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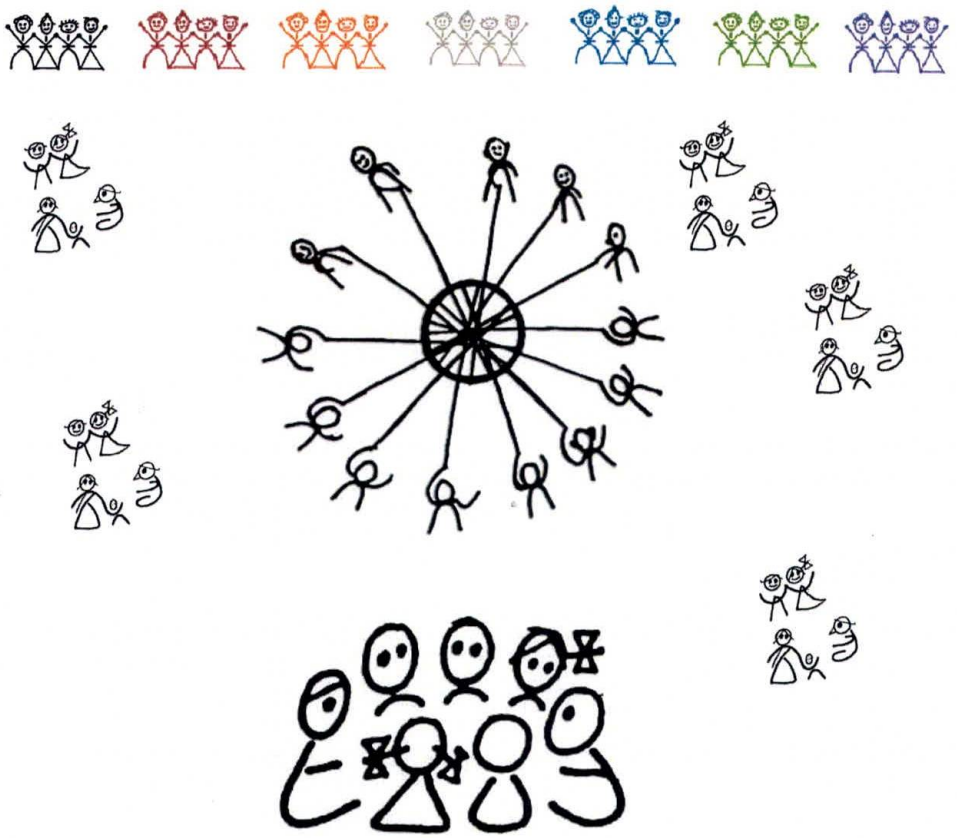
# Community Health Learning Programme

*A Report on the Community Health Learning Experience*

KHIROD BIHARI SAHU



School of Public Health Equity and Action (SOPHEA)

sochara
building community health

Society for Community Health Awareness Research and Action

# Report On Community Health Learning Programme

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# *Introduction*

After completing my MBA Istarted work in private company but I could not finding any meaning in the work I had taken up. At the end of the day I was not satisfied with my work, I was feeling uncomfortable and wanted to do something that was more satisfying.

So I started searching to do something that was more appealing to my heart. During these confusing days of my life I happened to meet Mr. Kumar who is a facilitator at SOCHARA. We had a long conversation; he could feel and understand my discomfort; it was through him I first came to know about SOCHARA and I felt it was interesting and appealing to my thoughts and I wanted to give it a try. I looked through the SOCHARA website and through the website, I came to know about Dr. Thelma Narayan. She is a pioneer in community health as well as public health and was part of Orissa's health policy group. Dr. Ravi Narayan, through the internet I found out, was a part of USA President Barack Obama's health advisory group so without any thought I wished to join SOCHARA.

## Learning Objectives:-

I had some objectives before joining the fellowship programme which included:

1. To understand what is social work
2. How these programmes help me to do social work as well as improve my self confidence in the field of community health
3. To improve my intrapersonal skills
4. To improve my writing and learning ability

## *The Collective Learnings*

When I joined SOCHARA I had no idea about community health or public health but day afterday I began to understand the real meaning of health and thehealth system. Through the classroom sessions, I learned so many conceptsthat directly influence community health. I discuss a few of these concepts below:

### Understanding oneself: -

Means to know yourself

- Be aware of your strengths, weaknesses, likes and dislikes
- Observe and be aware of your moods, reactions and responses to what is happening around you
- Become aware of how these moods and emotions affect your state of mind
- Examine how you interact with others
- Observe how your environment affects you

As a community health person perspective, it's more important to know and understand yourself better as, in turn, this leads to better decisionmaking, setting and reaching appropriate goals and ultimately to a more productive life which is ultimately helping the community as well as oneself.

### Intrapersonal and Interpersonal skills:-

These two skills are more important for community health workers because through the intrapersonal skills he/she may be using their own ideas or thoughts in solving some health issues or implementing some ideas which will help to develop community. At the same time interpersonal skills play a vital role in decision-making at the community level because a community consists of various types of people, sometimes its helps in getting some ideas or knowledge from others as it would be beneficial for oneself and others.

### What is Health?

As defined by the World Health Organization (WHO), it is a "State of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." Health is a dynamic condition resulting from a body's constant adjustment and adaptation in response to stress and changes in the environment for maintaining an inner equilibrium called homeostasis. Beside that my understanding of health is that it is the state of being free from illness or injury, health means absence of diseases or physically mentally fit with the ability to manage one's own daily needs.

**Physical**: - Physical health can be defined as an essential part of the overall health of an individual, which includes everything from physical fitness to overall wellbeing.

**Mental**: - A person's condition with regard to their psychological and emotional well-being. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

**Social**: - Social health is how you get along with other people, how other people react to you, and how you interact with society. It can be difficult for someone with autism to form relationships and make friends due to difficulties with social skills. Social health involves your ability to form satisfying interpersonal relationships with others. It also relates to your ability to adapt comfortably to different social situations and act appropriately in a variety of settings.

## What is a community?

A **community** is a social unit of any size that shares common values, or that is situated in a given geographical area (e.g. a village or town). It is a group of people who are connected by long lasting relations that extend beyond immediate parental or maternal ties, and who mutually define that relationship as important to their social identity and practice.

## What is community development?

**Community development** is a process where community members come together to take collective action and generate solutions to common problems. **Community** well-being (economic, social, environmental and cultural) often evolves from this type of collective action being taken at a grassroots level.

So far, in my experience of community development when I was in field I could not find any such programme organised in that area. As per the national five-year plan, the government is implementing many rural development programmes but due to the lack of education this community was not aware of such programmes.

## Community Health:-

Community Health, People living in a specific geographical area their having some biological characteristic(Qualities and characterization of various types of populations within a social or geographic group, with emphasis on demography, health status, and socioeconomic factors)

Community health is a process of empowering and enabling peoples to taking mutual decision towards their own health and also the belonging community. For empowering and enabling peoples through various approaches like give tem to health education to preventive the disesase instead of providing medicine,promoting apporpiate technology only not being as low cost but its should be culturally accepted and health also integrated to through other development likeincome ,nutrition etc.

**Public Health:-**Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases. Overall, public health is concerned with protecting the health of entire populations.

## Axioms of Community Health:-

There is some statement on community health which is the people's idea towards their ownhealth.

### Right and Responsibility

Community Health is a process of enabling people, to exercise collectively their responsibility, to their own health and to demand health as their right.so when we talked about right same time we think about our responsibility also because without responsibility the rights are not worked properly so when the health concernced we not being only think about what are the rights towards health made by the government as a responsibile person we should follow the guide lines for better health.

### Autonomy over Health

The Community Health Approach involves the increasing of the individual, family and community Freedom to taking decision over health and over the organizations, the means, the opportunities, the knowledge and the supporting structures that make health possible. The health structure should made in this way which more easy to available,accessable,acceptable and affordable to every community member then the community health should improve.

**Integration of health and development activities**

For better development of health status of country we should integrate or interlink all sectors like health,education,food security and others involved in developmentactivities to achievebetter health. To achieving the better health we should integrate all the system together which is easy to every community to accessing better health care services and all the health activites reached to every community.

**Building decentralized democracy at community and team level.**

For achieved better health or healthy community the system should be in horizontal form instead of vertical every community member should be take decision about their own health for that we should raise everyone's awareness about the system and as well as give education to take own decision towards their own health. As we know health is a state subject for we make the health system should decentarilized so it will be easily operated in each and every level of community.

**Building equity and empowering community beyond social conflicts**

Community health approach find out the recent inequity present in the community so that we should try to established the equity among the community to getting better health facility.for building equity and empowering inequity community we should providing better knowledge and awering the community about health ,with empowering them to find out what are the basic prioprities in their community so they are able to confront their own health issues in front of the public.

**Promoting and enhancing the sense of community**

The community health approach recognizes that the large majority, the poor and the disadvantaged are not themselves 'one community' even though they are linked through their poverty and social situation since they have internalized various social, cultural religious and political differences that divide society at large.

**Confront the biomedical model with new attitude, skill and approaches**

Instead of the top down approach of the existing biomedical model, we need some new strategies that involve community with new attitudes ,skills and approaches of the manpower. So instead of biomedical model we thought the community to accept the social model of health care system and providing the new idea and views to modified the traditional method like giving some training to *dai* to became trained birth attendant

**Health care system should be community oriented**

The community health approach evolves through community participation for that there is some ingredient which evolves to community provide better health like a super specialist hospital, well trained staffs other various advanced technology.but when I was compared with my field placement area it no one can't imagine the reality was so worst thinking about the super specialist model of the hospital there no roof in hospital building this was the real condition of the super specialist health system of our country. When we talking about super specialist hospital set up the hospital set up should be in 24x7providing health services with modern healthequipments and availability of hospital staffs with good connectivity with community but this things are dream like my field placement area.

As per my field experience, I could not find any reality of this statement made by people to achieve their best health.

## Social Determinants of Health:-

Individuals or group of peoples health is depend upon various factors or certain conditions which people are born, grow, live, work and age. These Health determinants are formed by the distribution of money, power and resources at global, national , local levels and also Individual level. And also the SEPCE(Social,Economical,Poltical,Cultural, and Environmental) factors also

Influences the health of the persons such as

**Social**:-Caste,Gender and age which things are directly influency the health conditions of a persons

**Economical**:- Its play a major role in a persons life when its comes in health its most important things to improving a persons personal life and health status.

**Political**:- Its seems not directly influence the persons health status but it's major health determinants.Its indirectly influences group of people or a state's health conditions.

**Cultural**:-The cultural belifes,traditions andcustoms very much important in group peoles health.

**Enviromental**:- Environmental conditions directly influences the community peoples health like in the droughttime,floods time health disparities are quiet unbelivible

So factors are play major role in community health

## Social action:-

The process where every community member should take action for getting the social determinants for their development. Such as the social action should be in two way one is done by the agencies if you consider the health then agencies should find out the health indicators,doing the biomedical test and others like medicines,healtheducation etc. The same time community should identify their own priorities ,what they need and collectively take decision to their better health then the social action is completed without these both two parties involvement the social action cannot possible

## Globalization:-

When I think about globalization I remember Dr. Ravi 's class. "Vasudeva Kutubakam" meaning the whole world is one; there are no boundaries or limits. This is especially for making profit or earning money. It can create more opportunities in developing countries but at the same time it is not focused on all of development so it can have some harmful effects. Due to globalization we got super or multi speciality health services but they are not easy to afford for every community member and influences the health very often to a developing country.

Due to globalization, the richer became rich or poor became poorer. As per my experience I found out in the tribal area of Odisha that the transportation facilities are very poor but on the other hand soft drinks are easily available in every village shop. While it is not easy to get any medicine it is easy to get luxurious commodities. From a health perspective globalization has its positives and negatives due to globalization we can easily get the essential medicines but at the same time it is not easy to afford it.

## Health System and Health Policy:-

The Indian health system includes public and private hospitals as well as specialised Ayurvedic hospitals offering this traditional Indian system of alternative medicine. English-speaking doctors are easy to find, as most Indian doctors speak fluent English. All major cities and medium-sized urban centres have private hospitals that provide an excellent standard of care.So far, my knowledge of the health system is that it consists of two types - public health system and private health system.

**Public Health System:-**

Under public health system the state government and central government run health facilities. These includeall the government regulating medical colleges and government running PHC, CHC and Districts Level hospitals.

**Private Sector:**

When we talking about private sector hospital its basically foucsing on profit making or money oriented but the same time the providing all the super specialist services to rhe patients and other hand their are some private sector hospitals are also available all the super specialist facilities but this organizations are not money oriented or profitmaking set up but the same time these charity or society hospital are set up only big cities and where the availability,affordability and accessibility possible when I related with my field placemeny are there no missionary hospital set up we find out

## Nutrition:

Nutrition is directly related to the food consumption of a person. We need nutrition for improving the immunity of a person as well as for getting some energy so good food should contain appropriate micronutrients, vitamins and minerals. As a community health worker, I should know about the nutrition because nutrition directly influences the health of the community If a person eating nutritious foods he /she may be protected from various diseases due to the strong immunityIf I relate my field work to this concept I find so many malnourished people so I try to understand the problem its not only the lack of health care problem it was also related to the food practices or dietary patterns of this communityhese people are not able to take all the nutritious food; they eat what is available to them like only rice without pulses or other green leafy vegetables so that they do not get all the nutritiou factors available in various vegetables, cereals and pulses.

## Women's and Children's Health:

When we talked about women's health here gender plays a major role in access tohealth care facilities Gender is one of many social determinants of health—which includes social, economic, and political factors—that play a major role in the health outcomes of women in India. Therefore, the high level of gender inequality in India negatively impacts the health of women. Women's health directly influences the child's health because we know mother is the first doctor to a child. Here the larger context of social determinants of health also influence the Mother and Child health

As per my field experience, I found out some health issues are still in the Adivasi area and Adivasi women facelots of health problems. These include

**Malnutrition and Morbidity:**

Nutrition plays a major role in and individual's overall health; psychological and physical health status is often dramatically impacted by the presence of malnutrition.In my field work area currently has one of the highest rates of malnourished women as comparision to other part of odisha. In my field placement area found that nearly 70 percent of non-pregnant women and 75 percent of pregnant women were anemicin terms of iron-deficiency. One of the main drivers of malnutrition is gender specific selection of the distribution of food resources.(Ref:-2)

**Reproductive Health**:

Reproductive health also most important part of the human health in the time of reproductive we should give more attention toward the womb and the mother so as result we got healthy baby which very important to society for that government have announced so many schemes or programme to taking care of mother and child and also during the prenatal, antenatal and postnatal period.

## Communicable diseases:-

Communicable diseases spread from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid. The terms infectious and contagious are also used to describe the communicable disease.

When I related with my field placement area firstly the scabies comes to my mind as the major communicable disease it is so rampant in this area without seeing we can't believe almost all the school going children suffer with this health problem beside that other major communicable diseases are malaria, TB etc.

## Communitization:-

Communitization is derived from the word community. It is for achieving some goal, there some action is taken by the community that is called Communitization. It is the process of enabling community towards their stewardship. Taking the advantage of the existing social capital in the state, the process of communitization of health services was initiated in the year 2005.It is basically an approach in National Rural Health mission. Communitization is the processes which strengthen health service delivery through community participation in planning, implementation and monitoring of different health activities towards development of ownership of health delivery by the community. In other hand communitization, it refers to the community action towards achieving their primary health care right. For achieving this right not only government responsible, community own self have same willingness itself then it will be successful. For Achieving this goal, there is some gap for bridging the gap there are certain mechanisms work for each level to support NRHM and improve the delivery of good health care services. Community accountability through

1. **Village Health and Sanitation Committee (VHSC)**: - As per the NRHM principle they define the role and responsibility of the VHSC these are like this VHSC create awareness about the programme and ensure community involvement, they analyze the health problem, decide the health priorities and take appropriate action to the problems. This committee also help in managing village health fund in the village cleanness and health improvement purpose. But in my field work time,I am found there not functioning any VHSC programme in the tribal area because the lack of education or awareness.I would try to found out the reason behind the non-functioning of VHSC when I asking about the VHSC the village people said what is this?

2. **Accredited Social Health Activist(ASHA)** is selected for every village. She is the female volunteer belonging to every village,selected by the village community the basic work of ASHA is routine check up of home visit and identify the other patients in community and helping them to refer nearest health centre and as well as antenatal care, postnatal care and leprosy detection for that she getting some harmony.As per my field experience I found that every community having ASHA but they are not working as per their work schedule because they are not able to understand their proper role in community health activities even also due to lack of accessibility, availability they are not able to help also the community. Beside that due to lack of knowledge and less aware about the programme facilities they are not fully involved in their job profile.

3. **Rogi Kalyan Samiti (RKS)**: -As per the NRHM every community should have RKS which is autonomous registered bodies in every community to help the PHC and CHC at every level to facilitate in day to day management in hospitals activities and deliver quality care to patients as per my field experience I am not able to find any RKS in any community level. So far my field placement organizations will be trying to enable every community member should be aware of what are the government program is going on in current scenario for achieving better health care.

4. **Panchayati Raj Institution (PRI)**: -Its working in PHC and CHC levels to helping plan and implementing a health program and health activities like VHND through this program they provide healthy meals to the community and also the accountability distribution of health fund in districts and block levels, but unfortunately in my field work area when I talked to the village Head (Sarpanch) He told that he did not know about this program.And also, when the meeting happened, nobody informed us. So I imagine where the funds are going on and who utilize this program costs.

## Tuberculosis

Tuberculosis (TB) is caused by a bacterium called ***Mycobacterium tuberculosis***. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal.

It is a major health problem in India Basically it is known as poor people's disease. For preventive and curative purpose government taking so many initiatives and also implementing so many programmes but still it is a major public health issue in our country that means there is some gap and also, the programme not properly advocacy or monitoring. For preventing or curative this infectious disease needs participatory action and community should be involved own self to rectify or solving this major issues for that community approaches towards the t.b control is a very essential.

Community approaches towards TB control it's a process .it majorly involves few steps

1. Identification of suspects

2. Key Players of the community

3. Roles and responsibility

4. Strategy

5. Monitoring and evaluation

**1. Identification of victims: -** First step is to find out the victim and suspects through early identification its help to prevent infecting others as well as cure the victim. If we are not able to early identification its causes for harmful to society and also the patient.

**2. Key Players of the community:** For identity the victims there so many players in community like individual, family, neighbour, community leader, NGO/CBOs and local health workers etc they are major key player to identify victims and taking action towards the curability or eradicating TB from community.For that we need provide better information regarding TB through various activities.

**3. Roles and responsibility: -**After identifying the key players we should identify every player role and responsibility towards preventing t.b like individual own self without any stigma he should enable to come forward to the community to avoid spreading this killer disease in a community like this others player also having some roles and responsibility towards to controlling this infectious disease.

**4. Strategy**: -For preventing and curative this infectious disease there should be some plan and programme because without plan and programme how could we achieve our target for that governmen tintervention so many programme like NTP, RNTCP and dots etc.

**5. Monitoring and evaluation :-** This step is most important because without evaluation how could we known about target its going right way or not, how the programme control this disease through process we analyze all our steps and we get the feedback which helps to rectify the major mistakes and give back new idea to control this killer disease in our community

## *Field Exposure Visits*

Beside class room session we had also some field visited in Bangalore with related with the various part or term of community and public health

**DOMMASANDRA PHC VISITING**: -Through this PHC visiting I know about actual government health system , how functioning and under this who are benefited. And through PHC which health issues are addressing and preventing it is give the clear picture about Indian health system how often working or taking care about the public .it is Sub-urban health care Institution its totally different to my field placement area covered the PHC . As I find out the Dommasandra PHC followed the Indian Medical Guideline try to overcome the all the public issues but some how due to lack of staff it is not meet the actual vision of PHC model.

**APD** (Association ofPeople with Disability):- It is a non-profit organization .It is main objective is to empowering and enabling the disability people for this field visited I found out how the integrity help to achieving any objective and goals easily. How the disability peoples are doing their work in a strong determination to achieving their goals.

**FRLHT**- After visiting FRLHT I found out why we need medical integration as well as how important the traditional health practitioner. FRLHT try to revitalise the traditional way of health system through documentation ofmedicinal plants which will be very helpful to future generation and the way the try to providing basic health need to community its tremendous eg:- the way they use the purifying the water purification in low cost its very intresting. The ayurvedic hospital set up is art of the state here they provide health check-up facilities through traditional way it is remarkable.

**Over all Learning:-**

Through the one years fellowship course, six months class room session and six months fieldwork session its give me lots up inner learning and the same time I gather lots of knowledge about community health ,primary health,different health systems avilables in India and the same time I learn how to enable and empower the community to towards their right and responsibility to health and also other social aspects.And beside that I have gain so may attitude towdars to my out of thes these two I find as a community health worker its more importants.

**Stewardship** means the management or care of something, particularly the kind that works. As a community health worker you should have the stewardship attitude for the community otherwise you can't reached to achieving your goal that is health for all.

**Solidarity** unity or agreement of feeling or action as a community health worker you should have the solidarity behavior for the taking movement towards to give equal health benefit through social action.

Refernces:
1.R.Narayan,T.Narayan,K.Gopinathan,K.Chakarvarthy.The Red Book.Community Healt.Axioms of Community Health.1987;2nd:44

2.Sources: Swasthya Swaraj Society .Base Line Survey.2010

# Field Learnings

## First Field Placement

Before going to Give the introduction about Swasthya Swaraj Society ,As a community health fellow I was placed there as an Intern for six months for my field work I was quiet happy when I know I was placed at Odisha For my field work because I am belonging from Odisha and its cery much intresting to me for doing my field work inmy own state.

### Introduction:

Swasthya Swaraj, an organization that dared to set its foot in the forsaken block of Kalahandi was born out of the inner call of Dr (Sr) Aquinas Edassery. It was started in the year 2013 to bring a light in the darkness of Kalahandi. With the guiding principle of "health as a right", the organisation believes that it is their duty to ensure the people of the community recognise that "health is their right". The belief that working with the community and not for the community sets apart Swasthya Swaraj from other institutions.

The organization started just 2 years ago is the result of many years of groundwork. Though the organization it is a budding stage, it lacks nothing short of dedication and passion to work with the community. Despite the setbacks and trials, the organization is growing stronger, and with each passing day the dedication and passion seems to light up more.

### Geographical location:

Swasthya swaraj reaches out to 75 villages from five-gram panchayats broadly divided into two clusters covering about 13000 population and 3400 households.

**Cluster I: Kaniguma cluster** - Centered around Kanigumagrampanchayat, within a radius of 25 kms, Kaniguma is 55 km from Bhawanipatna and 23 km from Th. Rampur the block headquarters.

Number of selected villages in this cluster are 45. Following is Gram Panchayat wise distribution.

a) Kaniguma GP-28
b) Sindhipadar GP-10
c) Gunpur-GP-6
d) Gopalpur GP-1

With a population of 8677 (2011 census) of which 95% are tribal's, 4% are SCs and 1% are OBCs.

**Cluster II: Kerpai cluster–** Centered around Kerpai Gram Panchayatwhich is 85 km from Th.Rampur and 101 km from Bhawanipatna. Number of villages in this cluster is 30 with a population of 4914 (2011 census) of which 88% are tribal's and 12% are SCs.

### Background info regarding the selection of catchment area and infrastructure:

Two tribal concentrated blocks of Th.Rampur which have the lowest indicators were selected based on the many years of groundwork done by Holy Cross sisters who were working with Gram Vikas an NGO that previously worked in that area. After the careful selection and pondering, the organization decided to concentrate on Kaniguma and later Kerpai.

The organization do not own fixed assets, all the buildings are rented or donated by the gram panchayats. The organisation belief is to provide health care needs wherever there is a

need, and so after the fulfillment of the present catchment area, the organisation will shift to the other needy area. Now the organization catering health services through on rented clinics.

**Evolution-**Where no doctors have gone before, nuns have dared to.
Swasthya Swaraj started official journey towards people's movement for swaraj in health after registration under Society Act on 26 March 2014. Even before official registration Swasthya Swaraj started its journey to reduce inequalities in healthcare by slowly exploring area In Th. Rampur block of Kalahandi district. Pioneers of Swasthya Swaraj are three hardworking and dynamic ladies, Dr(Sr) Aquinas Edassery, Sr. Angelina Thomas and Sr. Anis.

Dr (Sr) Aquinas Edassery is the driving force behind Swasthya Swaraj. She is an internist from St. Johns Medical College, Bengaluru who listened to an inner call and chose to work in the neglected communities as a primary health care physician. Dr. (Sr) Aquinas was chief functionary and chairman of society of sisters of Holy Cross Medico Social Centre for the Andhra Pradesh, Orissa, Karnataka and Kerala region as well as general body member of SOCHARA. She was working in St. Johns Medical College and later joined Jan swasthyaSahyoga(JSS) in 2012 and worked there till June 2013. She started her journey towards Orissa in 2009 and since that period has been exploring Orissa. After leaving JSS she came to Orissa and started exploring area with other two pioneers so as to identify community who is more deprived and vulnerable due to inequalities at various levels.

Sr Angelina was working in Bangalore with Dr(Sr)Aquinas but due to health issues she took break from serving community but after recovering, on 13 March 2013 she came to Orissa and started working with Dr. (Sr) Aquinas. Third Pioneer of Swasthyaswaraj is Sister Anis who was working with Gram Vikas for about three years in Th.Rampurblock and helped Swasthya Swaraj in identifying this area to work. Another most important helping hand in establishing Swasthya Swaraj is Ms. Palak Agrawal who met pioneers in April 2013 and one month after that she joined Swasthya Swaraj Group and played a major role in exploration and initiation of work. Ms.Palak Agrawal was working with SELCO (another NGO) who appointed her to work with Swasthya Swaraj.

Before starting of general Out Patient Department (OPD), Chief District Medical Officer (CDMO) and District Collector suggested Swasthya Swaraj to work in Kerpai region, as the area is most inaccessible with poor health infrastructure and poor health indicators. After initial help of SELCO Swasthya Swaraj started with first general OPD clinic in Sep 2013 at Kaniguma gram panchayat and two months after that at Kerpai gram panchayat. Initially organization was working with self funding and later SELCO funded for one year and after that stopped funding and that was the period when organization went through major financial crisis. Swasthya Swaraj didn't give up; helping unreachable and poor was their motto all the time even during the crisis. In spite of the humble beginning, many obstacles, uncertainties and anxieties a lot has been done in first year of the organization. After two years of journey, Swasthya Swaraj is providing health needs of 75 villages under five gram panchayats through well 2 established centresand with the help of community participation. Now Swasthya Swaraj has a team of doctors, public health specialists, social workers, nurses, laboratory technicians, educationists, clinic support staff, trainees and grass root level workers.

## Vision:

A society free from ill health, illiteracy and poverty, where every human being lives healthy and happy, in harmony with nature.

## Mission:

- We commit ourselves to empower the least and the last and the most unreached in the society; toliberate them from the bondage of ill health, illiteracy and poverty and thereby promote equity andequality.
- We facilitate peoples' movement for health by empowering the people for community action forhealth.
- We promote community based research on the unique health problems in the tribal pockets andfind solutions for them.
- All our activities and programmes are participatory, educative, empowering and based on humanrights and noble values of tribal culture.

## Philosophy:

With the guiding principles of Justice, Equity, Integrity and Compassion, the organization centers its work in the belief that the community achieves freedom from health inequities."

## Strategy:

1. Setting up a comprehensive primary health care system covering 75 villages in Th.Rampur block in participation with the people. This is being built on the knowledge and experience of the people and empowering the community to take control of their health and well being. Preventive, promotive and curative aspects of health are given equal importance.
2. Increased access to health care to the people in Th. Rampur block by providing ethical, rational, high quality primary health care at affordable low cost, with community's participation.
3. Educate and empower and provide technical and practical knowledge and skills to various groups of people- women, youth, adolescent girls, children, farmers, school going children, teachers etc. in the community to promote health and to understand that health is their fundamental right.
4. Community based research on issues related to the health problems of the poor in this tribal belt and on appropriate solutions.
5. Integrated approach to health care addressing the social and ecological determinants of health with a special focus on education in collaboration with individuals, government, other organizations and like-minded NGOs.

## Development Goals:

Since its inception the organization has strived towards achieving the goals simultaneously exploring other areas of work to supplement the existing programs. Whenever the needs arise in the community, the organization never hesitates to help. In the coming year the focus will be:

- Strengthening, stabilizing and streamlining the various activities already started.
- A detail study to look at the various factors which contribute to the high maternal mortality and the various ways to address this issue.
- Beyond the research the organization plans to take up advocacy to address this issue and improve the quality and availability of health services, food supplies, child care services etc. in this area.
- Education program like APD and health promoting schools program has been initiated and with has great prospects of additional activities to improve in the field of education.

## Swasthya Swaraj Team:

Swasthya Swaraj has perfect combination of team which includes Core team of professionals and ground level workers from community.

**Core Team of professionals**

Core team includes director who is working as clinician as well, three doctors of which one is on leave, two program coordinator one from MSW background and other from MPH background, one education programme coordinator with engineering background, one accountant, one laboratory technician (DMLT ), five nurses (One BSC, two GNM, two ANM ), two nursing assistant selected from the community, two lab assistants at Kaniguma cluster and three helpers at Kaniguma cluster. Two drivers cum social workers are also playing important role to reach difficult community and one data operator cum front desk boy.

**Team of grass root level workers**

Grass root level workers include 75 swasthya sathis-one per each project village, eight shikhya sathis, five field animators, two cluster supervisors and newly designated three shikhya sathi sahayikas.

1) **Swasthya Sathis:**

Swasthya sathis are most important community component of Swasthya Swaraj, they are the tool to reach the unreached community. There are total 75 Swasthya Sathis, 45 in Kaniguma cluster and 30 in Kerpai cluster- one swasthya sathi in each village. Swasthya sathi concept is very similar to ASHA concept of primary health care but due to circumstances of literacy and population coverage criteria is not mandated. These women are selected by the villagers themselves at the village meetings conducted by the *Gram Panchayat*. These village health volunteers are married women living in the village and with service mentality, which the villagers identify. Swasthya sathis are familiar with the traditions, customs, and superstitions, belief in community Literacy is not a criterion for their selection as adult female literacy rate is very low in these villages.

They are trained by the organization by intensive and ongoing training, equip them with skills and knowledge and empower them with leadership and communication skills to impart the knowledge they gained to other women and be a primary health care provider in their respective villages. Training module for swasthya sathi is three years consisting of swasthya sathis duties and responsibilities; diagnosis and management of all common communicable diseases such as malaria, diarrhea, vomiting, worm infestation, scabies, TB etc. Training also includes antenatal care, intra -natal care, post natal care, care of newborn, diseases of under 5, nutrition, first aid, home based remedies and herbal medicines, family planning.

Training is done once a month at two clusters, where swasthya sathis come with their children and stay for two days during training period. Training is taken in groups and required lots of energy and innovative methods. These swasthya sathis get wages of □ 250 for attending these training sessions. The women are paid the days wages instead of a regular stipend. This is because they will be missing their daily wages on the training days and their families are dependent on their wages. Their food and accommodation is arranged by the project, in addition to the travelling fare.
These trainings are in just beginning stage and once these Swasthya sathis will be fully trained and active in working will have greater impact in community.

At present they have been trained in BP measuring, temperature recording, height and weight recording, recording of data like death, pregnancies, birth recording in

community, diagnosis of few diseases and giving treatment like paracetamol for fever and chloroquine for suspected malaria case. These swasthya sathis also act as referral system who referred patient identify by them to clinics. Swasthya Swaraj is planning to select few Swasthya sathis to work as trainer who will work at village level and train other Swasthya sathis and community members.

**In short**, swasthya sathi will be a true companion and a friend to the village people especially the sick and needy helping in their healing process, in health promotion and play an active role in the development of the village having developed a critical awareness about the pathetic situation of the village, and be a change agent in the village society. She will also be instrumental in reviving Gram Kalyan Samitis (Village health & sanitation committees) formed by National Rural Health Mission (NRHM) in the villages. Swasthya sathis are not substitutes for ASHAs of NRHM or competitors with ASHAs. They will work along with ASHAs with better dedication and skills and knowledge, but not being part of or remunerated by the government health system

**2) Shikhya sathis:**

The first batch of shikhya sathis were 20 in number , 10 shikhya sathis in each cluster but at present there are four sikhya sathis at Kaniguma cluster and four at Kerpai. Few sikhya sathis are promoted to field animators and Kerpai has five field animators.

These are literate youth (men) from the villages selected by Swasthya Swaraj who have studied from class 8 to 12. Shikhya Sathis are being trained by Swasthya Swaraj to function as the community educators and motivators on preventive aspects of the killer diseases which take away many lives- malaria and TB. Shikhya sathis are being trained in mass health education and implementation of various activities in the community to control Malaria, TB and Scabies. The Shikhya sathis organize community meetings and educate the people on various aspects of malaria. They undertake implementation of various activities of community based malaria and TB control programmes. In malaria control they organize or they take up Spraying of houses in the villages, organize one day in every week in every village as 'dry day' to stop mosquito breeding, they propagate use of mosquito nets, undertake the treatment of the nets with deltamethrin, they organize children's clubs and promote malaria control activities and TB control activities through the children.

**3) Field animators:**

Filed animators are basically coordinating different activities in community with swasthya sathis.

Working of field animators is very much similar to shikhya sathis. Basically few sikhya sathis are promoted to field animators. Kaniguma cluster does not have field animators. Kerpai has three field animators and two sikhya sathi working as field animator who has been given few villages each and are coordinating different activities in their respective villages along with helping at registration counter and other activities in Kerpai clinic. They collect data like birth, death, pregnancy from their respective village and present in monthly meeting.

Responsibilities of sikhya sathis and field animators in their working areas:

1) A support to the illiterate Swasthya Sathi in imparting health education to various groups in the village,
2) Will help the Swasthya sathi to fill up her records and data collection
3) Will help in organizing ANC clinics and under-five children's clinics
4) To bring patients to the clinics and to referral centres
5) Will assist in school health programme.

6) Help in reviving the Gram Kalyan Samitis
7) As barefoot Vets in the villages as health of the livestock is related to the physical health of the people and economic security.
8) Helps in transforming the village school into Health Promoting School
9) Provides tuition/ coaching to school going children in the evenings to encourage their regular schooling
10) Encourages and educates children who are drop outs/ never gone to school to attend school (non formal education).

3) **Field supervisor:**
There are two field supervisors one for each cluster who is coordinating different activities with all grass root level workers. At the end of month they present report in staff meeting of which DATA presentation is one part.

Swasthya sathi Sahayikas are helping hands of Swasthya sathis, newly introduced group. At present there are three Swasthya sathi Sahayikas working at Kaniguma cluster. They have similar role like field animators.

Filed animators and field supervisors are salaried staff, sikhya sathis gets stipend for work and Swasthya sathis get certain amount for attending training sessions. After 3 years of training, when the Swasthya sathis are well trained and reliable, payment of regular stipend for the services they render to their village communities may have to be considered.

## Activities of organization:

To achieve the above mentioned development goals, activities are divided in three major categories Baseline survey, Health Services and Community Based activities. These activities will be carried out in two phases. Phase I is from May 2013-March 2015 and Phase II is from April 2015-March 2019.

Baseline survey has been conducted with the help of field animators and sikhya sathis. Also organisation is building their HMIS system by collecting data from Swasthya sathis from each village as well as cross checking with data collected by filed animators, sikhya sathis and filed supervisors.Healthcare activities

A) **OPD services in two locations:**
These are regular weekly clinics (Saturday at Kaniguma and Thursday at Kerpai), run by the medical team which include doctors, lab technician, nurses, ANMs and other support staff. These clinics offer good quality primary health care services follo wing the principlesof rational use of drugs and investigations at very low cost or free of cost. Medicines are also given with minimum cost and most of time free of cost. These clinics are signs of hope in an area deprived of health care facilities and are being very well utilized by the public on an average 100 patients come to Kaniguma OPD and 40 to 50 patients come to Kerpai OPD. Patient's apart from project village visits these OPD for treatment. The clinics are set up in buildings donated by the public- in Kaniguma, it is the Panchayat building which was donated by the Panchayat as per the decision taken at a full house meeting. In Kerpai, it was initially the Panchayat office and later shifted to the adjacent old dilapidated building belonging to another NGO which they graciously allowed us to use. Kerpai OPD is upgraded into 24 x 7 health center where Nursing staff stays to provide service apart from fixed clinic day and Kaniguma center will be soon upgraded into 24 x 7 health center after appointing nursing staff there.

B) **TB Clinics:**

There are total 55 diagnosed cases of TB in Kaniguma cluster and 6 to 7 cases in Kerpai cluster. All the patients diagnosed as TB are called separately every month on every 4th Tuesday in Kaniguma and 4th Thursday in Kerpai where counseling is given for individual patients, for families and as a group; this offers an occasion for open interaction to clarify their doubts, health education through various means. Nutritious food and take home nutrition supplements for one month, transportation for very sick patients, follows up of the patients and their motivation in the villages by the staff and the Swasthya sathis are also part of this program. The Postal Service is a functioning government department in these remote villages, having one postman per Panchayat. This department was wrapped in to contact the patients when the patients do not turn up on the due dates to the clinics. These patients will get a reminder postcard which the whole village will come to know and the patient will be forced to come to the clinic. This postcard also serves as a tool for health education. This intensified control program was inaugurated on March 24th- the World TB Day. The lack of an X-ray unit is a real handicap in running the TB control program. Screening of the child contacts of the TB patients will soon be started as part of the TB control program. The clinics, Swasthya sathis, community animators will have the complete record of TB patients detected in their respective areas and will give personal support and motivation to the patients in their families, closely follow up and monitor the regularity of AKT drug intake by the patient, health education to the family, trace the defaulters promptly and bring them to treatment.

**C) ANC clinics and under five clinics:**

Antenatal and under five clinics were initiated in March 2015. ANC clinics are conducted once a month in predetermined spots in each cluster by the mobile team consisting of doctor, senior nurse, ANM nurses, lab technicians and community health worker with the help of Swasthya Sathis. This is going to the people instead of waiting for them to come to us walking over hills and valleys. The venues of the clinics are the government primary schools or community halls in each p lace. In the ANC clinics it will be made sure that the women receive: detailed clinical examination, 2 Tetanus Toxoid injections, iron & calcium supplements, essential laboratory investigations including blood smear for malaria, and advice on nutrition, use of treated bed nets, and Tab.chloroquin 2 tabs per week starting from 3rd month of pregnancy. All the pregnant women who attend the clinics will be served one nutritious meals. ANC cards will be maintained for each pregnant woman. ANC clinics are combined with under-five health check up. Growth monitoring of all the children, blood tests - Hb &MP once in 6 months, Mantoux test (PPD) in suspected cases and other relevant essential tests are done. Along with medications, the children receive one nutritious meal and egg.

## Working Pattern of the Organization:

With the limited resources and manpower, the organization strives to fill all these gaps through thefollowing strategies:

1. Weekly meeting are held in Bhawanipatna on Mondays, where all the plans are made.

a) Preparing the monthly plan- activities and programs in advance and is intimated to every staff.

b) Weekly logistics are prepared on Monday and distributed to the 2 clusters.

c) In case of any changes in the plan, the staffs especially the staffs in the field are intimated during the weekly activities.

2. Monthly meeting of all the staffs are held on the 1stMonday of every month in Kaniguma, whereall the programs are reviewed and the monthly plan intimated to all staffs.

## Funding:

Main funding agency is TATA Trust. TATA Trust is funding organization since long time even before official registration. Funding by TATA Trust is done under south Odisha plan. Regular report is getting submitted to TATA Trust. Jan Swasthya Sahyog (JSS) is again supporting organization who is like mother house for Swasthya swaraj and provides ide ological, technical, personnel, advisory , medicine and equipment supply .SELCO Pvt Ltd, Bangalore through its sister-concern Sustainable Small Scale Infrastructure Development Fund (SIDF) supported by providing funds in beginning stage of organization. Organization is not receiving foreign funds as it is not yet registered under FCRA.

## Financial sustainability:

(1) Community Health Care Revolving Fund: This fund will be created with contributions from SDTT and matching funds from other sources and peoples' contributions (cost of the medicines & lab investigations paid by patients partially or fully + OPD registration fees in clinics). Interests generated from these funds will be then a resource for purchase of medicines even after the completion of the project. This will be then community supporting the curative services provided by the Swasthya swaraj clinics and the Swasthya sathis in the villages

(2) Corpus fund for Swasthya Swaraj Comprehensive Community Programme: Earnest efforts will be put in to build up this fund in 5 years' time. The aim is to support partially for paying the monthly stipend of the Swasthya Sathi.

## Conclusion:

Swasthya swaraj is newly started organization and is now in its toddler phase. Though it has started recently, organization has been able to deeply root in community in the form of Swasthya sathis who are actual connecting link between the community and the organization. The training of Swasthya sathis is going from strength to strength by passing many obstacles but once these Swasthya sathis will be fully trained, community will has its greater impact.

## Understanding of the Community

Working with Swasthya Swaraj was great learning experience for me. It helped me to know ground realities. How to work effectively with minimum resources was one of the key learning .It helped me to understand How to plan, how to implement things, how to monitor programme. It helped us to know public health issues and how to deal with these issues. This internship exposed me to different great people working in public health and also helped to know differentorganizations working on different issues. It helped to understand situation and then need base working. Importance of planning while working in public health is practically experience by me. It helped to know how different NGOs are reaching to Inaccessible communities. Importance of networking is understood working with NGO. How to get funds and whom to approach before conducting any event was learning for me. Capacity building of employees is one of the components of effective working, understood in Organization. It helped to understand how to work on already existing structures, how to identify priori ty places, their needs etc. I learned advantages and disadvantages of flexible working pattern. Importance of community participation, their training was great learning experience for me. Importance of implementing culturally appropriate programmes unders tood from Organizations working methods. I also understood importance of community based monitoring and community .participatory working style. I learned about importance of inter sectoral coordination to minimized problems. How to deal with government officers was again good experience.Overall it was great learning experience for me.

**Community Profile:**
Kerpai Gram Panchayat
Thuamul Rampur Block, Kalahandi District
Odisha

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**Introduction:**
Kerpai is one of the village of Thuamul Rampur block of Kalahandi district Odisha. There are total 30 districts in Odisha and Kalahandi has 13 blocks. Thuamul Rampur has 16 gram Panchayat under it and Kerpai is one of the Gram Panchayat of Thuamul Rampur block. There are total 33 villages under Kerpai gram Panchayat of which 24 are revenue villages and rest are hamlets. These 33 villages areKerpai, Maltipadar, Sargipadar, Tadadei, Mardiguda, Kachalekha, Serkapai ,Sungergarh, Murlimohi, Kutrumali, Mazigaon, Mahajal, Taramundi, Pindapadar, Padapoi, Chimrangpadar, Seikhal, Rupen, Danpadar, Silet, Melrupa, Bordizola, Muspang, Marguma, Kandulguda, Sarmandi, Pajukhal(Ruadei), Kutkhal, Durbdgurada, Zanzi, Bilamal, Sikelguda . Most of villages end with Suffix Guda, Padar and Mali in area.

**Time Line:**
1950 to 54: School constructed in Kachalekha village.
1975: Protest against mining activities in areas.
1994: drought in villages of Kerpai.
2001-2003: Temple constructed in village
2011: Electricity supply infrastructure built in area
2012-2013: Gram Vikas provided Water and sanitation facilities in village.
2013: Swasthya Swaraj started working in area.
2014-2015: Rajiv Gandhi training hall construction started

**Physical Aspects:**
Kerpai is nestled among thelofty hills and valley of Garhjat hills. Most of the physical features are almost plateau and valley like structure. The forest coverage in Kerpai is very less; timbers like Nilgiri andEucalyptus line the mountains in certain parts. Villages under Kerpai are all surrounded by different hills and which have specific names given by villagers. Similarly hills around Kerpai have names.

**Topography- Lay Of Land:**
Kerpai is more of a valley bounded by many small hills. The soil is red soil; with limited trees the grasses form a carpet like structure in the hills. On the west side there are Talchotaka, Patormali, sunyatukra hills, on east side Loramali, Kutrumali, Ranimali, Bundelmali hills and on North side is Bandagmali hill. Different villagers have different names for the hills. Small streams run through the valleys, water is abundant and easily accessible. Spring water is also available and feed the villages and paddy fields. Two major rivers originate from Th.Rampur - Nagabali, Indrabali, and these rivers flow through Kaniguma side. Shivnadi river flow through Sunger village of the Raygada district which a border with Kerpai. Nagabali river flow to Silet village, which is one of the villages of Kerpai GP. Due to the abundance of streams it is difficult to pin point which stream is originating from where. Since the hills are very lofty we see a lot of streams and tiny springs all the way.Kerpai is 3 to 4 lane village, the distance between the 2 lanes mainly the place where Gudi is situated is around 150 cm .

**Housing:**
Most of the houses are made of mud and bamboo; there are mainly 3 types of houses found in the village.

- Man shed- Bamboo and shrubs make the walls and the roof is covered with plastic sheets and shrubs. Very few houses of this kind exist, mostly a little away from the village.
- Traditional house- Made of bamboo and plastered with mud, with mud floor and painted with black dye which is prepared by burning the coir of palm tree which is water proof and is used to paint the floor and walls adjoining the door. Doorsteps and lower potion are painted with the black dye to make it water proof.Roof is usually covered with bamboo splits and topped with tin and clay tiles are placed. The reason for clay tiles is to keep the house cool in the summer and warm in the winter.
- Pucca House- Indira Awas Yojana house are the concrete houses built with the assistance of this scheme. The walls are plastered and roofing is done with tin only, but some people wish to place tiles on top of the tin

Except the man shed, the other 2 houses have two rooms, the first is the bedroom and the next is the kitchen. The height is max 5 ft; the breadth is 6 -7 ft but varies according to the family size. One aspect of the houses in almost all over the Kalahandi district is that the houses are not expanded horizontal but all houses are expanded vertically. Windows are completely absent with only 3 doors. Ventilation and chimney is completely absent making the house more dingy and stinky (except Indira Awas Houses).

Only few people have beds in their home, which are usually made up of bamboo and other wood. Mostly people sleep on the floor. The bedroom is also place to keep the corn and other seeds for planting in the next season. During Deepavali, fresh rice planting are also hung on the door. For people who have front porch all the activities are done in the porch otherwise in the sleeping quarter. In most of houses there is small part for hens and cocks (Desi Murgi) and few houses has cow shades within house or just adjacent to their houses All the houses are adjoined, if a person gets married, the person builds a new house adjoining to the next house or take up residence in the ancestral house.

**Daily Activity:**

Early to bed early to rise- men, women and children folks wake up before the sunrise, followed by which the daily chores are taken care of, men folks tend to animals and the women start the preparation for the meal. Later after the meal all the women folk go to the jungle (Dongar) and return before the sunset. Women are usually the bread earners, as they perform all the farm work and help the in other work like carpentry, collecting Siari pata (leaf for making plate) and other construction works also. Women work more than men in the community. One particular habit is that the community does not stay inside the house, they are always outside. The house is used only for cooking and sleeping.

**Patterns of Settlement:**

The history of each village states that a group of brothers or some family members moved from one village and settled in the new place. Most of the names of the village are originated from the specific features of the place. If anyone wants to start a new settlement; they talk to the elders of the village and migrate.

Usually the ST community does not migrate to the other village, except when they are expelled from the village. The SC community for trading and other purpose tend to migrate to other villages. If a person from one village migrates to other village, he/she is not considered a part of that village. Migration from one village to other occurs only with women, when they get married because, mostly no two persons from the same village cannot marry one another. When you belong to the same village you are considered as siblings of the same blood lines in some villages. Most of the villages can be considered as hamlets, all the villages except some few are composed of only 15-25 HH. In villages where SC, ST and OBCs reside the SCs and OBCs settle away from the ST settlement.

**Living Pattern Of Community:**
Nuclear family structure exists, except for few joint families. All the people of different economic status do not segregate, though there are very small variations in the economic status. ST, SC, OBC socialize except the STs do not eat at the SCs place.

**Social Structure:**
The concept of Caste and tribe is very deep rooted in the community, such that the community is divided into 2 structure- caste and tribe. The concept of Bansh (bloodline) also identified as surname is of great importance, because there are several surnames among the Majhi tribe. If you are from the same bloodline you will have the same surname (Bansh).Intermarriage among the same Bansh is strictly prohibited.Apart from these social structures, the differential in gender and sex is prominent but other than that there are no hierarchies.

**Gender- Male and Female:**
The community has a history of the importance of female, the divine power in which the locals relate to are also female (Devi). The workforce and economic source is also contributed mainly by females. Women are seen as fierce and strong, they are seen not only as childbearing species but also as a partner in the community and family. The representation of females in the Panchayat is also one of the good indicators of good gender relations.Though there is preference for male child, a girl child is also given equal importance. During the interaction and observation, good child rearing practice is seen and every girl is given equal rights as men. Except in the field of education, the girls lack so much behind because, the schools are far and parents cannot afford to send them. Girls are also expected to help the mothers in the chores.

A very astonishing discovery was the existence of bride kidnapping in the community. The practice of kidnapping a girl, from the community, if the parents and the girl refuse the marriage proposal. This practice was prevalent but the incidence is reduced. Once the girl is kidnapped and locked in the house, the girl and the parents have to agree to the marriage, because no one will marry the girl. This is a violation of human rights and violence against women. This is specially a concern for those who are below the age of 18. A girl who has refused a marriage proposal lives in fear because; the possibility of being kidnapped is very high. The community is also mum on this issue, whic h shows the casualness of the issue in the community.

**Political System:**
Kerpai is the seat of the Gram Panchayat; the Panchayat is headed by Mrs. Budu Majhi (Sarpanch).She is the head of all those villages under Kerpai GP .During the Panchayat meeting the women also participate, they sit in the other side of the meeting and are given equal chance in the political process.A good example is the selection of Swasthya Sathis by the Panchayats; the panchayats themselves select the capable women to work with the community. Kalahandi constituency covers Th.Rampur block and so Kerpai comes under Lanjigarh constituency. The present MLA is Bhalabadra Majhi of Indian national congress. There is only 1 seat for Th.Rampur block in the Kalahandi constituency.

**Existing Group**:
Each village has an existing group of ST, SC Samiti to work for the welfare of the existing community. In case of Issues between SC and STs the Samiti is responsible for solving the issues, following which the matter if not resolved is taken to the Panchayat and the Court as well.

These groups are also responsible for organizing festivals in the village, apart from them, there is youth club or SHG. Swasthya Swaraj is planning to have youth group (health club) to help the community in accessing the HC services.

**The demographic profile of Kerpai village:**

Kerpai is a small village with total 53 families and having population 227 of which 106 are males and 121 are females as per 2011 census. Population from 0 to 6 yrs is 51 which are 22.47 % of total population. Sex ratio of Kerpai is 1142 which is above 979 Orissa sex ratio. Child sex ratio of Kerpai is 962 above 941 of Orissa child sex ratio. Kerpaihas very low literacy rate which is 23.30 % of which male literacy rate is 36.25 % and female literacy rate is 12.50 %. Kerpai is 100 % ST village. Kachalekha village comes under Kerpai and having 80 families with population of 358 of which 185 are males and 175 are females. 0 to 6 yrs population is 71 comprising of 19.83 % of total population. Sex ratio is 935 and child sex ratio is 972. The literacy rate of Kachalekha is 45.5 % of which 60.40 % male and 30.43 % females are literate. Kachalekha has 174 SC people and 183 ST people.

Base line survey was done by Swasthya Swaraj in all 33 villages under Kerpai gram Panchayat show, total households 1154, Total population 5238 with male 2528 comprising 48.3 % and female 2710 comprising 51.7 % of total population. Children below 6 yrs of age are 902. If we categorized population age wise then it shows 192 infants, 271 in between 2 to 3 yrs, 323 in between 4 to 5yrs, 1387 people in between age group of 6 to 15 yrs, 2293 in between 16 to 45 yrs of age, 572 in between 46 to 60 age group and 192 people of 61 yrs and above age group. There are 2295 currently married people with separated or divorce are 21 and widows are 247.

Educational status in Kerpai gram Panchayat is very poor 81.1 % adults and 66.8 % of school going children's are illiterate, 8.7 % adults and 13.6 % of school going children's have attended upper primary school. 4.9 % adults and 1.8 % school going children's have attended high school. Only 1 % total population attended above high school level education.Income status of the community is also poor. 60.1 % households earn less than Rs.694 per month. Only 1.8 % households earn more than Rs.3001. (Baseline survey data)

Orissa has total 63 types of tribal of which Kerpai has Kandha Tribes as a majority and Schedule caste are Domba. Kutiya Kandha is sub-types of Kandha's. There might be other subtypes too. Kutiya Kandha lives in plain areas. As per their social system, generally the open caste people eat from houses of Domba and Kandha but Kandha people will not take food from the Domba houses. There is a lot of discrimination between Domba and tribal's. Kachalekha village has two separate groups, staying with good demarcationin between. SC people are more dominant in area and little advance than ST people. These villagers celebrate festivals together but have major caste differences.The primary language of people is Kui, some understand Oriya language and very few understand Hindi and other languages. Mainly people from SC caste speak and understand Oriya and Hindi to a certain extent.

Villages in Kerpai Panchayat are really difficult to reach and inaccessible, most of people depend on forest resources but with time these resources are getting diminished. Due to poverty, hunger and lack of employment now a day's people are started migrating interstate as well as intrastate. Different people have a different experience with migration.Mostly young college age students migrating to places like Bhubaneswar, Raipur in Chhattisgarh, Andhra Pradesh, Surat, Varanasi and Mumbai. Few youngsters went to Kerala as well. These people are not that much educated so they work there as construction workers, in agriculture such as spraying pesticides in Pineapple field, in various factories, watchman and in hotels. Few had a good experience , but many had a bad experience due to low pay, costly lodging and food

as well treatment by people from the area was threatening for few. So after doing work for a while, they used to come back but poverty and lack of employment in Kerpai area are pushing them for migration. There are agents in the community who take people to different places for employment and get commission per month on their work. There are incidences in a community where few girls migrated to metro cities for employment and when they came back were pregnant. Due to fear those girls did not share information but definitely there can be big racket behind this. People mostly migrate during non-harvesting period and will come back during the harvesting period.Most common occupation of people is agriculture. Agriculture is mostly shifting type of agriculture. Slash and burn cultivation is most common in this area. Mostly agriculture land is near streams. But this agriculture provides food security for about 8 months but during rest of months of the year there is severe hunger and shortage of food in the area. This is one of the reasons people migrate towards cities for employment. Most of the villagers collect various forest products for their livelihood of which collecting leaves for making leaf (small Patra) plates is very common in the community. On particular day contractor will come and will collect those dried leaves from villagers at the rate of Rs.10 per KG. Paddy field is most common in the area. Rice is cultivated in the fashion of terrace so can be called as terrace cultivation. Rice is stapled food here. Maize, Ragi, lentil (Kandul), black grams is also grown in the area. Jowar is also cultivated in some parts during kharip season on slopes of hills. In various areas bamboo, Nilgiri trees cashew trees, mango trees seen which is planned cultivation. Few of villagers having petty businesses like shops for daily use goods. Few households have goats, cock, hens and cows. In most of Villages, entire village has cement concrete floor but there is dirt and filth spread by cow and sheep, goat dung and their urine in entire village.

**Infrastructure:**

**Road connectivity and transportation**

Kherpai village is located about 90 Km from Bhawanipatna which is district headquarter of Kalahandi district. It comes under Thuamul Rampur Block which is about 85 Km from Kerpai. As Kerpai and villages under Kerpai are situated deep inside mountain ranges it is very difficult to reach the area, is an inaccessible hilly terrain, dense forest, having poor road d connectivity to town. Area is completely cut off from developing the world .Roads are poorly constructed and are curved roads going up and down due to Hills with few small bridges over water streams. Few villages are situated very far from Kherpai gram Panchayat are no vehicle can go there and the only way to reach there is by bicycle or walking. There is no public transportation available in this area. A private bus comes from Bhawanipatna up to Sunger village which is 10 to 12 Km from Kerpai. This bus comes once a day, on and off and most of the time does not come. At present this bus is not coming as road washed away during the rainy season. Due to lack of transportation people do not go out of their area. Very few people have a bicycle and 2 to 3 household have a motorcycle with them. There is no petrol pump available in the nearby area but the solution to this few petty shops keep petrol bottles which they sell by charging rupees 20 extra per liter. Most of the people go to other villages by walk and carry luggage on their head. Most ofvillages have a street which is well developed Concrete Street.

**Electricity**-Most of villages do not have electricity in their villages, few household has solar energy bulbs. Few villages have well-developed electricity infrastructure since 2011 but electricity supply is very poor which is almost equal to no electricity and now since 3 months there is absolute no electricity in these villages. So during night time, almost all villagers spend time in darkness. Villagers mentioned that electricity bill will also not come.

**Telecommunication**– Landline, Mobile Phones, and Television-There are almost completely lack Telecommunication. Few people are having a mobilephone, but there is no network in the entire area. There are hallo points in few locations like top of hills where a networkof BSNL, Airtel will come and if villagers want to contact someone then they have to climb the

hill to reach that hallo point to get the network.There are only three satellite Phones in entire Kerpai Gram Panchayat which works on and off and if villagers want to talk then they approach these people having satellite phones. Television is there in about 6 to 7 households in entire Kerpai GP. These Televisions work on Solar Batteries and have Videocon DTH. These all facilities are seen in SC families. ST families are not having TV and satellite phones, but few are having Mobiles.

**Water and sanitation**:
In most of the villages toilets are built with the assistance Gram Vikas organization through their water and sanitation program. As per baseline survey done by Swasthya swaraj, 791 households saying the availability of toilets comprising 68.5 % and 362 households saying non-availability of toilets comprising 31.5 %. But most of the villagers are using these toilets for keeping different goods in that and not using toilets for actual purpose. People are going deep inside forest for defecation. One of the reason is they are not habitual to sit in the toilet as well as they have to carry water inside the toilet to clean it.

Most of the villagers do not use water for cleaning after toilet instead use stones or leaves to clean anal region. Also villagers mainly females feel shy to go in the toilet and so they avoid going in the toilet. Main drinking water source in most of the villages is Gravity water supply through pipes. This technology builds by Gram Vikas in which water from streams get collected at one point on top of the hill and from there it comes to these villages. Villages like Sargipadar, Kutrumali Murlimohi do not have gravity water supply system. In these villages, they fetch water from Hand Pumps, streams, open wells but the main source is stream water. Kutrumali village face water crisis and people suffer a lot to get water as the villageare situated on top of the hill and they have to come down around 1 KM to get water.

**Existing Institutions:**
**Schools and colleges:**
In entire Kerpai Gram Panchayat, there are 15 schools most of which run till 5thstandards due to which students find it very difficult to continue further education.

School in Taramundi does not have school building,but teacher comes and teaches in Village Development Committee (VDC) house. Similarly in Rupen, there is no school building but teacher comes and teaches in Indira Awas Yojana House.

After 5$^{th}$standard dropout rate is very high as there is no availability of school in near area. After 5$^{th}$standard few students go to boarding schools at Saisurni, Kalyansinghpur or Bhishamgiri. Saisurni comes under Gunpur G.P. and Kalyansinghpur comes under Rayagada District and both having school till 10th standard. After 10thmost of student go to Rampur for college where they do daily Up and Down or else stay at a relative's house or in rented house. Other colleges are in Bhawanipatna, Dakota Science College, LanjigarhScience College and otherwise in Rayagada district. Boarding facilities for education are available in Gopalpur, Bhishamgiri and Dakota schools. In ST community, people do not educate children, in that too mainly girl child due to social security as girl child can be a victim of rape due to difficult way to schools and poor transportation, domestic work but in SC families, there is no such gender bias in education.In most of the school there will be a lack of teachers to teach or else teacher keeps the proxy teacher from that village to take classes in the village and give them some amount in place of teaching and in some villages teacher go for few days in a week.

**Police station:**
All the villages of Kerpai Gram Panchayat come under Thuamul Rampur Police Station of Kalahandi district. But most of the time people approach to Gunpur police Camp based to prevent Naxal activities in the area.

**Public distribution system (PDS):**
PDS shop is in Kerpai village near Gram Panchayat office where people from different villages around 13 km to 27 Km radius come to take ration. Both males and females come to take Ration. Women mainly walk a long distance and carry ration on their heads. If a man is coming then most of them carry PDS on a bicycle. As per base line survey has done by Swasthya Swaraj people in Kerpai Gram Panchayat have BPL, Antyodaya, APL ration cards.

**Post office:**
There is a post office in Kerpai village, mainly use for official use like getting PAN cards, Adhar cards, and Bank documents. It is working better as compare to other communication mo de. The Postal Service is a functioning government department in these remote vi llages, having one postman per Panchayat.

There are 8 Anganwadis (AWC) in Kerpai Gram Panchayat but seven Anganwadis do not have the infrastructure, Anganwadis are conducted in VDC houses. Anganwadi from Kachalekha village has infrastructure, but it remains closed most of the time.

NGO's and Organizations in Kerpai Gram Panchayat- Gram Vikas was working on water and sanitation program provided water supply in villages and built toilets in community. This project was taken under Odisha tribal employment &livelihoods programme. Sahabhagi Vikas Abhiyan was the NGO working in the area on agriculture-related livelihood but due to some disputes villagers destroyed their office. Antyodaya NGO working in the area in the field security, women empowerment through interventions likes HSGs and Livelihood. Antyodaya distributed slate free of cost to school going children in villages and also used to run a school for those children who are doing labor work. Swasthya Swaraj is working on primary health care in the area since 2013 having general OPD every Thursday, TB clinic once a month, ANC and under 5 clinics in different villages.

**Religious institution:**
Every ST villages have one temple in the middle of the village which has a similar structure in all village and is called as Gudi. It has a roof without walls. Villager's worship in the name of god called as DHARANI MATA. Dharani Mata Idol is three stones facing west side kept on Ground in the temple.

Entire temple will have cement concrete floor except the place where they keep Dharani Mata. Dharani Mata idol will be kept closed by covering it with stone or tile. There will be one big drum made up of cow skin in gudi (Temple). SC village does not have such temples.

**Costumes and other practices:**
**Nose and ear piercing:**
Almost all women in villages have a nose piercing done in a similar manner. Few women have two to three and can be up to six nose rings. All these rings are made up of gold brought from jeweler and piercing done by local people mostly on one another by local people. When asked the reason behind it few replied it's our tradition and we wear it to look more beautiful and few replied that if they will not wear it then they will not have a rebirth of a human being. Piercing is seen in small kids also.

Most of the women wears sari with typical style and most of them wrap that lengthy sari around them. Men usually wear loin clothes. Usually when girls start having menses, they start wearing sari with blouse and which indicate now girl is in age to get marry.
Ornaments are important part of females and wear necklaces made up of aluminum or silver. These necklaces are round like a ring.

Almost all girls around 5 yrs and above will have tattoos on their faces. Almost all women have tattoos on their various body parts. When asked they said these tattoos are for their beauty. There is much importance given to beauty in these tribes. Whenever they feel to do tattoo they take needle and do self piercing on body part with different design as they want and then they apply black ash on it with oil to make it black. This ash is prepared by burning Coconut or taken from kerosene lamp. This piercing process is very painful and they do it with breaks but women enjoys as it makes them more beautiful. On and off many people among community apply turmeric on face, hands, legs and other body parts to look beautiful. Boys and girls follow these practices. Many uses fair and lovely, ponds powder which are modern parts of their beatifying agents. Many of girls and boys know and apply Betnovate ointment on face so as to decrease dark spots formed after acne. Betnovate ointment is available in petty shops like any other fairness cream.

**Festivals:**
Rani Parab is one of the most important festival of paraja and Kandha tribes. It is celebrated in dark forth night in the month of shravan. Maka Parab, is celebrated which is part of Rani Parab, they do worship of maize grains and after that they start eating new maize grains. People said they do Dhan (food), Madiya and Makka (maize) Pooja on Rani Parab. It is celebrated to have good maize cultivation. They will make statue and will decorate that with maize grain. From Rani Parab onwards villagers will start eating new grains. On day of Rani Parab apart from worship all household cooks Chicken called as Kukuda in their Kui language. They drink Mahua alcohol on this particular day. Rani Parab is one day festival but different villages celebrate it on different consecutive day.

**Kichadi** is festival during November which is celebrated just before or after dipawali festival. Kichadi means mixture of different grains and they make food using all these grains called as Kichadi which very similar to Kichidi which we get in other parts of India. This Kichadi is prepared from new grains on this day and contain beans, pumpkin, rice, maize etc. chicken I.e. Kukuda and alcohol is part of most of festivals. It is one day festival.

**Bali Jatra** is another festival in which villagers form Gudi ( small temple like structure ) made up of sand brought from river on which they grow rice, maize, pulses and Something called I (could not understand term). They grow these seeds for a week and water is given to it by two girls only. These girls give water with added turmeric in it. After one week they do worship of these plants and throw it in river. During this week villagers make different tools instruments like hammer, Gun, axe etc. Gurus walk on fire during this festival and everywhere there will be programmes in community.

Tada Devi is another festival celebrated with worship of Tada Devi. Most common factor in all festival is animal sacrifices, drinking alcohol, music dance, natural resources worship.

**Health and healthcare**:
Health status of people is very poor in Kerpai gram Panchayat. Availability of health services is also poor and non functional. Most common diseases in area are Malaria, other febrile illness, Scabies, Tuberculosis, fungal infections, and malnutrition. Diseases like leprosy, etc are

also common. Infant mortality and maternal mortality is very high in area. Various health related practices in community

**Maternal and Child Health**:
It is astonishing to know that there have been 18 U5 deaths in the past 1 yr (baseline survey). There is a complete lack of both traditional and modern Healthcare ANC in the community. Pregnancy being treated as natural and normal phenomena, there has been no record of such traditional care for the expectant mothers. Touching of body fluids is a taboo, so the practice of self-delivery is also visible. Unsafe delivery practice and cutting of Umbilical Cord with kitchen knives, long duration of mother to baby contact as there is a practice of not touching the baby until both the mother and the baby is bathed.
Nutritional level of the mother and the children are also very poor owing to poverty and the dietary habits of the locals- change in the dietary practice i.e. from meat to rice and dal due to encroachment in the forest and modernization has been the responsible factors.

Due to the huge presence of malaria parasite in the community, children even below 6 months are tested positive and the incidence is very high across all age groups. Pregnant mothers and children being more prone suffer the brunt, which has an ultimate impact on the health status as well as the socio economic status.

They apply turmeric to infants and give bath with cold water during illness. Also after birth people apply burned goat dung on placenta so as to dry it. We saw one underweight dehydrated infant of around 50 days applied turmeric. Though child was suffering they didn't take child to hospital and after around 20 day brought to Swasthya swaraj OPD in dehydrated state.

**Mental health and Disabilities**:
People of the community seem to be carefree and happy, but due to poverty and starvation in the last decades and urbanization has destroyed the culture of the tribal's. There is some festival every month which people celebrate with great joy. The innocence and the carefree attitude is losing leading to increasing mental problems. There has also been a report of patients with depression and anxiety. Any kind of mentally abnormal behavior is linked with evil spirit and people go to guru to remove that evil spirit from body during which guru beats that person so as to remove that evil spirit. Alcoholism is predominant in community. Males and females both drink but alcoholism is very common in males. Jackfruits, Moha, tendul (tamarind), maize, rice, jamun are used to make alcohol. It is common in community because of easy availability. Western alcohol like beer is also available in one of the shop in Kerpai Gram Panchayat but mostly socioeconomically well people prefer it. Among the total population, 0.7% of individuals were physically disabled and 0.3% individuals were suffering from mental disabilities.(baseline survey)

**Healthcare providers and medical Pluralism**:
Most of people approach Guru's for getting treatment in community. These guru's are traditional faith healers who do chanting as well as give medicines brought from Forest. There are male an female gurus in community. New male guru's take training from other experience male guru for about 6-7 months. Female guru's do not take any training and just do chanting of mantras for treatment. Guru's do not charge for giving treatment but sometimes ask for animal sacrifices like cock, pig and goat. Most of time guru link cause of disease with entry of evil spirit, hurting of god near their fields or failure to complete commitment given to god etc. Guru ties some leaves on hand or around neck .They also tie treads prepared while chanting in eight shapes ar ound neck and shoulder. Most common illnesses for which people approach to guru are fever, snake bite, epilepsy, paralysis, dog bite (kamudiba ),

cervical lymph node TB ( locally called as pusiptpa), leprosy ( Bodo Rog in local term), diarrhoes (zada ), chicken pox, measles (Basant) , worms (Kurmi), jaundice, sickling, headache,Burn etc.

Guru takes rice in fist and makes three groups with the use of two fingers after that he makes pair of rice. If rice is in a perfect pair then the patient will be better soon, but if one rice remains at the end of pairing then patient's condition is bad. To decide whether a person will survive from this critical state or not, guru rubs that remaining rice with the thumb on the palm of other hand and if it becomes powder then the patient will die. Most of the time if guru said a person will die then, relatives also leaves that patient for dying and they wait till that time. Very few gurus' advice to go to the hospital after becoming condition worse. Few gurus' check pulse and decide whether a patient will survive or die. Guru does not share their medicines with common people which they bring from the forest. During snake bite guru will take alcohol in their mouth and with that they will suck poison from the site of bite as well as will do chanting mantra.

They will also check whether there is snake teethes at bite site or not by rolling hair at the bite site. After that guru will apply for medicine at the site of bite brought from the forest. People say a person will be saved when brought within 1 hr and will die if they become late.
There are Bengali doctors and Kabiraj in the community. They are quakes giving allopathic medicine.

They give tablets, tonics,and injections as a treatment. They give injection using the same syringe but change the needle and wash syringe with normal water. These quake visits different villages or comes during weekly market and practice there. People see healthcare means taking an injection for getting a treat and mostly refused tablets or will take the incomplete course.People prefer Gurus first as their health care provider then Bengali doctor or Kabiraj and whenever patient becomes critical then they approach health facilities that too rarely.The public health system is very poor in area. There is an acute shortage of healthcare services with professional in this area. People rarely go to the hospital. There is sub-centre in Kerpai but it is mostly closed as ANM does not come regularly. Sub-centredoes not have medicinal and RDK stack due to the corruption going in Centre. People also do not know about sub-centre. There is no register available at sub-centre. There are seven ASHA's in entire gram Panchayat, but three ASHA's to nearby villages due to lack of literate women in other villages. Knowledge of ASHA's is also poor and they are non-functional. As per information shared by ASHA, they get 10 RDK per month and their collector has ordered not to give medicine in the community due to their poor knowledge.

People prefer going in Saisurni and Sunger for treatment. Villagers from Silet village go to Kesignpurfor treatment which is 15 km from their village.

Private healthcare is not working in the area. There are no families or general physicians in the area. There is one private clinic which is of the quake in Sunger village.

108 and 102 Ambulances had never come in the village. Few of villagers called 108 ( SC villagers) but that time an ambulance went to another village so didn't come and also asked them to bring patient till the main road which is around 10 to 12 km far from the village. Large number of people does not know about 108. Few villagers called private vehicle from Raygada block which took around 1000 rupees. 108 ambulance services are provided from CHC which has a pharmacist, ward boy and driver with well-developedequipment. 102 ambulance has only driver and oxygen cylinder which is used for carrying pregnant women.

During critical state, people carry patients on a bicycle or on cot .Many prefer staying at home and do wait and watch. Many die in critical illness due to lack of availability of resources like transportation and health care facilities.

Poverty, hunger, lack of availability of food, illiteracy, lack of awareness, difficult to access area, poor government health infrastructure and corruption are all responsible for such poor health status of these people.

**RSBY Cards**:
40.4 % people from community have RSBY cards but rarely people taking benefit from it due to previous bad experience with healthcare facility. People mentioned about happening corruption in RSBY scheme. Many of the people are not reaching to health facilities due to other obstacles like lack of transportation, lack of information or improper staying facilities at the district hospital.

**Various government schemes running in Community:**
**Indira Awas Yojana**
Few of the villagers have got house through Indira Awas Yojana. Few families got money for building house but could not build it fully due to fewer funds. Sanctioning of Indira house occurs at Gram Panchayat level.

**WADI (Mango Orchard) Plantation**
This project is run through ITDA Thuamul Rampur. In this project government help to set up plantation of vegetables and other fruit plants. In Kerpai such projects are at 32 places. Beneficiary gets their daily needs through these gardens or WADIs.

**MGNREGA**
People used to get employments through MGNREGA scheme but now a day t hey hardly get any job through it. As per organizations baseline survey 65.4 % people in community have MANAREGA cards.

**Conclusion:** Villages under Kerpai gram Panchayat are facing many problems like poor health service delivery, Poor electricity supply, poor transportation services so poor connectivity to outer world and almost nil telecommunication services. Though infrastructure of schools, Sub-centre, electricity is good, its service delivery is very poor or almost nil. Illiteracy, poverty, high malaria burden, lack of information making the community more vulnerable. There are lots of inequalities in community at different level. The community has strong supernatural belief and poor health seeking behavior. There is a major gap between two castes in community. SC communities are mainly developed than ST. People in the community facing the new issue of displacement due to mining activities in the community. Overall for the development of community there is need of inter-sectoral coordination as well as strong monitoring and supervision of services available and provided. There is strong need of Behavior change in the community as well as health education before implementing any program.

**Learning:** Working in the community really helped me to understand various dynamics o f community. I tried to learn Kuyi language which is the main language of the community. I understood the importance of BehaviourChangeCommunication in community from the example of Toilets in the community. The participatory observation was great learning experience for us. We learned about difficulties to work with the community. Experience with community was very rich. Implementingprograms without understanding community results in failure of programme.

## Second Field Placement

After one month of a classroom session time to back the filed its quite interesting and tough because due to heavy raining first two days we are not able to join the field. The last field works time I just watched so many problems facing the tribal peoples in every aspect of their life expectancy. In the rainy season they are very much affected to reach their essential needs, especially the tribal peoples are hard worker many times they spend in a rice field in the rainy season because rice plant plantation is mainly done during the rainy season. I saw peoples are bent down till whole days in paddy fields for planting the rice breed plants. Tribal peoples are without any care about the heavy rain the hold one hand in an umbrella and doing their agriculture work in other hands. In between the one month gap in my field placement area so many changes occurs, this time, peoples having time to share them with me this time so different everyone busy in their agricultural work. And due to the whole days hard spend time in a paddy field with the heavy raining in the evening they are not feeling good and also last field work time due to hot summer peoples suffering various diseases for chilling hot. For me, I felt both the time people having health issues for lack of awareness they are more suffering if it's raining or hot sunny the high temperature in summer and the heavy rainfall in monsoon the living condition is becoming more serious or unpleasant. Reading the book "Towards an appropriate malaria control strategy '' by VHAI Delhi and SOCHARA Bangalore.I just think about that the clinic session I had attended next Saturday why so many tribal men, women and children's blood smear having of positive as per this book "Malaria, which was predominantly a rural disease in India has now over the years diversified into 5 archetypes with sub-ecotypes- mainly comprising of man-made changes in the ecology favoring vector breeding and areas of undistributed ecology largely in the **forests and regions of rainfall agriculture**. The archetypes are Tribal, Rural, Urban, Industrials and border that's the main causes for more tribal peoples affected by malaria. The major problem is that due to lack of education or awareness and social, economic condition very much influence the tribal people's ill health tendency". It reflects me after complete this week all the clinics and other activity in my field placement area I find vastly different lifestyle among the general people and tribal peoples in Orissa. The same time I just think about the National Malaria Control Program and the Objective of "Millennium Development Goals" Eradication of diseases and where all the government schemes. Where the service providers are gone in the actually needed or requirement time. Further, it reflects me that it's very challenging task to work until and unless we really want to put all the effort and give all commitment and passion towards them and make them changes. I always think working in the tribal area is so easy because these peoples are so shy and co-operative but this time, I face so many problems they are so rude or not interest in understanding my views because they are thinking the agriculture is more important than their health.And some people have no time to attain the village meeting also. This is the local people's situation. Government body: As per the various state and central govt. schemes for malaria control programs as per this every district headquarter hospital having malaria drugs warehouse they distributed the medicines for various voluntary health services provides organization. As my field work placement also provides health services as per that I went in districts head hospital to collecting essential malaria kits and drugs in approval of CDMO in the indent my field placement organization prepared, but it's not easy to get this medicine because of the government service employees attitudes of the in charges of the malaria drugs departments.It's taken two days getting the medicine and half of the requirements. And also the transportation is great barriers to reach into various places in this tribal area because the main task is crossing two, three rivers, at least, you reaching the field placement area in rainy season is quite tough.

**Malaria control program:**

Malaria being number one cause of mortality and morbidity in this area this is given great importance. Swasthya Swaraj makes use of all chances to learn more about Malaria control and implement it in a war footing level. All grass root level workers are getting trained in the diagnosis and treating malaria. At present, they symptomatically diagnosed malaria and treat as well as timely referring them to clinics or another health facility available. Various awareness programs like signs and symptoms of malaria, causes of malaria, mosquito breeding places and promotion of mosquito net are going in the community.

At present passive surveillance of malaria is going on at OPD and ANC clinic level. The monthly report is generated and sent to District Malaria officer. Education of the public by targeting women's groups, youth groups, adolescent girls, farmers groups, Gram Kalyan Samitis, school-age children, teachers is one of the components of the programme. Health education thru street plays, posters, flips charts, videos, wall paintings, exhibitions, competitions of speech, essay writing, paintings and debates in the schools will be done. Empowerment of the village communities by

a) Training of 2 volunteers in each village (Swasthya sathi and one male ShikhyaSathi), on various aspects of malaria with the help of MITRA, Bissamcuttack. They will be able to collect blood smear, do RDT, malaria treatment regimens and age/weight adjusted drug dosages, diagnose signs of severe malaria and refer on time, vector control measures, and preventive measures.

b) Educating the Jhola chaps(quacks), local healers and the witch crafters (if possible) on various aspects of malaria and enabling them to detect the signs of severe malaria and refer on time and to avoid irrational regimens of treatment.

c) Encourage and enable the community to access the services of NVBDCP.

Effective treatment at various levels:

a) Swasthya sathi&/ malaria health worker (Shikhyasathi) for every doubtful fever case, collects blood smear to be sent to nearest Swasthya swaraj clinic and does RDT (when available), gives treatment with Chloroquine / ACT .

b) Detects severe malaria cases and refer immediately after emergency measures. Community-based Research on the effectiveness of some herbal preparations on effective treatment of malaria and prevention of repeated attacks. Organization is planning to have botanical garden of plants having anti-malarial properties in its Kerpai clinic area.

I also had the chance getting associated with the administration works of the organization. So for I have condutected to recruitment procces with conducting or arranged the training programme for the newly selected staff over there. These activity are given below.

Besides that I was prepared HR Policy, financial policy and sexualharasment policy for my fieldplacement organization through the guidance of SOCHARA staffs so that time Iam realize how important the policy for an organization it is a legal frame work for the organization without policy we couldn't maintained the organization well manner policy is like a evidence for the organization it is help both employees and employer for maintain their harmony in the workplace as well as it was awarded the employees for their roles and responsibility and policy also attracted the employees towards the organization because in policy it was fully described the benefits giving towards the employees.Preparing policy it was not an easy tasked we should foucsed various aspect to prepared a valuable policy it is focused both employees and employer benefits.

**My Learning**:-Second field work time I learned lots of thing how to properly manage a NGO. It was a great opportunity for me to learn how to administer an organisation. My main learnings that time were:

Planning meeting:-Planning for staff meeting and as well as community meeting before that we should made a planned way otherwise sometime we were not got the proper conclusion or meeting might not be fruitful. Proper planning also saved the time also.

Communication:- I learned the various way of communication because some time I deal with the vendors for delivering some essential equipment for the organization I found out how the communication gap created more disturbance.

Negotiating:-As a community health worker sometime negotiating with community is a big deal for sustainability for your programme and organization

Meeting with government Official:-I have got a chance to meeting with districts magistrate to inviting her for a programme inauguration so that time I felt the knowledge about the programme how much needed because infront of her you should presented all the details about your programme,whom else attained the meeting,timeduration etc.so far fixing meeting with government official also so crucial.

Planning:- For some social level programme how you well organized through planning i learned and how to implement the plan in better way also I know.

## Overall field learnings

Basic thing I got knowledge about the various tribal groups having in orissa ,and understand the basic tradition and culture of the tribal community which help me to know about every individual group in this community how these are effect their decision making process for social, economical, political and cultural behaviours, I learned about the govt, health system working procedure same time find out the gap between the government system and community to reaching all the government programme to unreached community beside that how the non-government organization operate in the tribal community smoothly through my field work time learned,and other government facilities available for common public I am aware about the schemes and policy which is helpful to me implementing in my future work place. Same I developed my learning and writing skill.

## *Field Study*

# A study on health care seeking behaviour of peoples living in Talanehala village of Th.Rampur block,Kalahandi districts,Odisha


## 1. Abstract

The common beliefs, customs and practices connected with health and disease have found to be intimately related with the treatment of disease. The health problems of rural especially of the tribals need special attention because the tribal people have a distinctive health problem, which are mainly governed by their traditional beliefs, practices and ecological conditions. For the treatment purpose or for preventive from diseases still they approaches the guru Gunia and Kabiraj instead of the morden medical practices. The present study explored the community perspective towards the causes of various diseases prevalent and the health and health care seeking behaviour among the tribals. The study was conducted in the TalNehela Village,Kaniguma Panchayat of TH.Rampur Block in Kalahandi district in Odisha taking 40 households. Both qualitative and quantitative data was analyzed in the backdrop of the project objectives. Quantitative data was tabulated and statistically analyzed using Epi-Info 7 software. The study has revealed that the cause of illness and healing system are found to be associated with the magical- religious beliefs and it was also revealed that the factors like age, sex, education of the patient. Types of illness, severity of diseases, health care facility, belief regarding the cause of diseases and previous experiences affects the selection of different ways of treatment and finally the study concludes with the relevant finding that the villager's responses towards illness behaviour are guided and conditioned by their culture.


**2. Introduction** Health has been defined by World health Organization as "a state of complete physical, mental and social well - being and is not merely the absence of disease orinfirmity". Healthcare is the organised provision of medical care to individuals or community. Health or care seeking behaviour has been defined as any action undertaken by individuals who perceive they have a health problem or to be ill for the purpose of finding an appropriate remedy. (1)

Common beliefs, customs and practices connected with health and disease have found to be intimately related with the treatment of disease. The various socio-economic factors such as age, sex, educational qualification, the economic condition of the patient, also influence the health-seeking behaviour. The health problems of rural especially of the tribals need special attention because the tribal people have a distinctive health problem, which are mainly governed by their traditional beliefs, practices and ecological conditions. Some tribal groups believe that a disease is always caused by hostile spirits or by the breach of some taboo. Indigenous people perhaps everywhere consider ritual remedies for diseases caused by supernatural agents, and counter magic for those caused by witchcraft and sorcery practices. (2)

While studying health and health seeking behaviour among tribal communities in Kandhamal district, Odisha it was seen that the aetiology of malaria and its healing system are found to be associated with the magico-religious beliefs. Along with magico-religious practices, herbal treatments occupy a significant position in their indigenous method of treatment. While educated people are more exposed to the modern medical system in the case of malaria and other diseases tribal people prefer the traditional method of treatment, which is available near to their door. (3)

Orissa Health Strategy 2003 has advocated for improving the health status of the tribal population by reducing mortality and morbidity. It indicates that the tribal people suffer disproportionately from malaria, sexually transmitted diseases, tuberculosis, genetic disorders,

sickle cell anaemia as also nutritional deficiency diseases. These are some of the special health problems attributed to these communities. (4)

As per the Annual Health Survey of 2011, there is a lack of health infrastructure and the services are not provided on 24x7 hrs basis in many health institutions. (5) Kalahandi district is one of the less developed districts in Odisha situated in southern part of the state. The demographic characteristics of the districts reflect that is predominantly rural and has a high concentration of weaker section i.e. the Kondha tribes. They are simple, placid in nature and follow their traditional beliefs and values.

The majority of the people live in the countryside and depend on crude drugs of plants or plant products as effective remedies for ameliorating various diseases. Since there is the poor availability of good practitioners in health centres many tribes generally go for traditional healers. Besides this other factors affecting health such as nutrition, water supply and sanitation are not adequate.

On another hand there my field placement organisation 'Swasthya Swaraj' is providing primary health care services and conducting training programme in Kalahandi district where they are operating in two *panchayats* covering nearly 75 villages having more than 13000 population but at the same time the tribal people are facing barriers to seeking care due to lack of education, issues accessibility and availability.

This study will help my field placement organisation to improve the primary healthcare services and training programme in tribal belts.

**3. Statement of the Problem**

The literature available reflects that there are no much studies conducted on socio-psycho perspectives of health care behaviour. There are very fewer studies held on tribal health care seeking behaviour especially in the case of Western Odisha. The earlier studies have given more emphasis on particular aspects like health, an economic status where as thepresent study will give more emphasis on socio- psycho attitude towards health care aspects in (TalaNehela Village ,Kaniguma Panchayat of Th.Rampur Block)Kalahandi district of Western Odisha.

**4. Objectives of the Study**

- To assess the pattern of utilisation of health care services by Kondha Adivasis living in Kalahandi district
- To identify factors influencing healthcare seeking behaviour
- To identify barriers in utilising health care services of Swasthya Swaraj and government health institutions

**5. Research Methodology**

**5.1 Study Design**

Cross-sectional study

**5.2 Study Area:**The study was carried out in Talanehala village of TH.Rampur block, Kalahndi district, Odisha. This village fall under the primitive tribal of Odisha state generally known as Kondha adivasi. Most of these tribal community depend on cultivation for their survival.

**6.3 Study Population**

As Kalahandi District falls under Fifth Schedule Area and more than 65% populations are tribal and their living conditionis not much developed, it helps us in understanding their health problem. TH.Rampur is one of the tribal dominated blocks in this district where more than 70% people are belonging to tribal communities here mainly found kondha tribal community.

**6.4 Study Duration:**October 2015 to November 2015

**6.5 Sampling Procedure**

In consultation with my field placement organization usingpurposively sampling Tal Nehalavillage was selected.This village is fully unreached to main stream as well as this village is isolated by surrounding rivers and mountains the modern health facilities un available in this village so for that reason I want to know how these village peoples think and take care about their various health issues. This village is having 40 households. Out of these 8 house head working at out of states.

**6.6 Sample Size**

All the households were selected for the study

**6.7 Data collection:**

| Objective | Data collection technique | Data collection tool |
|---|---|---|
| Objective 1 | Survey | Questionnaire (NSSO)(Annexure 1) |
| Objective 2 | 2 Focus Group Discussion and 10 In-depth Interviews | Guide with audio recording and taking notes (Annexure 1) |
| Objective 3 | 2 Focus Group Discussion and 10 In-depth Interviews | Guide with audio recording and taking notes (Annexure 1) |

**Source of Data**

Data was collected from primary sources. Primary data was collected from the field using household schedules, survey methods, focus group discussion and in-depth interviews method.

**6.8 Data Analysis**

Both qualitative and quantitative data was analyzed in the backdrop of the project objectives. Quantitative data was tabulated and statistically analyzed using epi infosoftware. Qualitative data was interpreted thematically based on the information collected from the field.

**6.9 Ethical considerations**

**Risks and Benefits:-**

No risks were anticipated for the participants. This study doesn't have any immediate benefits for the respondent, however, the study helpedidentify various healthcare providers/facilities and also barriers to health services. The field placement organisation will provide training to healthcare providers identified and community workers to improve quality of care provided overcome the barriers to health service utilisation.

**Consent:-**

Oral or written informed consent (Annexure 2) was obtained after explaining the intention of the studyand providing a participant information sheet (Annexure 3) in local language.Every responded was free to withdraw anytime during the study and this right was informed to each and every respondent. On the withdrawal, any personal data collected during the study would have erased to protect the confidentiality.

**Confidentiality:-**

Confidentiality is a right of every respondent and it was protected during the study and after the study, all data was encrypted as anonymous at the researcher level and codes were used to identify the different respondents. Identity will not be disclosed to anyone including research supervisor and organisation.

**7. Results:**

### 7.1 Socio-Demographic profile of the study area

The demographic study area shows of total population of 165 in the village females(53%) are more in number than the males(47%). Out of total population 50% population is ST, 42% population is OBC and 8%population is SC.As per the table 50% of population is educated its considered(both formal and informal education) and 50% population is illiterate.In this village, peoples mostly prefer traditional agriculture system; otherthan that peoples are migrating to outside for maintain their life style. Out of total population, 45% people areelderly and child,18.8% housewives,17% doingtraditional agriculture for their family and other people go outside of the state for earning money.

**Table 1:-**Population Distribution by Gender, Caste and Educational Status

| **Gender** | **Frequency** | **Percentage** |
|---|---|---|
| Female | 87 | 52.7% |
| Male | 78 | 47.3% |
| **Education** | | |
| Illiterate | 82 | 49.7% |
| Literate (formal &non-formal) | 83 | 50.3% |
| **Caste** | | |
| ST | 82 | 49.7% |
| SC | 70 | 42.4% |
| OBC | 13 | 7.9% |
| **Occupation** | | |
| Notapplicable(child and elderly) | 38 | 45% |
| House wives | 31 | 18.8% |
| Farmers | 28 | 17% |
| Migrants | 8 | 4.80% |

### 7.2 Morbidity Profile

Table 2 shows19% of population wereailing in 15days period before the study was conducted. As per this table its shown 16% of population suffered from ill health on the day of data collection conducted.Table 3 shows the various ailment suffered by thepeoples living in Tala Nehala village.In 67% of those who were ailing in previous 15 days said they were having fever.Tribal people living in the TH.Rampur Block of Kalahandi districts Odisha suffering various types of health issues these are anaemic, pregnancy problem, body ache, burns, chest pain, fever, ear infection, jaundice, malaria, cold cough, giddiness, mouth diseases, skin infection, snake and insect bites.

**Table No.2:-** Morbidity Profile of the community

| **Ailing during 15days before study conducted** | **Frequency** | **Percentage** |
|---|---|---|
| Ailing | 32 | 19.4% |
| Non-ailing | 133 | 80.6% |
| Total | 165 | 100% |
| **Ailing on the day of Survey** | **Frequency** | **Percentage** |
| Ailing | 26 | 15.8% |
| Non-ailing | 139 | 84.2% |
| Total | 165 | 100% |

**Table No.3:-**Showing different types of ailments as per people's perceptions

| Nature of Ailment | Frequency | Percentage |
|---|---|---|
| Fever | 27 | 67.5% |
| Ear Infection | 2 | 5% |
| NoIdea | 4 | 10% |
| Others | 7 | 12.5% |
| Total | 40 | 100% |

**7.3 Hospitalization**: Out of total population 9% were hospitalised during the whole year when they fall sick.

**Table No.4:-**Hospitalization during 365days

| Result | Frequency | Percentage |
|---|---|---|
| Ailing | 15 | 9.1% |
| Non-ailing | 150 | 90.9% |
| Total | 165 | 100% |

7.4 **Treatment:**The tribals of this area practices both modern medicines and traditional practices fortreatment of diseases. They also have developed a faith on modern medicines and injections. The tribalvillagers went to the Swasthya Swaraj Clinic for their health treatment. The traditional healer also provides better health treatment on which most of villagers depend.The following tables whatpeople preferred for their treatment purposes. It's shown the various health provider chosen by the patients for the better health in first attained 61% population preferred to traditional healer or guru gunia, 13% govt hospital,11% NGO Hospitals and etc.

**Table No.5:-**Availability of Various types of Health care providers at Community and what is the most preferable place for getting health care

| Types of Health Care Providers | Frequency | Percentages |
|---|---|---|
| Traditional Healer and Gurugunia | 22 | 61.10% |
| Kabiraj | 1 | 2.80% |
| Private Hospital | 1 | 2.80% |
| Govt.Hospital | 5 | 13.90% |
| Ngo | 4 | 11.10% |
| Home Remedy | 3 | 8.30% |
| Total | 40 | 100% |

**Source of data:-Base line survey**

And also the study shows for the further treatment purpose people are more prefer the NGO hospital care.This table showing in 2nd attained mostly people were choose NGO hospitals its 76%.

**Table No.6:-** Follow Up

| Health careproviders | Frequency | Percentage |
|---|---|---|
| Kabiraj | 2 | 11.80% |
| Govt.Hospital | 2 | 11.80% |
| NGO | 13 | 76.50% |
| Total | 17 | 100% |

Through focus group discussion and in-depth interview I found out In the illness time mostly family members are taking care of the patient in their family when the health issue is not handle by the patient own self then he/she may be need help of the family member to taking care at the traditional healer/guru gunia.As per them some situation the patient own self manage to going at the treatment place and to going the healer they didn't faced any transportation problem because the traditional healer always available at the village also in one time treatment the patient may be became well there no need to follow up also.Some diseases continue two to three months and few diseases have cured within two weeks for treatment purpose they were firstly tried through the traditional healer for getting well. Somehow, many are managed through by the home remedy

**Difficulties**:-According to the village people there are not going to govt.hospital or govt. health care institution because of rude behaviour or government attitude of the government health worker ,beside that in village there not proper transportation facilities to going towards the hospital mostly they are crossed three river with hilly and rough road of 15km then they reached at the sub-centre and after 30 km he /she may be reached at CHC at the main time the doctor or health provider not the centre or hospital.

**Cost:** -As per them when they going to traditional healer for treatment purpose he/she may not be take any monetary fees whatever available or according to patient's capacity, he/she may be charged, its less expensive if we are going to govt. hospital its little expensive for that sometime we are sell our storage foods, pets and land also.

**Recommendation:-**We need freely health check up with medicine apart from that we need better drinking water, well transportation facilities and education also both formal and occupational.

**7. Discussion:**

Village Talaneha is so far from the TH.Rampur Community Health Centre (CHC) so that people still belief in black magic and prefer local quack for treatment. As per the village people most of this region belief on black magic as well as medical treatment. But people giving first preference to local quack & gunia treatment. During the field visit it was found that that, most of the villagers are not accessing the modern health care system. Dependency on quack and local medicine man is very high. Indian context every community have caste system in this village also different castes are find out but all are belonging schedueltribe.and I fast time know about tribals are also various caste Health care Seeking Behaviour

**8. Conclusion**

The concept of health, illness and health care seeking behaviour show the complexity of the tribals medical system in TalaNehala Village. Their traditional medical system of late has come in dispute with the modern medical system. The villagers perception regarding sickness, illness and disease to a great extent has still traditional. The cause of illness and healing system are found to be associated with the magico- religious beliefs. Along with herbal treatment, magico - religious practices are still occupying a significant position in their indigenous methods of treatment. In the context of decision making process head of the household play a dominant role. The analysis of the in-depth interview and focusgroup discussionhave shown the factor like economicstatus, transportation , types of illness, severity of diseases, health care facility, and previous experiences effect selection of different ways of treatment. It is shown that lake of adequate modern health care facilities keep people away from modern medical care. Finally, it can be concluded that villagers responses to illness behaviour is guided and conditioned by their culture.

**9. Limitation**

Time limit for conducting the study is considered as a major limitation of the study. The studywas conducted within one month. In order to extract the information regarding illness,I realized that it is required to spend more time in field. But due to other academic activities, it was not possible to spend much time in field.Another major constrain was a lack of proper communication facilities. Language problem was faced speak any other language except their local language (Kuvi).

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**Suggestions**

1.Proper communication facilities should be developed

2.Health centre should be established near to their village.

3.Proper health care facilities should be provided at the local area.

4.Health awareness should be created in the rural area.

5.Proper health education should be given to the villagers.

6.The government should extended support to local herbal medicine practitioners.

7.The government should provide health training to local quack.

8.Panchayat should take care the local environment to avoid the spread of mosquitoes.

9.A mobile health unit should be introduced to take care of village's need.

**Annexure-1**

| ***Particularsofmedicaltreatmentreceivedasinpatientofahospitalduringthelast365days*** | | | | | |
|---|---|---|---|---|---|
| *1. Sr1.no.ofthehospitalisationcase* | *1* | *2* | *3* | *4* | *5* |
| *2. Srl.no.ofmember(asincol.1,block4/5)hospitalized* | | | | | |
| *3. age(years)(asincol.5,block4/col.4,block5)* | | | | | |
| *4. typeofhospital(code)* | | | | | |
| *5. natureofailment(code)* | | | | | |
| *6. typeofward(free-1,payinggeneral-2,payingspecial-3)* | | | | | |
| *7. whenadmitted(code)* | | | | | |
| *8. whendischarged(code)* | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *9. durationofstayinhospital(days)* | | | | | | |
| *10. lossofhouseholdincome,ifany,duetohospitalisation(Rs)* | | | | | | |
| ***detailsofmedicalservicesreceived**(notreceived- 1; received:free- 2,partlyfree- 3,on payment- 4)* | | | | | | |
| *11. surgery* | | | | | | |
| *12. medicine* | | | | | | |
| *13. X-ray/ECG/EEG/Scan* | | | | | | |
| *14. otherdiagnostictests* | | | | | | |
| *15. whethertreatmentavailedbeforehospitalisation(yes-1,no-2)* | | | | | | |
| ***if1initem15*** *16. sourceoftreatment(code)* | | | | | | |
| ***if1initem15*** *17. durationoftreatment(days)* | | | | | | |
| *18. whethertreatmentcontinuedafterdischargefromhospital (yes-1,no-2)* | | | | | | |
| ***if1initem18*** *19. sourceoftreatment(code)* | | | | | | |
| ***if1initem18*** *20. durationoftreatment(days)* | | | | | | |

| **Particularsofspellsofailmentofhouseholdmembersduringthelast15days(includinghospitalisation)** | | | | | | |
|---|---|---|---|---|---|---|
| 1.srl.no.ofspellofailment | | 1 | 2 | 3 | 4 | 5 |
| 2.srl.no.ofmember reportingailment(asincol.1ofblock4/5) | | | | | | |
| 3.age(years)(asincol.5,block4/col.4,block5) | | | | | | |
| **numberof dayswithi n thereferen ce period** | 4.ill | | | | | |
| | 5.onrestrictedactivity | | | | | |
| | 6.confinedtobed | | | | | |
| 7.natureofailment(code) | | | | | | |
| 8.statusofailment(code) | | | | | | |
| 9.totaldurationofailment(days) | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10.whethertreatmenttakenonmedicaladvice(yes-1,no-2) | | | | | | | |
| **if1in item10** | 11.whetheranytreatmentreceivedfromgovt.sources (yes-1,no-2) | | | | | | |
| | 12.**if2initem11**,reason(code) | | | | | | |
| **if2in item10** | 13.reasonfornotreatment(code) | | | | | | |
| | 14.whetheranyothermeasuretakenforrecovery/relief (yes- 1,no-2) | | | | | | |
| | **if1in item14** | 15.whomconsulted(code) | | | | | |
| | | 16.expenditureincurred(Rs) | | | | | |
| 17.lossofhouseholdincome,ifany,duetoailment(Rs) | | | | | | | |

**Topic Guide for Focus Group Discussion**

To read out information sheet introducing you and the research project prior to takingoral consent

1. Health problems of people in your village
    a. What are the problems
    b. Who suffers from these problems
2. Various health facilities/providers available in/near your village
    a. Name them
3. Why do people go to
    a. SS – (availability, accessibility, affordability, acceptability, beliefs, culture & social)
    b. SS
    c. SS
    d. SS
    e. SS
    f. SS
    g. SS
4. Where do people mostly go for
    a. and why?
    b. and why?
    c. and why?
    d. and why?
    e. and why?
    f. and why?
5. What are the ways in which services at the SS can be improved?

**In-Depth Interview Guide**

To read out information sheet introducing you and the research project prior to takingoral consent

**General Information**

Name:

Age:

Sex:

Location:

Known Chronic Health Problems, including Substance Abuse:

Opening question: Can you tell me about a time when you were unwell in last one month?

Interview Guide

1. Description of the illness

Probes:

- What did you feel was wrong?
- When did you experience this?
- How did you try to ease the problem?
- When did you think of seeking help?

2. Care sought

Probes:

- What kind of help did you look for?
- Where did you go?
- Why did you go there?
- How did you go?
- Were you asked to come back for a check up?
- Did you go? (if not, why not)

3. Difficulties faced

Probes:

- How did you found the attitudes of health care providers? (in
- government facilities, in private facilities, in NGO run clinic if
- relevant)
- How did they behave towards you?
- What comments did you receive?
- How long did you have to wait to be attended to?
- What difficulties did you have in getting admission?
- What difficulties did you face in being nursed?
- What difficulties did you face in food arrangements?

4. Costs

Probes:

- How much did this illness cost you?
- What were the main expenses?
- From where did you get the money?
- How did you pay it back and at what cost (food, savings, assets)?

5. Recommendations

Probes :

- What do you think would help you to take care of your health and in getting health care?
- Can you list a few things that would be very helpful to you for getting health care?

## Annexure-2

## Certificate of Consent

A study on healthcare seeking behaviour of the Kondha Adivasis living in Kalahandi district Odisha.

Name of the researcher: Khirod Bihari Sahu

Name of the Institution: SOCHARA, Bangalore.

I have been invited to take part in the study about health care seeking behaviour. I understand that it involves me taking part in a survey. I have been explained the purpose and procedure of the study. I have been informed that no risk is involved in taking part in the study and that there will not be any direct benefits for me. I understand that the information I will provide is confidential and will not be disclosed to any other party or in any reports that could lead to my identification. I also have been informed that the data from study can be used for preparing reports and that reports will not contain my name or identification characteristics. I am aware of the fact that I can opt out of the study at any time without having to give any reason. I have been provided with the name and contact details of the researcher whom I can contact.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

**Name of Participant**_____

**Signature of Participant** _____

**Date** _____ **Thumb print of participant**

**If illiterate**

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

**Name of witness**_____

**Signature of witness**_____

**Date** _____

**Statement by the researcher/person taking consent**

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that his/her participation in the study is voluntary and that he/she can choose not to take part in the study. I have explained all the elements including the nature, purpose, possible risks and benefits of the above study as described in the consent document to the participant. I have also explained the participant about the confidentiality of information collected.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this consent form has been provided to the participant.

**Name of Researcher**_____

**Signature of Researcher**_____

**Date** _____

**Annexure-3**

## PARTICIPANT INFORMATION SHEET

Dear Participant,

I, Khirod Bihari Sahu. I am doing my fellowship programme in Public Health Learning Programme, SOCHARA, Bangalore. Thank you for your time and willingness to hear and read about the research I intend to do. This note provides an explanation of the nature of the research. This study will be done as part of my fulfilment of the Fellowship program requirement. This consent form may contain words that you do not understand. If there is anything you need clarity on, please feel free to ask me. At the end of this information sheet you will find my contact details.

**TITLE OF THE STUDY**

A study on healthcare seeking behaviour of the Kondha Adivasis living in Kalahandi district Odisha.

**PURPOSE OF THE STUDY**

The purpose of this study is to find out the difficulties faced by Adivasis people in accessing and utilising health care services. As you are a member of this Adivasis community I would like to learn about the difficulties and problems faced by you in availing health services.

**DESCRIPTION OF THE STUDY**

The study will be based on individual surveys that are expected to last about 45 minutes. I will be asking you information on your facilities at the Adivasis community and access, utilisation of health services. If you do not wish to answer any of the questions included in the survey, you may skip them and move on to the next question.

**RISKS AND BENEFITS:**

There are no risks involved in taking part in the study. You do not have to answer any question if you feel the question(s) are too personal or if talking about them makes you uncomfortable. There will be no direct benefits for you but your participation will help improve the understanding of barriers in accessing health services.

**CONFIDENTIALITY**

I have taken all the necessary steps to maintain confidentiality of the information collected. The information that we collect from this research project will be kept private. The study supervisor Dr .Aquinas Edessary will have access to the information collected. I will not reveal your name or any identifying characteristics to any other party and also will not include them in the final report.

**VOLUNTARY PARTICIPATION AND WITHDRAWAL**

Your participation in this study is entirely voluntary and should you wish to withdraw from the study at any time you may do so without giving reasons.

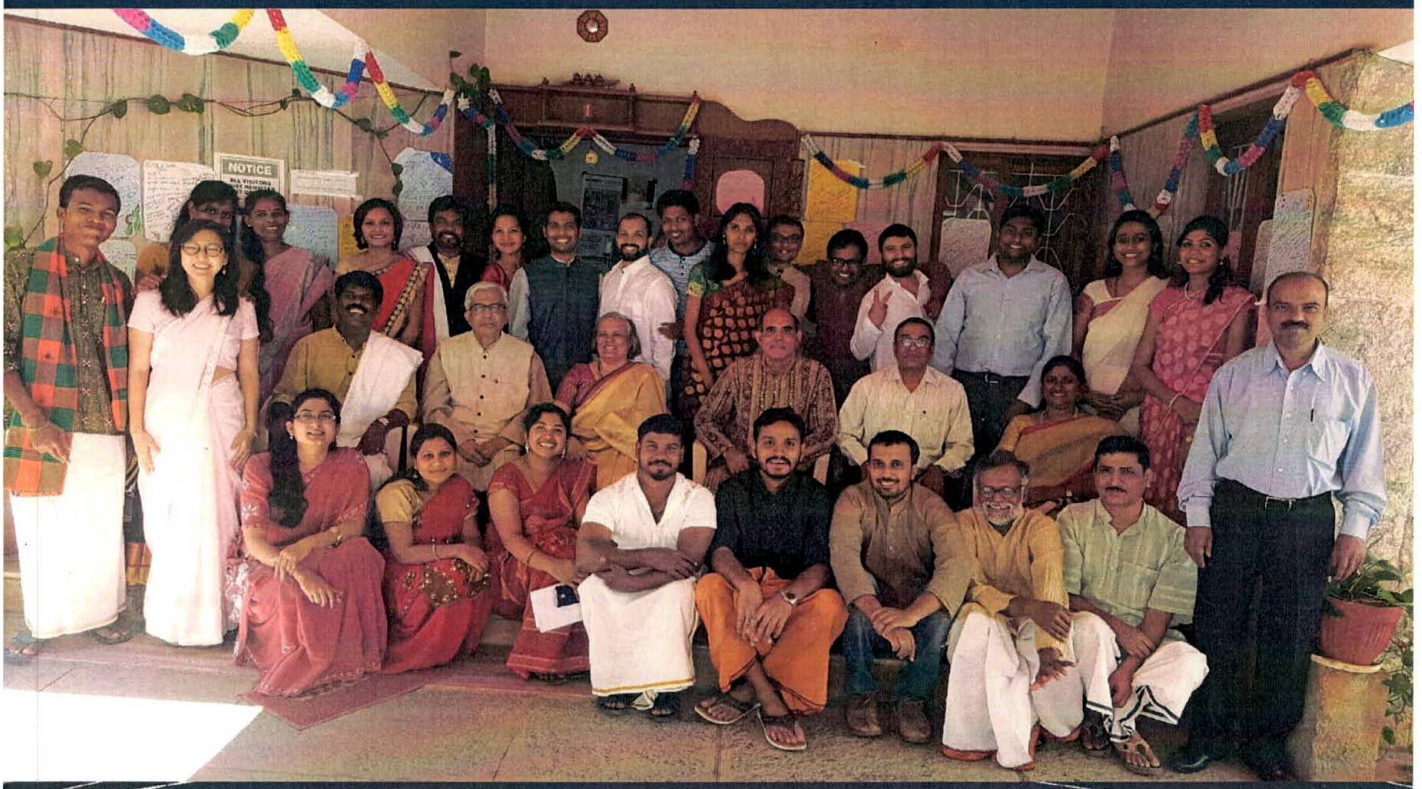
**CONSENT**

Your consent is required for your participation in the study. You can decide to participate or not.

**CONTACT DETAILS:**

Khirod Bihari Sahu
Contact Detail:08763402210
Mail Id:khirodsahu@gmail.com

Community Health Learning Programme is the third phase of the Community Health Fellowship Scheme (2012-2015) and is supported by the Sir Ratan Tata Trust, Mumbai and International Development Research Centre, Canada.

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