**. After 2000 Govt. of India boosts the speed of reforms and auctioned the natural

resources like: Coal, Mineral Mines, land and water also and formed Special Economic Zones (SEZ) in many parts of country.

All these new economic policies effect democratic nature of our country and our Govt.'s try to forget '**welfare state**' concept and as a result our health system badly affected. in 1978 our country signed Alma-Ata declaration with 120 countries and primary objective of the declaration was "Health for All" by 2000 but now World Bank and IMF change it "Health for who pays" and as result every year number of Private Health Care Institutions increased, worth of pharmacy companies increased but on the health index the scene is completely different. Our country is a heaven for multinational pharmacy & health insurance companies they are making a huge profit.

In conclusion globalization is not a new phenomena but present globalization is fueled by multinational corporate.

- **Social Stratification and Health:**

Before my learning sessions I understand caste and gender play a major role in a person's life or community life but at SOCHARA, I understand that it also effect health. Upper caste, class or high income group people easily utilize the public health services while another side of people unable to access the public health services. Gender based cultural practices also affect the health of a person like: higher number of anemic Women. Condition of public health services in low income group areas are in shocking condition. Every year we read the story of negligence like: institutional death of women in sterilization camp; lose of vision in eve camps etc. and all these happened with Low Caste, class or low income group communities. Most of the marginalized communities under high risk of health problem.

- **Research:**

Before Community Health Learning Programme Fellowship, I only know the data collection in community not more than that and little bit familiar with statical terms (Mean, mode, median; Standard Deviation) which was in my master's subject.

In SOCHARA I understand need of research for development and research is evidence(Facts and figures), sources of data(SRS, NFHS,DLHS,AHS, NSSO), Types of Research : quantitative and qualitative research : Quantitative Research quantify the things and incidents(How many, How Much, How Often) while Qualitative Research developing

explanation of social phenomena and finding answers of questions (Why, What, How), data handling and analysis(interpretation of Data). I understand more about qualitative research an in-depth interview or study of person /community to get in-depth understanding about the issue capture real situation and feeling of community. After collection of in-depth interview we analyze it manually or by the help of software.

VISITS AND PROGRAMME PARTICIPATION LEARNING'S

Transit Walk (Rajendra Nagar-Bangalore)

It was my first field visit in non-Hindi speaking area where most of the population migrant from various place like: Tamilnadu, Rural area of Karnataka and other areas also. As per my observation I think on the basis of problem we are united. People face many health problem but the authorities are ignorant towards it.

Snehdaan (Bangalore)

Snehdaaan is place where you can feel smile of HIV / AIDS infected children and their participation in games without fear. They try seriously while they also face discrimination in the society.

National Institute of Tuberculosis & Yashwantpur DOTS & AIDS Centre (Bangalore)

Visit of national institute of tuberculosis is a life time learning experience where I have learnt about key aspect of TB, Burden of disease, TB control programme (RNTCP), types of TB(Pulmonary(Communicable) and Extra Pulmonary(Non-Communicable), MDR and XDR). TB is a most dangerous disease but easily preventable in a specific time. TB patients have high risk of HIV also.

Association of People with Disability (Bangalore)

After the whole day visit at their workshops(Vocational), schools, screening of documentary and sharing of Person with Disability, I have learnt that Life is full of challenges but if we are competent to change it in opportunity than a person will be useful for himself or herself.

Anganwadi(Mailasandra-Bangalore)

All the Anganwadi are same but it was a model on the basis of cleanliness and child participation the centre worker was working there from last co many years and her interest keep the centre live. The centre worker's interest keeps it active and clean.

Primary Health Centre (Dom Sandra- Bangalore)

It was a first PHC visit for me and it is also a model PHC for me where doctors and staff are serving patients. I have learnt that in urban area health centers require multi-lingual information on public domain because many patients were not fluent in regional language.

Ekta Parishad (Bhopal)

During My first field work I have visited Ekta Prishad and am working on effective implementation of Forest Right Act, PESA and land right. They **believe in dialogue, non-violence and de-centralization.** Their sustainability is based on the following:

1. Re.1/- from a Family,
2. 1 hand of grain,
3. 1 person from a family,
4. 1 month for action
5. Ekta Europe and other Supporters(South Asian Peace Alliance SAPA)

Power of Poor: Most of the citizens of rural India are poor but they have instinct to struggle and survival (They survive on one meal, less sleep with out bed, minimum utilization of water) and it is energy or you can say power of poverty.

And after visit of Ekta Parishad I have learnt the essential elements and energy of people's movement.

Sambhavana Trust (Bhopal)

I have visited Sambhavana Trust and they are working for gas tragedy victims and fight for them inside and outside court with an alternative health centre under various settings (Research, Documentation alternative therapies etc.) and they have expertise on industrial disasters or chemical disaster. After so many of years of struggle people have faith on them and their work establish credibility among the people.

Kolar PHC and District Hospital (Bhopal)

During visit of PHC Kolar and District Hospital I observed that most of the Programmes supported by various agencies like: Unicef, UKAID, USAID etc., Hospital staff is co-operative but they have lot of pressure without any excuse while they have shortage of skilled human resource and I also observed that mental health is not in priority list in system while they have counselors on various subjects (like: Family planning).

M.P. Vigyan Sabha (Bhopal)

They are working with tribal community by 'Science for people' and 'Sustainable Livelihood by non-timber products' Programmes and the manufacture many herbal products (Soap, Honey etc.). But as per my understanding the success of any livelihood or another developmental programme require multicultural approach.

Centre for Integrated Development (Kolaras- Gwalior)

I have spent two days with Sahariya tribe community, visited four villages with Mr. Sabu there. I observed that the life of Sahariya community is difficult and most of the developmental Programmes are on paper they are struggling for minor entitlements like: PDS Card, Voter Id, and Land. I have learnt so many things there but the important learning is "Without struggle or fight they can not survive".

PARTICIPATION

CHESS (Fire Flies-Bangalore)

Representatives many countries discussed health, environment, mining, land acquisition, energy policies and its impact on health and environment. After sessions and open discussion and play I have understand that in India we have very limited access to clean energy, recently Govt.'s establish a new trend to pass ordinance (Executive power) without which is easy in the interest of corporate or multinationals which is against the democratic values, coal mining create many health and environmental problems like green house gases-black lung disease-food scarcity and global warming.

Bhoomi Festival (Vasteras – Bangalore)

I saw first time that the festival is based on social issues with creative workshops and documentary screening. After participation in the festival I understand the importance of culture and its relation with people. Documentary screening division was outstanding they screened 5 minutes to 10 minutes documentary on climate, people's struggle and commercial food production and it was full information and efforts. It was a really "learn with fun" experience.

Women's Day (SCMI-Bangalore)

The programme was organised at SCMI where Dr.Revthi Kutty addressed problem of Dalit women and societal attitude towards marginalised community. And as I understand that the women from Dalit community face double problem (Inside and outside community).

Free drug distribution-medication policies (Bangalore)

The programme was organised by SPAD and others at SCMI where the discussed the free drug distribution-medication policies and regulations regulating health services. After discussion I understand that the health services also need a regulator in the interest of patient.

Conversation on Anti-Discrimination (ALF-Bangalore)

Alternative law forum (ALF), was organized a conversation on anti-discrimination on the basis of disability, caste, class; gender. From last few years they are exploring the possibilities of a movement against discrimination of all forms which could lead to the drafting of comprehensive anti-discrimination law. They interviewed 85 persons in south Indian states who belongs the stated identity. I have attended many Programmes on caste, gender and disability but it was first programme for me on class based discrimination. While day programme teach me many aspects of discrimination and I have learnt the following:

1 **Disability and discrimination:**

1.1 After RTE and SSA we have a good programme for CWSN and we can protect and develop their level through.

1.2 Most of our structures (Cinema, Malls etc.) are not disabling friendly but not anybody raise the voice.

1.3 Systematically our approach I right but the major barrier is attitude.

1.4 Disability has strong relationship with class and caste.

1.5 Social participation floor or level differs on the basis of disability.

1.6 We need reasonable accommodation also (Mental).

2 **Caste and Discrimination:** Indian judicial system is not fully equipped to address the caste based discrimination and Prevention of Atrocity Act (POA) is the single remedy among the Dalit community. Caste is not a physical unit it a Psychological unit in our mind when Dalit raise the questions attack happens it not a matter that it will be institutional or structural attack. Implementing agencies (Police, Judiciary; Beurocracy) are busy to maintain the colonial system. When we raise the question of discrimination they raise the question of reservation while the duration of duration of reservation is sixty years but the discrimination has long history.

3 **Gender and Discrimination:** First question comes in mind how we can measure discrimination? Before talk about gender based discrimination we should talk about religion based discrimination (Muslim and other minorities) because it's common in pubic domain but nobody want to address it. From last twenty five years a group of people demonizing the words: Secularism, Tolerance; Equality, Social Welfare and if you talk about people's right they divert it by responsibility.

They establish a parallel code of conduct which is beyond law, they say we respect law and legal system but they did not exercise it.

After independence to till date communal riots are the permanent feature of our democratic country and in the communal riots women are the main victim we have seen in Gujarat, Kandhmal and other places. Few laws are also barricade to exercise the democratic rights like: law on Beef and Religious Conversation (In M.P. Religious Freedom Act). On the basis of religion Muslim community suffered by many social problems like: Triple talaq, Halala, Shariya Laws, democratization process of community, absence of ideal role model (Like: Ambedkar, Phule etc.)And actual representation in the society and other places. Across the country every Government is in busy systemic ghettoisation of Muslim community. Women of Muslim community have double burden of discrimination and Governments are decisive by the nature and every time they follow populist approach on the name of majority or faith. Muslim women are faceless creature from independence to till date Govt. only consider Muslim Men's (Fundamentalist, Conservative and Orthodox)Voice on the basis of participation they never realize the women of community face problems in the community.

Many people advocate the uniform Civil code in the matter of gender but they simply present CUT PASTE version of Hindu family law on Muslim women while within Islamic domain community have many remedies. And triple talaq is also a constitutional challenge in India.

Member of **Trans Gender** Community also raise the issue of discrimination within the community also on the basis of their caste, they face discrimination in religious places (Like: children of Satan) and Honor Killing.

4 **Class Discrimination:** class based discrimination is not a new thing for India before colonial era oppressed class community face discrimination. After independence our constitution gave us right to equality or neutrality of law but in practice oppressor class (Imperious class), implementing agencies neutralizing the law in the interest of corporate. Slum dwellers, domestic workers ; labour unions face many problems like eviction, living wages, labour rights but nobody is interested to solve it. On the name of development without rehabilitation they evict the slum dwellers from their shelters, they limits the rights of labour on the

name of labour reform. Karnataka have rich history of labour movements and it is demand of time to coordinate all the labour movements. Workers of Honda (Rajasthan) also shared their experience in the factor and the nature of labour court there.

National Meeting on 'Maternal and Neo-Natal Health' (Bhopal)

The National Meeting on 'Maternal and Neo-Natal Health" organized at Bhopal by the Common Health (CH) in collaboration with the Society for Community Health Awareness Research and Action (SOCHARA) for two days. I have learnt without addressing these:

- Denial of services(in health care services),
- VHND Monitoring,
- Blood Availability,
- Availability Essential Medicines.

We can not handle maternal and neonatal health properly.

Free Drug (Bhopal)

It's a two days workshop on free drug distribution policy by Prayas at Bhopal they discussed the policy and its logistical system contents with Govt. Officials and others. After attending the programme I understand the complexity of the issue like: essential drug list and practical problems of supply, implementing problems and if you start a scheme without preparation (Logistical) you can get adverse result. So we need proper planning before initiating any scheme and network of other beneficiaries who monitor it.

Beedi Labour Meeting (Bhopal)

I have participated one day state level meeting on Beedi Labour Condition and Future Strategy, activists, representatives of Beedi Rolling Union, Journalist and researchers participated. In the meeting they discussed the problems of Beedi rolling labour, the role of labour welfare board and successful cooperative model of Kerala Dinesh Beedi also. After participation I learnt that one side union or collective is important but another side they need support for their future because the consumption of Beedi is decreasing so they require alternative employment also.

Workshop on "Religion, Culture and Constitution" (Harda)

It was two day meeting with local leaders, lawyers and students of Harda District who work for peace, communal harmony and development. In the meeting people discussed religious values, politics of religious identity, multi-cultural heritage and constitutional values. After participation I learnt that Religion, Culture and constitution is co-related and have an important role in society but from last few years people use it for their political interest, they propagate religious identity not values while values of religion and constitution is the core element. All these practices are the tool of exploitation against marginalised communities. I also addressed session on Health and Constitution.

MFC (Raipur)

In Raipur all he fellows of SOCHARA visited three slum areas of Raipur in three groups to know the Mitanin Programme and I have **observed** and **compared** these from Madhya Pradesh **(One day Field Visit)**:

- The Mitanins of the area getting support from system (SHRC), they fight for community in the hospitals and they are not assistant of ANM. Sometime they complained about ANM and Hospital staff also.
- A person's orientation is important regarding programme and services.
- Community supports a person who works for them.

- If we compare condition of MP and CG ASHA (Mitanin) is totally different, in MP they feel like they are Govt. servant not activist.
- In MP they are busy with Hospital and ANM but in CG they support other activities also like: Utilization of untied fund.
- In MP it's hard to found but in CG they wrote the Mobile Numbers on Wall with toll free Complain registration Numbers.

Theme of MFC meeting is Urban Health and the following points are my learning:

- We are following global trends in business and other area of life than why we are not advocating universal training for medical practitioner.

- JNNURM & RAY is focused on urban poor but it is not addressing the problem of migrant labour and their health is in under threat. Construction sites are major breeding point of disease and most of the construction labors are migrant.
- On paper s it is easy to find health services in rural area from Govt. but in urban area it's hard.
- In context of waste-management our local authorities follow colonial system. Burning of waste is dangerous we can replace poly-bags with our jute or other bags and packaged food to other traditional food (Ground Nut, Jaggry) because packaged food increase waste.
- Urban area ghettoisation (Dalit, Muslim, and LGBT) is also violence prone area.
- Health care Facilities and Health Seeking Behavior have huge gap.
- Cost recovery idea is not appropriate in health.
- Health is more than illness.

Learning from First Field Placement

My first field placement was in SOCHARA Bhopal in urban slum of PC Nagar in this field work I have to understand about he community and find out the problem in community.

Understanding of Organization

SOCHARA Bhopal is extension of Bangalore SOCHARA and focus on public health issues like: Malnutrition, Maternal Health, Mental and Occupational Health and other community initiatives also. Through capacity building, research-study and advocacy SOCHARA intervene on public interest matters with alliance of Fellows-Collective (30 districts) and other originations, campaigns. In Bhopal, SOCHARA intervene in six (PC Nagar, Ishwar Nagar, Gulab Nagar, Indra Nagar, Meera Nagar, Sai Baba Nagar)slums directly and the primary interventional area are Anganwadi, support USHA, ANM, Mahila Arogay Samiti and slum community. Main focus of the organization is community participation in health services. The focus area at present is malnutrition, Mother and Child health in slums.

The main objective of the organization is democratization of health services through Community Action, Research and supports most of the grass root organizations. To address the malnutrition they are educating empowering Asha, Anganwadi worker with mothers of children and they also promote local food in place of packaged food item.

Understanding about Community

Bhopal is the Capital of Madhya Pradesh and basically administrative city, it is famous for lakes and historical buildings (Places, Mosques etc.). But last thirty years Bhopal Gas Tragedy is the recognition of the city and victims still waiting for the justice. After this man-made disaster Government of Madhya Pradesh Recognized large number of slums and residents of slums got Patta. Bhopal Municipal Corporation is the principal provider of civic services to the residents of Bhopal. Key activities under BMC comprises (Bhopal Municipal Corporation)

Street Lighting
Citizen services

Health & Sanitation

Heritage cell

Garden

Water supply

Fire services

Housing Status of Bhopal Urban Poor: Land is an important economic resource and the ownership of such economic resource is important for every family and household. In Bhopal, only 62% of the slum households have Patta, which is an important document given by Tehsildar for land ownerships. Households with Patta usually live in Pucca houses the households have Possession Certificate document and might be living by Semi Pucca structured homes of slum households. The main reason of rising population in slum areas is Migration and it is becoming a serious issue for cities. Growing urbanization and employment opportunities have attracted majority of the people away from their home to earn basic livelihood. In Bhopal municipal corporation recognized 366 slums it means that the municipal corporation is responsible for civic amenities. Most of the people n slum areas migrated from one place to another within the city.

Earlier I have stated that SOCHARA intervene in six slums actively at No.12 Bus Stop and after transit walk I decided to experience or understand Ishwar Nagar community. Ishwar Nagar is a largest slum area in No.12 Bus Stop Slum most of the residents migrated from one place to another (Like: Habibganj Naka, Abbas Nagar, 12No. Stop etc.) From last 30 years. Most of the resident's native place is from Maharashtra, Sagar and Rewa and they live in their ghetto or pockets from last 20 years. Election after election they got entitlements like Patta, Ration Card, and Electricity connection, Road, Water, School and Anganwadi also.

Culture: People follow their own culture and marry in similar community. Muslim celebrates Eid and Hindu celebrates Diwali and Marathi speaking people celebrate Dr.B.R. Ambedkar's Birthday on April 14.

Livelihood: The major source of livelihood is construction work for men and domestic work for women recently they have other sources also like Sand Loading and Unloading.

Main Concerns of Community: Livelihood is the primary concern of the community because nature of their job is uncertain and second is health because they live in very

unhealthy environment and most of their money goes on it and their last priority is education they enrolled their children in schools Government, private and madarsa also. They understand the importance of education so the children of the area enrolled in schools.

Social Problems: As per my interaction with community members, children and other Voluntary organizations members the place is full of problems by the system and by the people. People face many problems: Seasonal Employment, Alcoholism, Gambling, Addiction (many: Whitener, Tobacco), Domestic Violence, Child Abuse, Eve-Teasing, disease (Typhoid, Jaundice, Malaria, etc.)Malnutrition, Stress-Anxiety etc. By the system they face many problems like the whole slum area have water supple pipe lines but MCP Supply water from water tankers, roads without cleanliness, drainage is choked, everyplace is full garbage, all the Govt. health services is 5 K.M. far from the area and uncertain Housing status due to JNNURM and Ray.

Social Determinants of Health: the Social determinants in community are (SEPEC):

A) Poverty,
B) Clean Dr inking Water (Sanitation),
C) Housing ,
D) Health,
E) Hygiene,
F) Child Labour,
G) Education,
H) Health services,
I) Common Place.

Medical Pluralism: People from these slum areas try their traditional remedies if they have any idea of illness after that they go to Private clinic, Govt. Hospitals and traditional healer. In jaundice, typhoid and metal Problem they prefer traditional healers and shrines. In minor illness they prefer Private clinics (Bengali Doctor) or nearby nursing homes in case of urgency. In delivery, TB and other cases they prefer Govt. Hospital (Dist. Hospital and 1100 quarter Clinic). Some of community members avail services of Traditional Birth Attendant at the time of delivery but after the Ladli Laxmi Scheme and Maternal Health support Scheme the number of institutional delivery increased.

Day by day the number of immunization and visits at Anganwadi increased due to Active visits of ASHA's and also in VHND. They are also facing problem of storage space, water, electricity and rent also.

The first information point about health is ASHA and Anganwadi in the community.

Institutions in the Field Area : Ishwar Nagar is the largest in the area and it has Anganwadi, Govt. Primary School, a Private Middle School, Fair Price Shop (PDS) and Child Learning Centers (NGO's). All these institutions are easily accessible to the community and they utilize the services as per their necessity. In district hospital they have Breast Milk Bank, NRC, One Stop Crisis Centre (Violence against Women); Blood Bank also.

Learnings: During field work I have learnt the following with community members and others (Govt. Officials-WCD, Health, and Education):

1. **Observation**: Before CHLP I observed many things but after joining the Programme I utilized it in my life as an experiential learning. In initial stage language and circumstances is the major barrier for a learner but observation gives us a new dimension to think about the life.
2. **Systemic and Critical Thinking:** Before CHLP Programme I have experienced Flow-charting in computers in my college days but it is also essential in life without systemic thinking we can not plan activities and assume the result. Critical Thinking is necessary for a person and it requires logic and address issues collectively in the interest of society.
3. **Research & Documentation: I**n simple way we need facts and figures to establish any issue or thought and it require Research (Re+ Search) and it's not a new thing. It depends on aim and objectives. Research and other activities need documentation for record and other purpose also. Both were new for me before CHLP but not now.
4. **Social Determinants of Health (SDH):** Social Determinants of health is collection of Social, Economical, Political, Cultural and Environmental condition which determine the health of society. After joining CHLP, I understood that many health problems like: Malnutrition, TB etc are not only health problem and we can prevent many diseases by real development.
5. **Organization and Alliance:** The **CHLP** taught me many collective actions in community and organization and alliance is essential for it without organization and alliance we can not achieve goals in the interest of community.

6. **Analysis and Assessment:** Before any Programme we need real assessment and analysis to understand the nature of problem and its root cause, after that we can plan or strategies the activities.
7. **Relation between Development (Globalization) and Health:** Before CHLP I thought that health is an independent issue but after joining the programme I understood that it is inter-dependent issue. We can prevent many diseases by development, behavioral-attitudinal change and social dynamics. Irrational Urbanization and industrialization also affect our health.
8. **Communitization and Public Action :** Communitization and Public Action is very important aspect of life, in my opinion communitization is similar to democratization where community decides many things what is best in the interest of community(Like : Local or Regional needs and solutions). Real Democracy is based on people's participation (Planning and Decision) and action.
9. **Prioritization and Resource Mobilization:** To address any social issue prioritization of problem is essential because our society faces many problems in day to day life but we can select it as per our Skill and Knowledge with community consent. After prioritization we need resource to run it so local resource mobilization is necessary.
10. **Equity and Empathy:** We need Empathy to empower the community and our community health journey starts from equality to equity.

Conclusion

After completion of one year learning fellowship programme, I understand clearly that health is not an independent content in human life its depends on social, economical, political, cultural and environmental conditions. Active listening, learning, observation and intervention create bonding with community and it is an asset for any kind of intervention. Without community recognition and support we can not address public interest matters. I always remember tap turner off rather than floor mopping and balloonist approach to see a problem in collective manner.

Reading

2. Where there is no Doctor,
3. Everybody Need a Good Drought –P.Sainath,
4. Article on Health Right
5. Article on HIV -Yogesh Diwan
6. Maternal Health Dialogue(News Letter)-Maternal Health Right Campaign

Paradigm Shift

• Me	We
• Bio Medic Remedies	Social & Other Remedy (Not Alternative)
• Observer	Analytical
• Specific Approach	Wholistic Approach
• Global	Local
• Independent Problem Analysis	Inter-Dependent-Problem Analysis
• Critical Thinking	Collective Efforts (Combination)
• Economical	Valuable, Sustainable
• Class	Community
• Equality	Equity
• Sympathy	Empathy
• Floor Mop- Per	Tap Turner Off

Research Study Report

A Study on Health Services Utilization by Beedi Worker at Rahattgarh

Aim:

- This study aims to identify the health problems and explore barriers in accessing the health services of BWWF and CHC by Beedi Workers at Rahatgarh, Dist. Sagar(M.P.)

Specific Objectives:

- To identify the health problems faced by Beedi Workers with reference to their socio-economic condition.
- To document barriers in accessing the services of BWWF clinic & CHC).

Background of Community

In this neoliberal world nature of many industry has been changed, some industry travelled from small scale to factories and some has been travelled from factories to house hold nature and beedi manufacturing industry is one of them which comes in the second stage, from factories to house(in unorganised manner). Basically Beedi manufacturing industry is situated in rural areas where there is no alternative employment and cast factor is also involved in it. Most of the labours in manufacturing of beedi belong to scheduled tribe, in Tendu Leaves collection, SC and Muslim community in beedi rolling (manufacturing). The beedi industry is the one of the many among the unorganized sectors all over India. Due to unorganised nature of industry and large number workforce of women and girls create huge profit to Sattedar(middle-man) and owner at low cost, risk and liabilities. It is a unorganised, labour intensive, back breaking and vigorous occupation.

In M.P. 10.21 lakh labours have identity card in the beedi manufacturing industry and as per the Govt. data 60% women involved in it. And beedi rolling labour faced two types of identity first one who have labour departments Id(for minor health and other problems) and another one is identity card with salary slip(For Major benefits Pension, social security etc.) and the second one category is very low in numbers(hundreds). The main centres of beedi rolling in MP are Sagar, Jabalpur, Tikamgarh; Damoh where most of economic activities are based on agro-forestry and industrial economic intervention is very low.

Many studies exposed that these workers suffer from various diseases due to their occupation and socio-economic condition. They suffered with many diseases but initially tobacco dust affect their eyes, respiratory system and long duration sitting posture gave them neck ache, backache, spondilitis, lower limb swelling, digestive problems and also they suffered with TB, Asthma, skin disease and Cancer. To address the health problems of Beedi worker Govt.

Set few clinics(Under Beedi Worker Welfare Fund) at block level and district where the number of Beedi worker labour is high. In the context of health services Rahatgarh also have BWWF Clinic and Community Health Center(CHC). But the condition of BWWF Clinic is similar like Beedi Rolling labour and CHC with 22 beds serve the Population 31537, where most of the 5945(Census 2011) belongs beedi rolling process. A male doctor and a compounder look after the BWWF clinic with limited Three Day Medicine. Most of the beedi worker suffered with various health problems and these health services are busy to refer them to district hospitals at Sagar. Due to their socio-economic condition it is a very big problem to them.

Three acts directly address the beedi industry and labour and nine other acts also address it but the Acts does not apply to the occupier or owner of a private dwelling house involved in the manufacturing process with the help of his family or anybody who is dependent on him.

Many studies exhibited the health problems, welfare schemes and its impact on beedi worker but the gap between health services and health condition of beedi workers health still exist which needs to be address.

Methodology

Study design

Qualitative study

Type of study

- Descriptive study

Sampling unit:

- Sample Size type: 20 families involved in beedi rolling.
- 10 women (5Muslim and 5 Dalit Women) 10 men (5Muslim and 5 Dalit men).The respondents will be selected from in 5 wards out of 15 wards of Rahatgarh, District Sagar(M.P.)where the Muslim and Dalit are more who are involved in beedi rolling.
- Inclusion Criteria : Respondents from 5 wards where Muslim and Dalit dense population live, who involved in beedi rolling and utilized health services within a year.

Techniques and tools

- In-depth interview

Tools

- In-depth interview guideline

- Observation
- Consent form
- Recording

Results:

Background of community and work

In my study I had 20 respondents in that 5 women from Muslim, 5 from Dalit, 5 Men from Muslim and 5 Men from Dalit Community and they are involved in Beedi rolling from last 10 – 20 years. These two (Dalit and Muslim Community) communities are largely involved in Beedi manufacturing process and in the Rahatgarh they do not have any other livelihood options there.

Health problems faced with reference to their socio-economic condition.

Among 20 women(Age 30-55) and men(Age 30-55) participants they are involved in beedi rolling most of them are literate, their family size is between six to seven, a large number of Beedi labor own house but not on their own name and all the houses are Kuchcha, only men have other livelihood source which is only Hammali in Mandi; they all have Beedi Labour Card which have limited entitlements (Ration, Hosital,Death Claim (without ESIC, PF) and other type of Beedi Labour card issued by labour department but endorsed by beedi company and number is too small(this contains all social security entitlements.). Govt. fixed the rate of 1000 Beedi is Rs.92/- but they get only Rs.55-60/- per 1000 Beedi. If three or four person involved in beedi rolling in a day they role only 1000 beedi.

Abida B Said *" Yahan beedi Nahi Banayege to kya karenge or koi Dhanda bhi to nahi hai."*

Beer Singh Said*"Beedi Card se Ration to Mil jata hai per uske liye paisa bhi to chahiye or ration bhi time per nahi ata hai. Kabhi kabhi mandi mai majduri bhi karlete hai."*

Prem Bai said *"bhaiya Baap dada ka ghar hai to rehlete hai nahi to mushkil hoti bahar jayenge to kiraya bhi chahiye jaise bhi ho gujar karlete hai. Beedi cards to banjata hai per uska fayda lena asan thode hai."*

Anjum B(Divorcee)Said *"Hum Padhe Likhe(8^{th}) bhi a hai per yahan to Beedi Banane ka kaam hi mila sakta hai."*

Mohammad Yusuf Said,*"Bahut Kuch Badla hai per yahan kuch nahi badla Bachpan yahi dekha rahe hai. Sattedar hi yahan sabkuch hai. Ekbar dharna diya tha to majduri Rs.92/- ka rate fix kiya tha per kaun deta hai."*

Shakila B. Said,*" Bachche ko anganwadi mai kuch mil jata hai per bade kahan jayeunke liye to yahan beedi banana hi ek rast hai. Vaisse to bacchchon ko koi beedi banana koi nahi sikhata per dekhte dekhte sikh jate hai or apne maa-baap ki madad karne lagte hai per school sab jate hai."*

Rahatgarh administered by Nagar Panchayat and all the wards have anganwadi and the children of Beedi labor go there regularly. All the children of Beedi labour enrolled in Govt. School after Right to education the enrolment of children increased and they get free education, uniform, mid day meal and scholarship also there.

Due to poor socio-economic condition most of the Beedi rolling labour face similar health problems like : Malnutrition, Anemia(food Scarcity),joint pain, stomach pain, problem in delivery, (sitting position), cough, respiratory ,eye problems, TB(Tobacco Dust), Cancer and skin disease(Tobacco Contact).

Regarding health problems one of a lady Kama B who recovered from TB and now her daughter-in-law getting treatment said a very strong statement ,*" Lagta hai Bimari se hamara rishta ho gaya hai, ek to iti pareshani uprse bimari ab kya kare."*

Sufiya Said,*"mere Abbu Beedi Seka Karte the ab Saans lene me mushkil hoti hai kamzor bhi ho gaye hai, ghar mai koi or admi bhi nahi hai meri ek behan or Maa hai."*

Shabnam who volunteerly work for a CBO and Beedi labour Said,*"Choti Moti Bimari taklif to chalti rahti hai per agar delivery ke time Sagar bheja to Rs.2000-3000/- ka kharcha matlab kisi se paisa lena padehga jis ko chukana beedi banakar hi hai. Ab agar ggharwale kamate hi Rs.4000-4500/- hai or 6 khane wale to karja kaise niptaye."*

Jagdish(Recently recovered from Piles(Operation) Said," Beedi Card Choti moti bimari ke liye to thik hai baki ke liye khud hi kuch karna padta hai nahi to marne se zyda jina mushkil."

All the respondents whom I have interviewd are associated with Beedi Labour Union and women are involved in CBO named "Hausla" where they learn tailoring and embroidery also.

Barrier Accessing Beedi Worker welfare Fund Clinic(BWWF) and Community Health Centre(CHC)

All the Beedi labour utilize both(BWWF and CHC) the health care services as per requirement, knowledge and referral. On the basis of accessibility, availability, acceptability, affordability; quality we studied these health care services and respondents also shared their like and dislikes onn it . BWWF clinic Treats minor disease and refers the patient to district **BWWF Hospital**. The patients face the following problems:

- On the paper hospital open every day but Doctor Visit once in a Week for three to four hour.
- Shortage of medicine always there,
- Lady Doctor is not there.

Kamla Bai Said,"*Beedi Aspatal paas mai hai per Doctor nahi hota hafte mai ek baa rata hai to bhid bahut hoti hai. Bachchon ko or hame choti moti bmari mai yahan ka ilaj kaam kar jata hai."*

Sheela Rani said," *Hamari do delivery hui per humko janch karana hoto CHC mai jan padega jo door hai or Hamara Beedi aspatal mai Lady doctor hoti to kaun jata."*

Kear Bai said, "Beedi aspatal mai kabhi bhii jao dawa ki hamesha dikkat hogi."

Shyam Bai said, *"ek din doctor ata hai to ek din aspatal chalo hota hai, mera beta le jata hai to uski majdoori jati hai. "*

Azizuddin Said," *Kuchdino pahle mere aant ka operation hua per hame hoi madad nahi mili sab kuch bahar se karna pada. Bahut mushkil hai."*

BWWF clinic is in the centre of the city, clean, provide spectacles ; behavior of doctor and support staff is nice but most important thing is proper treatment which is not there.

Community Health Centre (CHC) have 22 beds, TB, Delivery, Vaccination and other facilities are there. Most of the Beedi rolling labour visit there for delivery, vaccination and TB treatment. They face the following problems there:

- *Permanent Residential Doctor is not there nurse and other staff manages the CHC.*
- *They prescribed medicine from outside.*
- *They terrorize them on the name of referral, referral means Rs.3000/- + for delivery and it's a heavy burden for low income group community.*
- *Accessibility is the main problem there because there is no proper road.*
- *Staff treat them rudely.*
- *Building is good.*

Shabnam Said, *"aspatal achcha hai per Doctor samay per nahi hone se mushkil hoti hai or kabhi kabhi sister log Sagar bhejne ka naam lekar darati hai."*

Anjum Said," *Delivery ke liye jate hai vaise to beedi aspatal jate hai, yahan per sidhe sidhe kuch nahi hota chila chili hoti hai per aspatal hamara hai to kyon kahi or jaye."*

Ganga Bai Sai,*"is aspatal tak pahuchna sabe badi mushkil hai koi thik rasta nahi hone se badi pareshani hoti hai, barish ke din mai to or mushkil hoti hai."*

Mohammad Sharif said, *"log yahan nahi aayenge to jayenge kahan per yahan zydatar dawa bahar se likh dete hai. Staff ka vyhar bhid per nirbhar karta hai agar zyda rush hai to phir mushkil hoti hai."*

Kama B Said, "*TB ke ilaj ke liye ye behtar jagah hai meri bahu ka bhi ilaj yahi se chal raha hai. Agar yaha nahi hota to maloom nahi kya hota. Bas aana mushkil hota hai per kya kare."*

In conclusion we can say that the CHC need Proper Road, skilled full-time human resources ; sufficient medicines to serve the people of Rahatgarh.

As per the labour department the beedi labour have these entitlements :

- PDS(For a member 1 KG wheat, 1 kg rice- sugar, 4 liter kerosene 1 pk salt),
- Death claim (<60yrs get Rs.11500/-),
- Health Schemes benefit (like free drug and treatment at authorized hospital),
- TB Treatment Rs.10000/-
- heart & cancer Rs.2.5 Lacs, free vision aids,
- Housing support Rs.40000/- for 600 sq feet
- Girl marriage Rs.5000/-
- Scholarship to student (class 1 to 5) Rs.250/-
- For Shed construction Rs.2.5/- lacs

But I practical it is hard to get these stated entitlements most of the beedi rolling labour get PDS,Free drug and treatment at BWWF clinic and spectacles but other entitlements is far.

Strengths and weaknesses of the study

Strengths:

- The main strength of the study was the whole hearted corporation of the responders even in their limited time.
- I conducted the whole interviews alone for all respondents and I collected the maximum details I can in limited period.

Weakness:

- Sundays are not holidays for them so it is very tough to take their time within the busy schedule.

- Since I conducted the interviews alone I feel like data that I collected incomplete and would have been better if I had a companion.

Conclusion

From the study positive and negative result is seen: health problems faced by beedi labour and health care services there. Most of the health problems are related o their socio-economic condition and the response of health care services is not adequate towards the marginalized community. utilisation of health scare services is not a easy task for community while the system is not friendly. Active participation of the community is a hope for change and they need a information and support system to utilize the existing entitlements.

Reference :

www.censusindia.gov.in/2011census/population_enumeration.aspx

Memorable learning

- Language is not a barrier observation and reflection is important. (T.N.)
- Skill and knowledge is the key of success. (Sam)
- Political analysis is necessary to analyze the policy. (PSS)
- Qualitative and quantitative method compliments each other. (ASM)
- Story telling (Dastangoi) is ancient tradition of our culture and culture is important, it decides manything. (RN)
- Discipline maters but humanity first. (KKJ)
- Work with smile. (SJC)
- Your adult so behave like adult. (ASGR)
- Before doing anything think about nature. (AP)
- Caste and class maters in our society (Sabu)
- **Work with people** not **for people** (ALAN)

Future Plan

- Collect print media reports on health issue of last six month (Jan–Jun'16) and
- Start Health Right campaign (After July'16) with collective support.
- Start youth recreational activity in Mhow or Bhopal.

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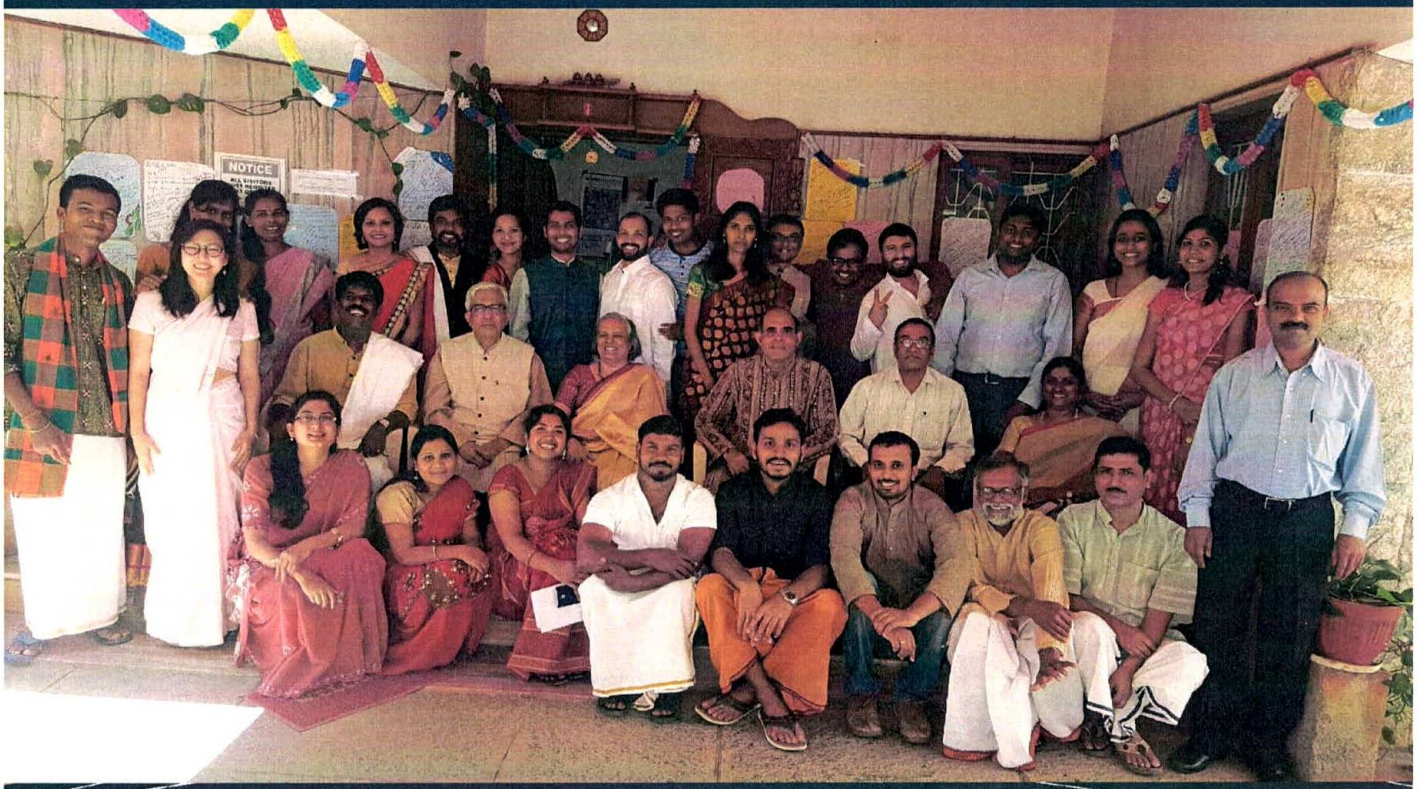

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