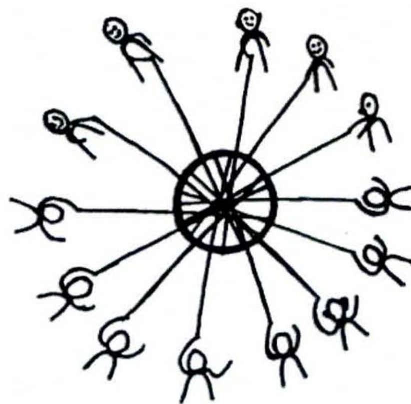
CHLP-2015-22/FR170

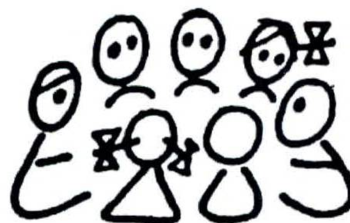
2015-16

Community Health Learning Programme

A Report on the Community Health Learning Experience

DR. SURESH RAGHUNATH





School of Public Health Equity and Action (SOPHEA)

Society for Community Health Awareness Research and Action

JN 16/6/16

CHLP Final Report

Dr.Suresh Raghunath

Mentor: Dr.Ravi Narayan

CHLP-2015-22/FR170

Introduction

The following pages attempt to describe the journey and learnings of a student on a quest for personal and professional clarity after the beginnings of his Professional Educationin Health.

While words cannot begin to describe the richness of the experiences afforded by the CHLP over 5 months, this document attempts to document my learnings and experiences before and after I was introduced tomy Mentors, Facilitators and Fellows at SOCHARA.

The CHLP is a one of a kind program with an equitous approach to community health education and sensitization to the Social Determinants of Health which reaches out to a broad audience of students ranging from masters students in mainstream universities toexperienced professionals from a wide spectrum of disciplines and backgrounds who embark on a transformative journey together in a quest to understanding health better and delivering better health for all. The students of our batch came from diverse backgrounds from various states in India and formed a well-represented cross section of Indian Society. Just sitting in a CHLP session and observing our fellow travellers can open one's world view to our country and to the borderless potentials ofhumanity.

The program immerses students in the realities of health and healthcare through classroom learnings, experienced mentors, resources, videos, articles, theater, songs, poetry, real stories, experiences, simulations, games, interviews, symposia, meetings, workshops, and a broad array of field visits and real world responses and scenarioswhich allows each student to visualize, implement and understand the effects of the learnings and training in the classroom in the context of the real world and to reflect on the new learnings from each experience before bringing them back to the classroom and to practice. It also exposes students to the on the ground realities of working in various organizations across India and brings students face to face with people working

for decades to bring about change from the ground up who provide invaluable guidances and sharings during the journey.

While the process brings out the potentials and capabilities of the students through a transformative journey, the mentors andwell-travelled travellers who have already walked the walk and done the journey before, refine and develop the skills and attitudes that emerge through the process and reorient attitudes to better fit the relevance and needs of each scenario.

At the end of each one's journey we share our experiences and learnings with our fellow travellers and learn so much from each other that no write up or document will ever be able to do justice to. I shed a tear as I glance through the pictures and writings as the memories of the experiences remind me of how priceless the 5 months were and how I have not been able to do justice to the learnings and experiences with my report.

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Secret Worlds Within Our World: Enchanting Milestones on aPath

Sittilingi: A Prelude:

Aprayer comes to me in my final hours in medical school as an intern, which takes me on an interesting journey full of coincidences and surprises in the months and years that follow and reveals an alternate beautiful universe from medical school to me.

I ask for us Divine Grace, ultimate fulfillment, deeper meaning, positive growth, reverence and awe,imminence and transcendence, a blazing Life and a Glorious Death, all in harmony with the Highest Good and filled with unexpected and unfathomable Blessings, as we shed layer after layer of illusion, and move into ever new, ancient, exciting and restful waves of life divinely inspired on this earth and beyond this earth. May a benevolent universe fulfill our highest aspirations and release the lower ones in a harmless, appropriate fashion. May everyone in this world and beyond this world be blessed with everything they deserve in a kindly, loving way.[1]

Time Warp:

Many diverse worlds coexist within a 100 km radius of the tiny bubbles we live in, each one different and oblivious to the other. As I travelled back home from the tribal hospital in a beautiful forest valley encased within the Kalrayan Hills, I had to change 3 buses across 2 states. As you change buses the crowd changes and you get a visual bite into a different world slowly transforming itself into the next. In the first bus from the tribal hospital there are chances you may find animals in the bus- livestock accompanied by people dressed very basically,often barefoot, going to the nearby village from the forest, perhapsunaware of the joys of returning to network coverage. Manual laborers: men, engaged in physical work in the fields, brickworks and construction give their legs a well-deserved rest in the second bus after a long day at work. At the connecting town to the metropolis, the final shuttle ferried products of education and enterprise- teachers, nurses and small business owners, travelling to the Bangalore in nicer clothes, embroidered sarees and jewelry.

I sat at a table with a self-proclaimed urbane crowd in Bangalore a few hours later at a restaurant, grappling with culture shock within my own country, time-warped by what felt like half a century of material development and half a century of spiritual entropy. A Japanese-Indiancomic made clever jokes about the city and modern Indian society as we know it, which made no sense to the real and pressing jokes in the surrounding worlds, not so far away.

Contrasts in Vibrancy and Character

As I watched the external landscape change through the windows from the forest through the various intermediate worlds to the city, the lushness and greenness fades to concrete, I also notice a change in the internal landscape of the crowd from the colourful to the grey, from the gentle, naive and kind to a hardness and mistrustfulness. I found the pace of life increasing, purity, naivety and innocence fading. There is a shift of focus from what is the minimum I need to live to how much more can be gotten. The

change springs up at the expanding borders of material development, the border is a dynamic continuum which I like to call the illusion of a material civilization.

There needs to be a balance. The lack of exposure and child-like naivety in the secluded remote populations allowed gullible tribals and their families who were unaware of the pace of life and ways outside The Valley to be cheated into loans designed never to be paid back, into debt and bonded labor for decades, by loan sharks from nearby towns. We need to strike a balance between extremes to live a peaceful, healthy life. A lot can be learnt from either world if only they talked to each other and learnt from each other about the good things each of them has to offer.

Influence of Media and Technology

As the borders of material development push their frontiers closer towards the Valley, the influence of media and communication systems encroach even some of the most far thrown areas, where you often find outside small hamlets or huts a satellite dish for a satellite TV even though there is a seeming lack of a toilet in the same dwelling. There were advertisements to IT education and subliminal messages promising a better life on the walls of thatched structures in some villages, and buses from technical schools ferrying youth to their prospects of a prosperous destiny.

It was interesting to watch the nurses from the community at the tribal hospital sit around a television spontaneously dubbing an old Hindi movie they didn't understand a word of into local Tamil. They were for the first time being exposed to the habits and cultures of the reel world which was such a far cry from their world.

Minimalism and Detachment to Fear:

There is a lack of fear to leaving doors open to the elements, walking barefooted for years on sands that are home to poisonous reptiles and worms that suck the blood out of your system. Locking your doors is an alien concept. There are neither locks nor robberies. The fear of the unknown and the need to control it is sparse, and refreshing. The result seems to be thateven animals and reptiles are seemingly friendlier and non-confrontational. There was a scorpion who decided to join our evening banter where we washed our clothes behind Ravi and Prema's place. Animals and reptiles do not feel a need to retaliate as long as you give them their space and maintain your consistency. The community thrives without the crutches of factors creating an aura of false security and self-preservation in normal day to day urban life, community-ship thrives without this limiting factor, Material lack fosters spiritual inner strength in the community and maintains motivation among the people working here to create better lives for their families and the people who cross their paths.

Little did I know that repeating this small prayer with a heartfelt request would have the power to expose me to some of the most fascinating worlds and people who exist not too far from the worlds we live in. Little Paradises, Heavens on Earth, which would elude the eyes and the hearts of materialists even if they chanced upon them.

SOCHARA-DFY

Chennai Flood Response Program

January 4th 2016- January 14th 2016

[1] A dwelling destroyed by the floods near our camp site in Shastri Nagar, Palavedu, Thiruvallur

[2] A resident of Ambikapuram, wading through the waters of Ambethkar Street in Thiruninravur District

[3] AnDRF Army Officer rescuing a woman on South Boag Road, Chennai

[4] Children enjoying a new experience in the face of calamity and discomfort

Acknowledgements

This report on the Chennai Floods would not have been possible without the inputs of Dr.Ravi Narayan of CHC Bangalore, Ameer Khan and Suresh Dandapani of SOCHARA's Chennai Cell,Dr.Ravikant Singh of DFY, Team Members of the DFY Chennai Response Team: Shandeepan Ganapathy, Pozhil Sampathkumar, Dr.Balram Jadav, Sheikh Javed Majeed, Jacob Oommen Arikupuram, Dr.Roopali Agarwal and Rashmi Panga.

Introduction

This is a report about the observations and learnings of a SOCHARA CHLP Flexi Fellow who visited Chennai in January 2016 in response to the Chennai Floods as a part of Doctors For You's (DFY) Chennai Flood Response Team. There was massive flooding across the Indian state of Tamil Nadu in the month of December 2015. Chennai experienced the heaviest rainfall in over a century, driving thousands from their homes, shutting down factories and paralyzing the city and surrounding districts. Many school children were displaced from their homes during their mid-term exams, subways, hospitals and entire localities went underwater for the better part of a week. Low lying areas around Chennai are still under water and dealing with the aftermath of the flood.

Doctors For You (DFY) is an NGO which responds to disasters across the country and aims to attain the 10 sustainable development goals through frontline action through its developmental projects in the heart of insurgent Assam (Kukhraganj, Bodoland), Bihar, Jammu and Kashmir, Mumbai's slums and Nepal. DFY focused its action on affected areas in and around Chennai and Cuddalore.

[source: www.un.org]

Action Response

The SOCHARA-DFY tie up was facilitated by SOCHARA's Chennai Cell. Mr.Ameer Khan, SOCHARA's Unit Coordinator facilitated the project with Shandeepan Ganapathy who is DFY's Emergency Response Manager in India and Nepal. Dr.Suresh Raghunath from the Bangalore CHC was available to them since they were in immediate need of Doctors for their programs in and around Chennai.

The DFY program was three pronged and consisted of Medical Camps, School Programs and Community Development Projects. During the visit between 4th January and 14th January 2016, 3 Medical Camps were conducted and 4 schools were visited for the school health programs of which 3 schools allowed the NGO to run its programs and 21 Community Representatives from various hamlets in Thirunandravur met with the NGO with the issues they are facing after the floods.

The first two Medical camps, were conducted in Alapakkam, an Industrial Area in Chennai, which is rather interesting since the boom of industries in the industrial areas in Chennai over the last 15 years

has contributed to Climate Change in the region and climate change coupled with other structural lapses have led to the disaster. The Final Medical Camp was conducted in Shastrinagar, Palavedu, Thiruvallur District and was visited for inspection by WIPRO's Operations Chief to assess a long-term relationship and funding since WIPRO supported DFY's Responses in Tamil Nadu alongside Cipla.

The schools visited as part of the school health programs were:

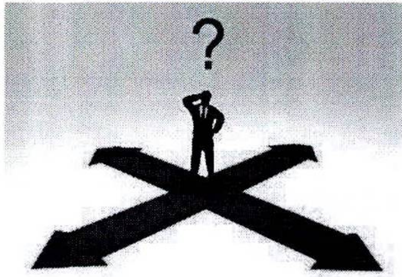
1) Government Higher Secondary School Thandurai, Pattabiram, Tiruvallur District

2) Villivakam Panchayat Union Elementary School, Alapakkam, Chennai

3) N.Sama Rao Nursery and Primary School, Singarachari Street, Triplicane, Chennai

R.R.Traders, a partner to DFY that allows DFY to store its Medicines in their storehouse at Pattabiram, Thirunindravur and assembles Hygiene Kits and Dignity Kits for DFY's Chennai Response program. They arranged for a meeting with 21 representatives of hamlets of 750 population around their office in Pattabiram, to hear their issues, DFY has started developmental projects with these communities .

Method Of Selection of Camp Locations by DFY



1) **Approach Government Authorities to Identify Flood Affected areas**
   Following the floods Chennai was divided into 30 zones, An IAS Officer was assigned to each zone to monitor the activities and accelerate response in their zone, Dr. Balram Jadav, a public health professional associated with DFY works under an IAS Officer- Rajendra Ratnu who is the Monitoring Officer assigned to Area 4. He would bring data to DFY for their programs. The main funders were WIPRO and CIPLA, the first two medical camps were conducted at Alapakkam near the WIPRO office at Alapakkam.

2) **Approach Locals, Informants, Panchayat President and Ward Manager to identify schools and areas requiring medical attention.**
   The team accompanied Pozhil to Sureshnagar in Thiruvallur District, she attempted to meet the Panchayat President and Ward Manager to get permissions and information to conduct activities around the area. We met and spoke to a village elder and informant- Kulasekaran.G a retired factory worker from the Ministry of Defence's Heavy Vehicle factory at Avadi to find out about the issues in the area, he shared with us his experiences with the floods.

3) Approach Institutional heads (Principal/Headmaster/Headmistress)

We met Tmt.R.M.Meenal Headmistress, Government Higher Secondary School Thandurai, Pattabiram, Tiruvallur, Mrs. Sugantha Malar- Headmistress of Villivakam Panchayat Union Elementary School andthe Principal of N.Sama Rao Nursery and Primary School to know the School Schedule before fixing a meeting so that exams and holidays don't impede the programs and vice versa, DFY's team shared information to increase awareness at the institutional level such as the health program manual published by the Tamil Nadu Government (*Palli Nalavazhil Kalvi Thittam*), Scheduled the Programs and executed it with the support of school staff.

Medical Camps

[5]

[6]

[5]Talking to Industrial Workers at the health camp in Allapakam Industrial Area
[6] The camp at Shastri Nagar, Palavedu a settlement in Thiruvallur District

The aim of the medical camps was to provide psychological support and relief to the flood affected people. Three Medical Camps were conducted during the visit, Two in Alapakkam Industrial Area on the 4th and 5th of January 2016 and One in Shastri Nagar, Palavedu, Thiruvallur District on the 13th of January 2016. Around 350-400 people were treated at the medical camps over three days.

There was a mixture of cases secondary to the floods and diseases occurring normally in the community. The Major Systems Treated by the DFY Camps in Reducing Order of Frequency in Dec-Jan were:

1) Respiratory Diseases
2) Nutritional Deficiencies
3) Skin Problems
4) Diarrhea
5) Non-Specific Body Aches
6) Gastrointestinal Problems

Most of the people who came to the camps came with complaints of Cough, Fevers, Running Nose, Generalized Weakness, Easy Fatiguability, Dermatitis, Non-Specific Body Aches, Headaches, Abrasions and Ulcers. There were a few people who came with Hypertension, Diabetes Mellitus, COPD, Otomycosis and Hypothyroidism. Some Cardiovascular Problems, Developmental Disorders, Neurovascular Problems and Surgical Problems needed a referral to a higher centre.

Focus Audience of Medical Camps in Chennai:

The focus audience of Medical Camps in Chennai Industrial Workers working and residing in Alapakkam Industrial Area, Primarily: Welders, Printing Press Workers, Steel Plant Workers, Automobile Plant Workers, Tailors, Kitchenware Factory Workers, Labourer, Construction Workers, Coolies and Drill-bit operators.

Flood Related Health Problems:

1) Respiratory Diseases
2) Nutritional Deficiencies

3) Skin Problems
4) Diarrhea
5) Non-Specific Body Aches
6) Fevers
7) Non Diarrheal Gastrointestinal Problems

Occupational Problems:

These were the problems that came up during the camps which I considered to be Occupational

1) Body Pains
2) Exertional Palpitations due to lack of age appropriate tasks
3) Arthritis of Fingers, Back and Knee problems

Many of the people presenting with these problems in the camps had an occupational history of longstanding unprotected lifting of weights or other labour intensive heavy work for long hours through the day. The workers did not work with gloves or hard hats and worked on tasks that were not appropriate for their age.

Here are some case studies I found Interesting:

A 45 year old woman, illiterate with poor eyesight works as a drill-bit operator for roadworks on a daily wage. She is obese and she complains of chest pains and chronic body aches. She works 10-12 hours a day operating a drill for roadworks and has to manage the household chores once she goes back home, she cannot think of any other way to subsist and cannot afford to go to a hospital.

A 27 year old man works as a manual labourer for a company, he has shifted boxes of supplies all day without protective gear for 7 years. The joints on his fingers are swollen and he has chronic lower back pains. He decided to go back to his company and coax his superiors to give him gloves and didn't want a change of job.

Strengths Of Medical Camps:

1) Facilitates Entry into the Community
2) It Provides Psychological Relief to a community during a disaster and can be a useful spiritual support.
3) Fills a lacuna of Primary Health Care Demand to a Community
4) Caters to Normal Health Problems and Problems Secondary to the Disaster
5) Facilitates Organizational tie ups with External Agencies
6) Publicizes Organization to Community, Funders, Doctors and Support Staff
7) Publicizes Pharmaceuticals for Pharma Companies

8) Publicizes Products of Sponsors
9) Popularizes Funders
10) Provides Data For Diseases in a Community
11) Helps the Organization identify problems in a focus group or a focus area
12) Facilitates Networking among Medical Professionals and Public Health Professionals
13) Facilitates a Deeper Understanding of Common Knowledge, Beliefs and Practices of a Community through one to one interactions under the garb of a free Clinical Checkup
14) Useful in Early Response and Rescue Phases
15) Useful in Frontline Areas of Disaster
16) Facilitates knowledge and understanding of Medical Systems and Authorities in Affected Areas
17) Facilitates Contact with Authorities for Larger Scale Issues and Changes

Weaknesses of Medical Camps:

1) Empowers Organizations and Individuals and not Communities
2) Impact of program affects a small group of individuals per day
3) Band Aid Impact: Impact of program is more short term than long term
4) Area of effect is small, with a radius around the medical camp location
5) Difficulties in Following up cases
6) Pushes products into communities
7) Not possible to give long term treatment or treatments which require monitoring
8) Medicines used for normal illnesses unrelated to floods can be used in an area of genuine need and shortage but it is impossible to turn down people with genuine health issues.
9) Acute care for critical/complicated cases requiring specialty or superspecialty treatment requires referrals to tertiary care centres which are often not accessible, unaffordable or have failed to provide quality care to the patients.

Opportunities:

1) Access to Community
2) Access to Authorities
3) Access to Institutional Heads of Organizations
4) Access to Funders
5) Access to Medical Professionals
6) Access to Allied Professionals and Support Staff
7) Access to Pharmaceuticals
8) Access to Data
9) Access to Referral Networks

Threats in Medical Camps:

1) Lack of sufficient infrastructure to manage all health problems
2) Lack of Medicines for all

3) During Election Time Political Parties in power may try and stop NGO Work that is very visible like camps because it may remind people to ask what government is doing about filling the lacuna in Primary Health Care.
4) Alternatively Political Parties may take credit for medical camps to get more votes
5) People are suspicious of visible work and someone even asked us if we were doing our work for votes
6) False Cases and Malingering can be rampant since medicines are free which is a waste of time and resources and deviates resources from where they are truly needed.

School Programs: Children as Agents of Change

[6]

[7]

[8]

[9]

[6]Children at Villivakam Panchayat Union School listening to the health talk

[7]True Companionship: A child talks without talking

[8]Engaging with students at N.Sama Rao Nursery and Primary School

[9]Talking about Deworming to Children and School Staff

[10] A class of naughty, somewhat rowdy adolescent boys who wouldn't let me start my talk on Reproductive Health for the first ten minutes transform into friends for life after the ARSH talk on reproductive and sexual health

Social Reform in Tamil Nadu: Influence and Trends

Since Tamil Nadu comes from a Social Reformist Culture originating from the Periyar Period, Social and Welfare Programs are a subject of Pride and Healthy Competition between the DMK and the AIADMK through their periods of alternate rule in the state. Government School Health Programs in Tamil Nadu are excellent but implementation is variable and dependent on the quality of implementation of the local authorities at the municipality in which the school is located and is sometimes more on paper than in reality. NGOs play an important role in filling the gap in the delivery of services.

School Health Programs: Children Are Agents of Change

DFY conducted school health programs at:

1) N.Sama Rao Nursery and Primary School, Singarachari Street, Triplicane, Chennai on 6th January 2016

2) Villivakam Panchayat Union Elementary School, Alapakkam, Chennai on 8th January 2016

3) Government Higher Secondary School Thandurai, Pattabiram, Tiruvallur District on 9th January 2016

DFY's School Program focused on the following Agendas:

- Discussing Health Programs and Policy with the Institutional Heads and Teachers
- Deworming
- Nutrition
- Sanitation
- Child Clinic
- Health Awareness
- Hygiene Talks
- Adolescent, Reproductive and Sexual Health Talks (ARSH)
- First Aid Kits and First Aid Education to Teachers

At the School Programs we would interact with the children and talk to children on a range of health topics and answered their questions if they had any, what are germs? the various types of germs, routes of transmission of infections and disease how to protect ourselves from these. We also spoke to them about Dengue, Malaria and brainstormed about how to protect families from vectors, Whether everyone had access to water, practical approaches on how to make water safe to drink. Students

demonstrated to each other the six steps of hand washing. Boys and Girls were separated and we would discuss with the students about safe and unsafe sex, sexually transmitted diseases and responsible sexuality. Students asked many questions about sex and sexuality and many myths were debunked. Mass Deworming was conducted at Villivakam Panchayat Elementary School. Chewable 400 mg Albendazole tablets were given to the students. Every school was given a First Aid Kit and the Physical Education Instructors were explained to, if they had any queries how to best use them. We distributed nutritional supplements at the Villivakam Panchayat Union Elementary School and gave every school a Model First Aid Kit.

The Model First Aid Kits Contained:

1) Betadine; Povidone Iodine
2) Medicated Betadine Gauze
3) Plain Gauze
4) Roller Bandage
5) Antibiotic Creams
6) Hand Sanitizer
7) Gloves
8) ORS
9) Deworming Tablets

Focus Audience of School Health Programs: Principal/Headmistress, School Teachers and Staff, Students - 90% of the children in these schools were from slums. They were children of Rickshaw Pullers, Autorickshaw Drivers, Small Shop Owners, Beachside Vendors, Taxi Drivers, Domestic Workers, Construction Workers, Labourers and Unemployed

Types Of Schools Visited:

1) Urban Private Slum School

2) Urban Government Slum School

3) Rural Government Slum School

Some Observations:

The parents of the students in these schools have a Seasonal Variation in Income, their livelihoods are affected during times of disasters or even rough weather for that matter, there are periods when the families have to manage with zero income. However, Parents want to pay fees even during times of economic hardship.

Parents of slum children seldom have time to meet teachers.

The Children are often more educated than parents and enable their parents with new knowledge and skills.

Strengths of School Health Programs:

1) Empowerment of Institutions and Communities, not Organizations and Individuals
2) Brings out your inner child as facilitator
3) Deeply Satisfying and energizing experience with Sharp, eager, vibrant, enthusiastic agencies of hope.
4) Impact of a few hours interaction lasts for a lifetime for both the facilitator and the facilitated
5) Affects large groups of people and their families
6) Has a large area of effect across thousands of homes
7) Brings out confidence in the Children
8) Brings out Community-ship in the Children
9) Nurtures Creativity, Leadership and Life skills
10) Children are the emotional and spiritual barometer of a family or institution, School Programs help you assess a community from a spiritual perspective if you spend a day in a school
11) Schools are a barometer of efficacy of government programs in a ward or municipality and allows organizations to assess the spiritual quotient of the local authorities and agencies before starting other work which needs their involvement
12) Easy to review and follow up with the institutional head once rapport is established
13) Empowers Teachers and Students
14) Improves Teacher-Parent Collaboration
15) Facilitates Institution-Government Collaboration
16) Can affect institutional policy which will become a part of a student's habit and a life after they become adult citizens.
17) Increases Awareness at an Institutional level
18) Change is by word of mouth. Strength and impact of the program is a function of: strength of inspiration, potency of the messages and memorability of engagement between the students and the facilitators. These are intangible functions that aren't limited by infrastructure, human resources, institutional or government policy and thus makes it a very potent program.
19) Allows for large scale one time health interventions to children. Eg.Deworming, Immunization, Nutrition.
20) Promotes Healthy Sexuality in Adolescents
21) Myths and Taboos about Sex Are removed
22) Educates Adolescents about the Dangers of STIs and Unwanted Pregnancies
23) Promotes healthy, respectful and responsible relationships with the opposite sex
24) Promotes Population Control at a young age
25) Reduces Sexual Insecurities
26) Screens reproductive diseases and allows early intervention
27) Able to identify, screen and refer children with massive health issues that require medical attention to ethical pediatricians

Weaknesses:

1) Empowerment of Institutions is a function of intent, Involvement, engagement, moral fabric and skills of the institutional head, if one of these is lacking it is difficult to tie up with government agencies and bring about a lasting change.
2) Nepotism and favouritism is common when we make teachers an agency to screening malnourished or sick children, they would bring their relatives or friend's children or their favourite pupils rather than genuinely sick or poorly nourished children.
3) Malingering for free medicines was common
4) Teachers would use relief and aid materials for their personal use or for their families
5) Boys were often given more preference than girls unconsciously and girls unconsciously blindly accepted the inequality
6) Some Teachers were scared of approaching authorities. They felt unheard, invalidated and demotivated to bring about a change as they believed nobody would listen to them
7) Conversely Some Headmasters were overly dependent on the authorities out of fear and would refuse to make any independent decisions without a nod from above.
8) With Limited resources and a large audience of sick children, it is impossible to decide who deserves the resources and attention.
9) The program could increase sexual curiosity and the chances of underage sexual encounters.

Opportunities

1) Empowering teachers and institutional heads with awareness of programs
2) Empowering Teachers with skills and tools and networks to negotiate with government agencies for regular implementation of the programs
3) Capacity Building of Students in Leadership, Health Awareness and Self-Regulation through health clubs and moral debates.
4) Helping Government Agencies with implementation and delivery of services for its programs
5) Collecting health and family data for future programs and interventions
6) Sanitation and improvement of school toilets and providing a model for toilets in the community

Threats:

1) If the Teachers and Students are both unruly the whole program has the potential to go to waste.
2) Embezzlement of Resources by school staff
3) Following a program, if a few children fall ill institutional heads are wary that they would be blamed and have to face consequences
4) Some wards are very tightly regulated and programs cannot be conducted easily in these wards without the blessing of the authorities and it is difficult to get their approval.
5) Children may miscommunicate instructions and this may lead to more problems than before, it is thus important to keep instructions as brief, simple, entertaining and comprehensive as possible.
6) Sexual Curiosities may increase after sex talks and adolescents may have underage sexual encounters out of curiosity.

Community Dialogue: Process

Indupriya of R.R Traders organized for us to meet 21 representatives from hamlets spanning a 750 strong population around Pattabiram, Thirunindravur, they spoke to us about their lives and the issues they faced before and post-floods. They were women who wanted opportunities to make money to either help a child go back to school or help a sick person at home with a serious medical condition get treatment. R.R Traders is training and employing some of these women to pack Dignity Kits for DFY's programs. The remaining women have now received employment from Gunj, another NGO partner of DFY. R.R Traders is looking to train two Widows at the Coimbatore Office of Arunachalam Murugasan to manufacture sanitary napkins and is planning on investing on a Machine that costs Rs.65,000/- to manufacture their own sanitary napkins once the training is completed. They are looking for ways to contact the office and are assessing the cost of funding the entire training program.

Water Purification

Water supply is from Government electric Borewells, stored in overhead tanks. Water is also brought to villages from borewells in Tankers, Lorries and Tractors. People in the middle class choose to buy drinking water privately if they can afford it.

In badly affected areas, since there was no way of telling if contamination of water was at source or during transmission or at the point of collection till the water samples were analyzed Chlorine Tablets were Distributed along with the Hygiene Kits and Dignity Kits.

Contents of Hygiene Kits: (Distributed specially where these are not accessible)

1) Soap and Towel
2) Nail Cutter
3) Shaving Kit
4) Powder
5) Toothbrush
6) Toothpaste

Contents of Dignity Kits:

1) Sanitary Pads
2) Contraception
   - Sindoor
   - Bindi
   - Condom
   - Oral Contraceptive Tablets

3) Iron and Folic Acid Tablets

Sanitation Program

Model Toilets are being built by DFY in Villivakam Panchayat Union Elementary School. DFY is also building toilets in communities around Pattabiram, Thirunindravur without access to toilets. Two sets of Model Toilets have been built over a span of 8 days.

Waste Disposal

Most of the garbage is incinerated but often waste is thrown by the roadside or into open drains.

Stagnant Water is a huge problem and needs the intervention of Engineers, Civil/PWD Department, Local Health Inspector/ Corporation who need to coordinate with the Village Health Sanitation Committee.

Possible Solution?

Sandbags can be used along with bleaching powder to cover the wet roads to facilitate temporary movement until the water is drained.

Vector Control Program

They Identify Larvae to decide Anti Larval Measures.

Usually:

Aedis Egypti is found in Stagnant Water
Anopheles is found in Flowing Water

Either Anti Larval is sprayed followed by ABATE Oil Emulsion once a week

Or

The water is completely drained and the pits are filled up.

The vector control program is in effect in Area 4 and Cuddalore as DFY has written permissions to conduct these activities in these areas, They purchased 2 microfoggers and are looking for a full time entymologist to coordinate and conduct these activities.

Educational Program

DFY has started a library with 500 books which were donated by IIT Alumni and a librarian was appointed from the community. The community was looking for a tutor, to tutor children who cannot afford private schools and have dropped out.

In response to the demand for a tutor, It was suggested to Indupriya of R.R.Traders to help put the children who have dropped out into Government Schools or approach private schools via the Right to Education Act. Shortly after the discussion with her, she read up about the RTE act, approached Amudha Matriculation School, a Private School in Moggapair, Chennai and negotiated to put Shwetha back into school. Shwetha's father who was the primary breadwinner of the family has Cancer and does not work anymore. Shwetha got admitted on 25th January through the Right to Education Act. Shortly after admission the school demanded Rs.2,700 as Van Fees which Indupriya has paid for from her pocket.

Indupriya is now starting an Association to systematically put children back into school every year.

Shwetha with her mother who now works at R.R.Traders and helps Assemble Dignity Kits for DFY

Positive Outcomes:

1) Following the community dialogue, Indupriya is going to start an Association to enroll children from the community systematically into schools through the Right to Information Act every year
2) DFY is going to ensure sustainability by tying up institutional heads of schools with people in the nearest municipality hospitals.
3)

Personal Learnings:

1) **Enthusiasm** drives a team in a disaster scenario. There were members from DFY in the team who played an unsung role in maintaining motivation in the team and maintaining an upbeat environment throughout and I got along well with these people, working with them was very easy.

2) **Communityship:** To coexist and foster a community in a team from diverse religious and geographic backgrounds by singing songs on our trips to the fields and making silly jokes or just laughing for no reason, for that matter.

3) **No more Stage Fright after this one:**
To communicate to large audiences and answer their questions in a language I don't think in. Though Tamil is my native tongue, I never really had the opportunity to spend much time in Tamil Nadu and we don't speak much Tamil at home, but since I was the only member on the team in the field that knew some Tamil I would end up being the speaker to the audiences. It was a joyful experience engaging with large audiences, especially when they were enthusiastic, I would have never thought before this trip that I would have enjoyed it as much, that I was capable of doing this and that it would give me so much satisfaction for the rest of my waking day. Those days were so happy we would laugh ourselves to sleep. My roommate and I.

4) **Professional Confidence:**
   This visit gave me the confidence to conduct an OPD with an array of medical issues with a team of allied staff. I enjoyed talking to the people who came for medicines and listening to their interesting stories. I watched the entertainer in me spring out during this trip in both the camps and the school talks to cover up for how serious I am on the inside. He is entertaining to both me and the people outside. I wish he visits more often he is fun.

5) **Networking**:
   I learnt to network and connect people who can help each other on this visit. I also learnt that I can talk to organizationally senior folks naturally and they value this if you exercise some degree of judgement and sensibility. Circumstances allowed me to meet two of the three founders of DFY and the Global Operations Head of Wipro. Being honest about my thoughts has helped me on this trip, because these organizational heads valued an honest input when they ask for feedback, though this has not always been the case in other places and experiences I have been through. The Wipro Operations Chief has asked me to talk to him after I come to Bangalore and the founder and co-founder of DFY have said they are interested in coming to SOCHARA to talk to Ravi and Thelma and the fellows and shared their contacts. Also within the team Dr.Balram who is the Public Health Expert for DFY will be joining us at MFC in Raipur thanks to Rahul. Indupriya from R.R.Traders who is a Community Leader is in touch with Ameer.

6) **Knowledge Dissemination is a Powerful Tool** when you empower Committed Community Leaders with essential information and they follow through and implement actions
   .
7) A few hours of interaction and attention is enough to change peoples lives and make friends for life and beyond.

Contact Networks

Dr.Ravikant Singh and the Chennai Response Team after the final medical camp

In the picture from left to right are Jacob, Janardhan, Suresh, Ravikant Singh, Pozhil, Roopali and Javed.

Dr Ravikant Singh
President
Doctors For You
Address:
Flat-101/102,Building No-31,Natvar Parikh Compound,Near Indian Oil Nagar,Govandi,Mumbai-43
Mobile Number: +91 9324334359
Web Address: www.doctorsforyou.org
Office Landline: 022- 32253919
Email:<ravikant.singh@doctorsforyou.org>

Articles:

http://timesofindia.indiatimes.com/india/Dial-Dr-Courage-during-disaster/articleshow/20237005.cms

https://www.iimcal.ac.in/iimc-mentored-project-social-need

Dr. Ravikant Singh is interested in meeting Dr.Ravi Narayan and Dr.Thelma Narayan and addressing the fellows at SOCHARA. He was interested in sending people from the communities in Bodoland, Bihar and Kashmir where his organization conducts developmental projects and training workshops to attend CHLP and go back to help their communities with DFY.

Dr Rajat Jain

Vice-President & Co-Founder

Doctors For You

Phone Number:
+91 9868665228

Web site address www.doctorsforyou.org

Dr.Rajat Jain is a Radiologist from Maulana Azad Medical College, Delhi and is the co-founder of DFY. He met us in the beginning of our Journey with the Chennai Flood Response Team. He too is interested by the creative work at SOCHARA and is interested in meeting and addressing the fellows. He said he would be coming to Bangalore in the last week of March and said he is ready to keep a day aside for SOCHARA during his visit to Bangalore if communicated to in advance.

http://doctorsforyou.org/Golden_ruby_award.php

Shandeepan Ganapathy

Emergency Response Manager, India and Nepal

Shandeepan Ganapathy is the National Emergency Response Manager for DFY's activities in India and Nepal. After his Bachelors in Hotel Management he went on to Jindal School of International Affairs where he did a Masters Program in Humanitarian Law which led him to interesting United Nations Projects pertaining to Conflict and Disaster Management. He has helped negotiate the release of Child

Soldiers from the Philippines and has played an active role in Disasters in Nepal and Jammu and Kashmir for DFY.

Phone Number:+919711854216

Email: shandeepang@gmail.com

Pozhil Sampathkumar

Team Lead, Chennai Response Team

Pozhil Sampathkumar is the Team Lead of DFY's Chennai Response Team. After finishing her Bachelors in Visual Communication, she went on to Jindal School of International Affairs to do a Masters in Humanitarian Law with her colleague Shandeepan Ganapathy who was a year ahead of her, She has applied to Universities in Sweden for her second Masters in Conflict Management

Phone Number:

+917358271410

Email: pozhil.dfy@gmail.com

Jacob Oommen Arikupuram

Asst.Director (Incharge), Senior Program Manager,

DFY-Centre for Community Development and Peace Building

Jacob Oommen Arikupuram is incharge of DFY's Bihar Development Projects. He too is a product of Jindal School of International Affairs. He comes from a political family in Kerala, He is the nephew of Oommen Chandy, who is the current Chief Minister of Kerala. He aspires to do his PhD in the United States.

Address: Ground Floor Sangitanjali, New Kunj Colony, Rajendra Nagar, Patna, Bihar - 800016

Phone Numbers:

+919645071986

+918294839340

Sheikh Javed Majeed

Disaster Risk Reduction Field Officer, J&K

Sheikh Javed Majeed looks after Developmental Projects in Jammu and Kashmir. He has 6 years of field experience, his work is currently focused on the development and risk readiness of regions around Bandipora region in Kashmir. He is a certified trainer in Basic Life Support.

Address: 112 – Munawarabad, G.P.O Khanyar, Srinagar, Jammu and Kashmir - 190001

Phone numbers:

+919796352175

+917812854057

Dr.Roopali Agarwal

Medical Officer, Doctors For You

Dr.Roopali Agarwal is an MBBS doctor who has been active with DFY's disaster response programs in Nepal, Uttarakhand, Assam, and Jammu and Kashmir since 2012. She used to run a private practice but currently is more interested with work in Disaster Management. Her husband is a Hospital Administrator in the Army and her Daughter is working towards her Bachelors in Engineering in Chennai.

Phone number:

+919477451346

Email:drroopali@live.in

Dr.Balram Jadav

Public Health Consultant, DFY

After finishing his MBBS, Dr.Balram went on to do his Masters in Public Health from Jawaharlal Nehru Medical College, Belgaum, he has published a paper on Mental Health issues in Disaster Management, He has worked with the DFY Team in Jammu and Kashmir and Nepal prior to doing his Masters in Public Health.

Phone Number:

+918123885139

Rashmi Panga

Research Officer, DFY

After finishing her Bachelors in English Language, Rashmi Panga went on to Jindal School of International Affairs, she collects and records data across Tamil Nadu from all DFY's Activities everyday and prepares DFY's reports for the head office and the funders.

Phone Number:

+919884027333

Janardhan Reddy

DFY Pharmacist

Janardhan Reddy used to own and run a Pharmaceuticals Shop in Vishakapatnam for over 30 years. He has relocated to Chennai to be with his daughter who works in a Software company in Chennai.

Phone number:

+919176172921

Raipur,Chattisgarh:MedicoFriends Circle

Introduction and Reflections:

The medico friend's circle meeting was arranged in a pastoral center attached to a church. Since most of the people at the meeting were inclined to serving the poor or marginalized it was poetic and special that the meeting was held in a place of devotion since devotion and dedication are partners toselfless servitude. The writings on the walls of the Pastoral Centre were meaningful and spiritual which I felt was the underlying current of the meeting, no matter how worldly the discussions were:

My Lord and My God,Make me an instrument of your Peace.

Where there is hatred, let me sow love,Where there is injury, Pardon.

Where there is discord, may we Unite, Where there is doubt, may we Believe.

Where there is error, let there be Truth and where there is Despair let there be Hope.

Where there is Sadness let us sow Joy and where there is Darkness. Let there be light.

The friends' circle meet gave us an illuminating overview not just of health in the urban scenario but of health in its various colors, contrasts and pluralities across India.

The sessions were well arranged thematically on the first day and topics flowed and interplayed well with each other well, Dr.Prabir provided lucid imagery of the evolution of industrialized cities from forests and the evolution of culture and ideas from the universities, When it comes to the shift of themes in the urban scenario from the self-sufficiency of the agrarian economy to the commodification of health and life in the milieu of today's emerging urban culture- The coin of Desire has two faces: Oppression and Distress. There needs to be a reorientation from the desire for the coin to the desire of a better life and there needs to be an appropriate reprioritization in the health services. The problems that were being discussed in the mfc meeting were in the context of India but I felt these were problems which can potentially in the future plague many other countries across the world. As we start finding comprehensive solutions to these problems here, people from other places who face similar problems with an ailing global economy and failure of health and healthcare delivery systems can be helped as well with appropriate answers.

Ravi Duggal made me think when he talked of real commodities being converted into paper commodities like land which is bought, sold and traded these days as a paper commodity and not as land. Are we dealing with the crisis of real world commodities being treated as paper commodities and human beings being treated as real world commodities with the rise of commodification and materialism? Is there an alternative to the homogenization of people into groups or quantities on paper? Can the Urban poor be seen as one homogenous group? Or must they be divided by social vulnerability?

The papers were not presented by the people who wrote the paper but by a friend, I felt this was such a wonderful idea that fostered community-ship and trust within the group. On the second day the issues being addressed were more fragmented and didn't flow into one another like the first day but they were all important issues. When you are trying to cover a broad range of issues in a couple of days you are going to have a day where the talks feel fragmented from each other as a broad range of issues need to be addressed. The end session on the 2nd day was chaired by incoming convenor of the mfc, Jashodara Dasgupta, I feel jealous of facilitators who were able to engage a large group of people to talk to each other and wished I had the skills to conduct groups in this fashion one day and ever so surprisingly on the very next day of we got an email from our facilitators saying my name had come up asking if I would like to attend a workshop on Qualitative Analysis after my return from Orissa, segments of which would orient me to the skills I found so fascinating to watch at the meeting. To me the segment at the end of

the mfc meet that Jashodarachaired was the best session in the meeting because we had a chance to listen to and engage with key people on the ground in the frontline, working on issues related to the failure of the Bilaspur Medical camps and the violations of Women's Rights in Bastar. We had a chance to look at the postmortem reports of the Women who died at the medical camps and were given copies of the letter to the chief minister of Chattisgarh by Women's Rights activists across India and the Justice Commission Reports . Having these artifacts in our hands while the key people involved with these issueson the ground for years spoke to us face to face made the issues feel so palpable and real and made us feel we were involved with these issues firsthand though we were only listening and learning. Also since Yashodara is an expert on Women's Rights issues she was able to provide interesting and insightful interjections while these issues were being discussed. Just listening to the manner and the pattern of these discussions opens up your world view and the way you approach large meetings.

I felt the seating arrangement created a subtle power dynamic with most people sitting on the chairs and some sitting on the ground. While there is the argument that it is due to biological reasons and people have arthritis and were getting old, a lot of young people and people without arthritis were sitting on the chairs too. The people sitting on the chairs were more engaged in the conversations and more comfortably because they could see each other eye to eye and capture attention quickly if necessary.

Urbanization, Inequity and Health in India: A Landscape

Presented by: Dr.Prabir Chatterjee

Dr.Prabir Chaterjee Drew a mental picture of the evolution of cities from forests through agricultural lands to polluted cities.

Shift of Paradigms:

As one left the village the village was self-sufficient and gave food but once people come to the city, food is not available as food, but as money, food may continue to come from the rural areas, also villages need money.

He talks about the desire of people to be urbanized. The paper discusses agrarian distress as the fuel for the city. The university is the first place where people from the village get an idea about the *liberacci* ideas in the city. Women found a liberation and a freedom that was unfamiliar and anonymous. It is possible to spend a whole day in the city without encountering someone you know but also life in cities can be congested and unpleasant.

He spoke about incidents in Sundur. In 1991-93 young doctors who came to do their post-graduations opined that Sundur would explode in the future with the mix of educated, uneducated and classes, violence, death and silence, 10 people were massacred.

Impacts post-independence:

Disorganization of the Informal Sectors

Post-independence there was industrialization and development of development blocks. The villagers gave food to the industrial blocks and the state started retreating from its role in financing the villages. Parallel to this, the state started retreating from its responsibility to pay for healthcare. Labour laws were diluted. There was a tendency to employ informal labour and this coupled with privatization of services led to the boom of the disorganized informal labour.

There is a dichotomy in urban-rural class and gender, The smart city and the municipal corporation.

Divisions in the paper:

Urban Health: Accidents, Hazardous locations and Hazardous occupations in the city were discussed,

Gender roles: Women manage to work and take care of their homes.

Medical services: ESI, RSBY, informal sector within the city were discussed, there is a difficult to get access to primary healthcare

Government Services started collapsing from the 1980s onwards, there is a struggle between the economic forces and the disorganized government also facing a steady but disorganized resistance from some forces within the government. Funding arrangements are complex and tenuous including central, state, municipal, ad hoc and private funding. There is no standardization of government salaries across states, the logic of salaries tends to run against the dominant free market pattern without adequate ideological support or motivation. As a result some practitioners barely spend 2-3 hours in a government clinic in a day. Medical supplies to government medical posts are irregular and follow complex organizational routes that leads to the unavailability of certain drugs. Hence prescriptions are written by doctors to private pharmacies and are sometimes given benefits by the same for doing so.

Privatized care: Dr.Prabir separates the smaller disorganized private sector and the larger corporate sector. Insurance is not lessening the out of pocket expenditure and has strengthened the corporate sector. Schemes like Rajiv Aarogyasri are designed to provide the poor free medical care for catastrophic illnesses but are being used as instruments for transferring government funds to the corporate sector. Also although it is purportedly free it ends up extracting from the patient's out of pocket expenditures and exceeds what the patient would have paid for without insurance. Appropriate, timely and economic treatment of illnesses is replaced by expensive, delayed and outlandish forms of treatment.

The Problem:

Between the collapsing public health systems and the zeal for profits in large corporate hospitals, the urban ill encounter an impasse. Any choice be it public, private or alternate care, will result in a situation where a rational recovery to "full" health is almost impossible. The poor know the impossibility of their predicament and try to make the best of a hopeless situation. They seek some form of palliation in an endless struggle to live and sustain their bodies (*Source: In towards a Critical Medical Practice, Lakshmi Kutty, Hyderabad OBS 2010)*

Solution:

Using informal networks and through strengthening of its resources, experimenting with new kinds of community self-help organizations that draw on available public and private resources with a focus on depending on and empowering women and children, building a group with a participatory democratic approach however small, is possibly the most radically transformative step of all to solve the problem from the ground up [*Inputs from Prabir Chatterjee, Dhruv Mankad, Devaki Nambiar, Aditya Pradyumna, Sheela Prasad and R.Srivatsan].*

Discussion:

Hidden Cities and Hidden Populations

Urbanization is not just social anymore but it is state run. The decision makers are the state government. India has a good census and a good definition of census which reveal that there are many hidden cities. Within every city there are hidden populations like Koliwada in Mumbai. An important kind of hidden city in every city is the floating population. The floating population in Mumbai on the local trains alone is more than 4 lakhs out of the 65 lakhs travelling per day. The Total population of Mumbai is about 25 Million.

The rise of informal labour within the Government Sector

Even within the government sector there is a rise of informalization of labour with contractualization of the medical workforce and there are massive differences in the benefits received by a permanent employee and a contractual employee.

Issues with Worker's Welfare:

Overcrowding, Lack of health access, lack of regulations, acts and rules made by a top down approach.

Do boundaries exist?

The loose definitions of boundaries of urban and rural were talked about and the politics of urban and rural. Srivatsan in a private discussion opined that urban and rural do not have a boundary but exist in continuum to one another.

Conversion of real commodities to paper commodities:

Land has been converted from a real commodity to a paper commodity globally, there is massive trading and India is the biggest actor. Gujarat has passed a new policy that all land can be bought and sold public, private, urban, rural and tribal.

Can the urban poor be seen as a homogenous group? Or must they be divided by Social Vulnerability?

These nuances need to be captured in the paper before you can talk about any entitlements be it food or nutrition or education or health.

Rahul: Urban Migrants in India

50% of the GDP is from informal sector and 90% of workforce comes from Urban Sector. There is a significant contribution by these migrants and their contributions go unrecognized. This has an effect on the health of the migrants.

Migrants: Some Statistics

3% of total World's population are migrants. As per the global perspective migration plays an important role in movement from rural to urban. Since a large number of migrants are internal she speaks about migrants from an Indian Scenario. Skilled migrants go to Gulf countries and India is a destination for migrants from Bangladesh and Bhutan. 3.7 Million people are migrants in India

Migrants and Public Health:

Untreated migrants are a health threat and become breeding grounds for endemic diseases and increased drug resistance. Migrants contribute to the economy but the national policy is not in favour of migrants.

How do Migrants emerge in the Urban Fabric?

Their work has subsidized work and development yet they face extreme social exclusion in the urban areas, they do not get electoral representation or access to education, healthcare and financial institutions, Also the urban infrastructure is not enough to contain their needs in the present and in the future.

Migrants come under labour laws, they provide them with certain entitlements, the inability of labourers to access these entitlements was discussed. States spend less than 10% of the cess collected for migrants through the Building and Other Construction Workers Act,1996.

The health outcomes of the urban migrants does not fare favourably with their non-migrant counterparts due to low wages, lack of job security and inability to access healthcare services in the urban areas,

What are the Differential barriers migrants face to access to National Health Programs?

1) Procedural difficulties
2) Knowledge Gap
3) Language barrier
4) Distance and Time.

Public sector: Stigma

Private Sector: High costs

Limited Awareness of Portability of Schemes among Migrants:

For example, RSBY *(Rashtriya Swasthya Bhima Yojana)* has interstate portability but the knowledge of RSBY among migrants is limited

Only one Act covers injuries: Interstate Migrant Act, 1969

Similarities in issues faced by women migrants and children:

The migrants are not homogenous but they are looked at as a homogenous group. There is a need to look at them in a segregated manner. Migration occurs as a result of rural underdevelopment and urban areas see them as a burden rather than a valuable population. NGOs and CBOs are trying to address their problems but there is a lack of access and delay in access to healthcare due to lack of knowledge, poor health traditions, poor support structures, lack of early childcare and educational support for their children.

How can the state become accountable and make them access services?

State interventions need to focus on the living conditions and working conditions of migrants. This would require coordination between various ministries, local health bodies, NGOs, CSOs, Trade Unions, Social Activists and Researchers with a proper role clarity for each actor and a clarity of strategies to improve the lives of migrant workers.

Migrants are important contributors to growth and development hence logic dictates that they get some benefit from the growth and development they contribute to.

Life and Work in Jeedimetla: Mithun Som

Presented by Anuj

Anuj presents a 5 theme montage

How migrants live:

In a typical situation they live in an apartment or room or different migrants stay together,

Water Supply and Conveniences: Water comes at a particular time and they have to stand in queue for water, there is no gas connection and they have to cook on a wood stove or kerosene stove. They share common toilets and bathrooms on each floor. Women generally take water to their rooms and take bath there because men use the common toilets. There is no planned housing for migrants in urban areas. Pollution and living conditions are not in their favour.

Hazards Workers Are exposed to:

1) Poor cramped housing and living conditions
2) Exposure to hazardous gases and polluted water

Advantage to workers working in larger factories:

They are provided with accommodation within the premises

Problems Faced: Their freedom is curtailed

Factors Contributing to migration to Cities:

1. Indebtedness due to poor crop or marriage in their family,
2. Land Availability
3. Agrarian Distress due to weather dependent factors
4. Lack of Opportunities
5. Financial dynamics: Private bore-well payments
6. Unavailability of credit at reasonable rates
7. Changes in farming technology: High input costs
8. Emerging opportunities elsewhere
9. Land Grabbing
10. Displacement due to development projects
11. Medical refugees
12. People with alternate sexualities feel very uncomfortable in the rural setup and migrate
13. Conflicts and violation of rights by armed forces
14. Availability of a Variety of industries where they can earn more

Classes in Urban Slums :

1) Recognized slums
2) Unrecognized slums

Work conditions:

Limits

1) Work conditions
2) Pressures of working: Pressures of taking leave and losing pay
3) Environmental conditions: Pollution and hazardous work conditions
4) Unions are not allowed to form as there are pressures that they will lose their pay
5) Much of the employment is from informal sector
6) Overtime is an important factor wage policy and overtime policy lacks clarity and homogeneity and varies from industry to industry

How inclusive is the universalized insurance of RSBY in Chattisgarh

Raipur has 1/3rd of empaneled hospitals in RSBY.

They interviewed 375 Patients about RSBY.

Findings:

Enrollments:

90% of the family was aware of the scheme but only 57% were enrolled because of lack of awareness of enrollment drive. When they were enrolled 40% didn't receive the card on the same day.

Most women with gynecological problems visited government hospitals and private centres for other problems. Their choice was not influenced by RSBY. Only 1/3rd of the women with RSBY got free treatment, 90% had to spend out of pocket.

Beneficiaries: Private hospitals

Women's health in urban Vadodara

The Paper calls a bluff of Gujarat being a developed state and points to health indicators which is less than states like Tamil Nadu and Kerala

SAHEJ

75% of families have ration cards. 22% have BPL cards. The families lack even basic facilities required for living in a dignified fashion though they lilve in cities. There is a lack of awareness in communities about their rights and entitlements. Strategy to demand health rights by SAHEJ. Most women accessed healthcare from the private sector and quality of care was poor. Costs between private and government health care were compared. There was a lack of documentation in *Bastis* which were marginalized

Challenges:

1) There is consistent struggle in these communities to get a functioning *anganwadi* in their areas although there is demand mobilization.
2) Lack of processes for regulations.
3) *Mahila Aarogya Samhitis* are perceived more as somewhere you would get insurance rather than a place which can hold a system accountable.
4) People don't know where to access these schemes

Insurance issues:

All insurance have a common rejection criteria: pre-existing conditions are rejected so people paying premiums do not always get the insurance they were promised after paying their premiums if they have a pre-existing condition. Rejection rate is 66%.

Gender theory:

Gender Strategic interests vs. Gender needs were discussed

Keshav Desiraju: Inequities in Urban Health

Presented by: Raman

The paper presented is written by a former health secretary of a country. He was expected to be at the meeting. So the presentation was prepared and made in a way that most of the questions were addressed to him.

Keshav Desiraju presents a snapshot to the inequities in urban healthcare with a focus on Chhattisgarh however Raman looked at the data in the larger context of India. Raman opined that two perspectives came across and clashed in the paper:

1) Keshav Desiraju as the Individual and
2) Keshav Desiraju as the Bureaucrat

Meso-level and micro-level details were missing and the paper gives a bird's eyes view on issues, which is frustrating since it would have been useful to have a worms eyes view of important issues he encountered during his term in a key position in the health system.

The paper asks important questions:

Who Provides Healthcare? Who Pays for Healthcare?

Is there a right to Health or Healthcare?

Is it always and only the responsibility of the state to provide primary health care? And what happens when the state has budgetary constraints, a lack of resources or has other budgetary priorities?

The paper states that the answers are ambiguous at best with the government's position on investment in the sector remaining non-committal- as the paper was written before the union budget was released. The paper discusses how to ensure adequate and skilled human resources, proper human resource allocation, Maintaining quality healthcare services and ensuring universal and free access to healthcare facilities.

Discussions around the paper:

We don't have a way to look at urban poor health status through the existing data systems. Is there something like Urban HMIS? Even if more women are seeking institutional care it doesn't mean they automatically get better health care

Equity:

How to ensure Equitable leadership? How to ensure transparency and accountability on all these issues?

Systems for social determinants and health infrastructure and Regulations in the larger context were discussed.

Ravi Duggal:Urban health care issues and Challenges:

Presented by:Cheenu Srinivasan

Cheenu Srinivasan said we had a relatively good healthcare system until the 80s after which it was downhill and the private sector dominated.

He tried to analyze why this decline happened. One of the reasons is that until 1982 we had a national health policy which talked about rural healthcare and primary healthcare in a focused manner soon after the Alma Ata. Although governments changed, the spirit of Alma Ata carried on until somewhere in the mid-80s when economics intervened and the country went to debt – The IMF inflicted the Washington Consensus after we borrowed money from this source whose basic spirit is "everything in life should be seen as a cost - the cost has to be recovered and the price should be decided by the market". This outlook is wrong, because the market doesn't work in health services and the market doesn't work in education services. The Market only works when buyer and seller have equal power. Not understanding the basic concept of market failure Washington consensus was imposed on India.

Knowing very well that once unveiled, this policy is going to be politically explosive, they promised a "Safety Net" which was not implemented - promises were broken. As a result there was private investment in healthcare, the educated middle class benefitted and hence didn't raise a voice while the public health sector crumbled. In the early 80s and late 70s Bombay's hospitals were great but due to the privatization and rising costs of medical education the prices shot up to the ballpark figure of Rs. 25000/- per head per day of hospitalization and became unaffordable to most people. User fees by IMF were discussed.

The crux of the article is what we had in terms of public health care needs to be recovered and the government is not investing the money necessary, hence inequities in the health system have been increasing.

The Challenges in Urban Planning to Overcome Health Inequities in India: Dhruv Mankad

Presented by: Sandhya

India has 8928 urban areas or towns as per Census 2011, 53 are cities with more than 1 million population.

Table 1: Number of Cities and Towns in India, State/UT wise[1]

States & Union Territories (UTs)	Urban Population 2011	Number of Cities, Towns, Census Towns, Notified Towns etc.
Andaman & Nicobar (UT)	1,18,366	5
Andhra Pradesh	1,46,10,410	296
Arunachal Pradesh	3,13,135	26
Assam	43,98,542	243
Bihar	1,17,58,016	203
Chandigarh (UT)	10,26,459	8
Chhattisgarh	59,37,237	221
Dadra & Nagar Haveli (UT)	1,60,595	6
Daman & Diu (UT)	1,82,851	8
Delhi	1,63,68,899	112
Goa	9,06,814	77
Gujarat	2,57,45,083	479
Haryana	88,42,103	189
Himachal Pradesh	6,88,552	67
Jammu & Kashmir	34,33,242	215
Jharkhand	79,33,061	229
Karnataka	2,36,25,962	416
Kerala	1,59,34,926	536
Lakshadweep (UT)	50,332	6
Madhya Pradesh	2,00,84,260	561
Maharashtra	5,08,18,259	537
Manipur	8,34,154	58
Meghalaya	5,95,450	22
Mizoram	5,71,771	24
Nagaland	5,70,966	26
Odisha	70,07,716	272
Puducherry (UT)	8,52,753	11
Punjab	1,03,99,146	277
Rajasthan	1,70,48,085	336
Sikkim	1,53,578	9
Tamil Nadu	3,49,17,440	1,111
Telangana	1,36,08,665	264
Tripura	9,61,453	42
Uttar Pradesh	4,44,95,063	981
Uttarakhand	30,49,338	134
West Bengal	2,90,93,002	921
All States & UTs	**37,70,95,684**	**8,928**

Challenge 1: Gathering Data about Health Impact of Scale of Urbanization

Highlight:The need for reliable and segregated data published by reliable institutions

Tamil Nadu, Uttar Pradesh, West Bengal, Maharashtra, Madhya Pradesh and Kerala have more than 500 urban areas each, with Tamil Nadu having the highest number with 1111 Urban Areas. These 5 states cover 52% of the Total Urban Population and total number of Urban areas in India.

Many areas are block and district headquarters as well as suburbs, not yet incorporated peri-urban villages, industrial townships or traditional market areas. Segregated Data about health infrastructure and its accessibility, health status of residents of such towns , and of hidden cities within metros is sketchy and sporadic.

Challenge 2: Bringing the Private Health Sector under the Public Health "Gaze"

Highlight: Invisibility of the Private Health Sector

Most of the towns with >20000 population are estimated to have atleast a few private hospitals or clinics or public health facilities. In towns with population >10000, a PHC is likely to be available. There are serious gaps in Maintaining Data and notifying public health authorities by the private health sector.

Challenge 3: Governing the Climate Changes within the Public Domain:

Highlight:Limitations to the Elected Bodies-

Elected bodies don't have much power because they have limited capacities and have problems related to revenues. The policy is made by the state.

Healthcare is just one component of healthy life, to make towns livable, factors like quality of drinking water, sanitation, food, and psychological and social well-being need to be addressed. Urbanization brings all these aspects out of the purview of the central and state governments and places it in the hands of the public through the process of decentralization. Creating Nagar Parishad, Nagar Panchayat, Notified Town Committees, Municipal Boards, Cantonment Board without much legal power since most urban planning is approved by the State Government and not by local bodies and building their capacities to carry responsibilities of creating structures, planning its service provision, implementing the schemes and generating revenue to sustain them are the biggest challenges. Addressing these challenges would be good governance to eradicate health inequity and sustain a higher quality of life.

Is there a window of opportunity in the smart city mission?

Smart City Mission: Major changes in 11 infrastructure elements of urban life:

1) Water
2) Power Supply
3) Sanitation
4) Public Transport
5) Housing
6) IT Connectivity and Digitization
7) Good Governance
8) Sustainable Environment
9) Citizen Safety
10) Health and
11) Education

In the current format this smart city model does not include vulnerable populations.

There are definite steps we can take:

1) We can create an alternate vision document to improve the quality of care in government hospitals and to marginalized populations.
2) We need indicators about livability which needs to include factors like crime rates and road accidents.
3) We need to create playgrounds rather than parking lots.
4) We need to shift from creating smart cities to livable cities
5) Trying out workable models in smaller cities such as bikes on hire, changing the architecture of the city
6) Low cost good quality private healthcare
7) Highlight the voices of people in slums

There were voices in the meeting advocating interdepartmental integration - Transportation, housing and health needs to be integrated and not be looked at as independent entities.

Would smart city reach the goals it has set out to reach?

The session concluded with a couplet in hindi."*Aag ke sholonse sara shehr roshan ho gya, Ho Mubarak, aarzu-e-khaar-o-khas puri hui*"

(Flames of the fire made the town enlightened, Congratulations! Desire for thorns and hay for a nest were triumphed!)

Urban Health Programme in Chhattisgarh State: Evolution, Progress and Challenges of Urban Health Programs in Chattisgarh: Opportunities and Challenges: Samir Garg, Anju Khewar, Shikha Gupta, Prafful Kushwah, Rizu, Ashu Sahu, Priyanka Sahu

Presented by: Rahul ASGR

Of the various programs the Mitanins was the most important. However without a complete system in place, community health workers cannot be introduced to the urban areas

Is there a need for more health facilities in Urban areas: Once view is that since Urban areas already had a district hospital or government health facilities if additional services are required this can be done by the PPP model. There is a need for primary health care through sub-centers and *Swasth Suvidha Kendra* staffed by ANM as the constrained spaces in Anganwadis are not sufficient for provision of antenatal care.

Was Voluntary Community Health Worker feasible in urban setup?

From the decade long experience of implementing the Mitanin CHW programme the common belief is that though certain communities in urban areas lack cohesiveness to allow ownership of CHW, CHW are still very much in need for preventive and promotive health work amongst the urban poor and for linking them to formal healthcare services.

Which population to cover: Should the programme cover only slums or entire populations of the cities?

While NUHM talked about providing services to the entire urban population with priority to slums, Chattisgarh decided to have an explicit focus on slums including non-recognized settlements.

Are the healthcare challenges in urban areas different?

One perception was that urban areas have poorer sanitation, HIV, lower demand of preventive services and greater demand of curative services and hence the program should focus more on these issues. The

final design was dominated by the opinion that since Chhattisgarh's urban IMR was the worst in the country the program must address primary healthcare more comprehensively.

Baseline survey in 2012: Utilization of Maternal and Child Health Services by urban slum populations

The survey was conducted in Chattisgarh by the State Health Resource Centre

Findings:

1) Urban slums were *doing better* in terms of: literacy rates, access to toilets, ARIs amongst children, Malaria and Child Malnutrition.
2) Urban slums were *worse off* in terms of: immunization, breastfeeding, diarrhea and utilization of family planning services.

Progress

Current Status of Achievements against requirements:

Percentages of the *current status (As of December 2015) to the recommended requirement*

Mitanins:- 97.089%

Mahila Arogya Samhiti (Women's Health Committee):- 95.28%

Swathya Suvidha Kendra (Sub-Centre):- 64.175%

ANM:-76.28%

Urban PHC:- 83.33%

PHC Medical Officers:- 36.11%

PHC Staff Nurses:- 54.62%

PHC Lab Technicians:- 72.22%

Mobile Units:- 100%

Reaching out to the homeless

The program has faced challenges in reaching out to the homeless population. Though Mitanins identified 3000 homeless population they could reach out to less than half of them. Attempts to link the homeless to municipal shelter facilities failed as almost all the shelters were non-functional.

Conclusion:

1) NUHM can be extremely valuable in bridging the gap of access to health for the urban poor.
2) Community processes, outreach through ANMs and strengthening formal healthcare institutions are crucial.

3) There is a threat to the Chhattisgarh Urban program due to a funds crunch
4) There is a need for the government to roll out the NUHM not just in Chhattisgarh but across all states.

Discussion:

Politics and Allocation of funding

How much is the state allocating when the policy is not passed by their party? The politics influences financing and budgets.

The Role of World Bank and USAID

Where exactly do they stand on key issues and discussions?

Niti Ayog

How are they pushing for insurance?

Initiatives by Delhi State Government: Mohalla Clinics, Nirantar Monitoring Dashboard

Mohalla Clinics:

Delhi is much better compared to many other cities and they are making arrangements to reach people in satellite cities but there are many gaps in implementation.

There is an initiative by the Delhi government to start *Aam Admi Clinics* now called *Mohalla Clinics* covering 15000 population in the *basti*s of Delhi with all modern facilities, OPD, immunization, ANC, Basic Lab Facilities and Medicines. It takes primary care to the doorsteps in these areas with one Medical Officer, Nurse, Lab Technician and Pharmacist per clinic.

The Clinics run in two shifts. The Staff can choose to come in the mornings or in the evenings so the Staff are not overworked.

Concerns: Rapid upscaling to 1000 facilities, is it pragmatic?

Nirantar:

Nirantar is a software, earlier you needed to stand in line in the OPD for an appointment now you can book your appointment in advance on your mobile. Also, the (health?) data of the people using this software is stored against their mobile numbers.

Nirantar has a monitoring dashboard which shows availability and non-availability of drugs in the inventory, it is being implemented across the state so you can check inventory across the state. If you think there is a shortage in one clinic you can acquire from another clinic that has excess stock.

Accessibility to temporary migrants

JSY Entitlement is through cheque but temporary migrants cannot access these entitlements because they cannot open a bank account as they don't have a permanent address or identity.

Why are we stuck to categorization?

What is the need to segregate Urban-Rural?

What we call healthcare in urban areas isn't restricted to the urban population when so many people are coming in from rural areas, by making this classification we miss out the entirety to meet the healthcare needs of people in any place whether it is urban or rural.

Market in Urban Healthcare

What's the Public-Private Partnership? How do they help healthcare get located? When we have too much healthcare it's not good enough because it leads to lot of misuse and malpractices. What is the number of doctors you need for a community? What kind of research is taking place to remedy the situation? If there is a number of market forces there needs to be countervailing forces or there will be no solution to existing problems. Are the policy instruments that are manipulating and regulating the market useful?

Anuj onhis experience with Interdepartmental Integration: In Surat he had a cross learning workshop. Students from the Departments of Urban Planning and Public Health had to do a study together and present their findings to the faculty. Initially it was interesting but later it was uncomfortable because of clash of ideas because each one saw issues from the perspective of their department and training.

Anuj on his Observations on Mahila Aarogya Samhiti: ASHA is a member but in many constituencies ASHAs have also become the President.

Problems he noticed at the meeting: He observed many women are sometimes more interested in gossip rather than what happens in meetings. They make their own little groups and keep chatting. There is no clarity on how the funds are utilized

Is putting funding into NHM a good idea?

There is not much happening at a policy level. 40% of NRHM was supposed to be allocated by the state and with the treasury role they are using the funds for other things.

Who makes the rules?

One who holds the gold makes the golden rules.

Contractual Agreements or Permanent Employment?

Contractual arrangements can help the efficiency of a system because once a government employee becomes a permanent employee, false security sets in and they stop working sincerely. People perform

better when they are under contract. But on the downside contracts can easily allow for exploitation at the workplace by the employer in the private setup and subvert any kind of voice of the employees.

Srivats on Urban Community:

We have to rethink what community is. How to democratize community in an urban setting?

Whether the transplanted model of NRHM will work in the urban setting depends on things like the *Mahila Arogya Samhiti.*

Aditya on Urban Health Policy in the Context of Environment:

Since we are talking about policy related to Urban Health we need to talk about two things:

1) **The Delhi Air Pollution Experiment**: Once the experiment was done there weren't enough health professionals looking into the results.
2) **The Chennai Floods:** Though doctors and public health professionals responded there needs to be a policy level reform to prevent such issues from happening in the future.

Issues in UHC:

1) No permanent doctors
2) OPD is in constant transition
3) Strikes from medical doctors and nurses
4) All policy has been centralized in the PMO office. The health ministry cannot do anything and health policy is lying in deep freeze.

Day 2:

Medical Pluralism and health care for the poor

From the existing policy's perspective AYUSH doctors are seen as quacks that need to be eliminated from the system. Legal cases for, against and about alternate practices were discussed. Informal doctors bring patients to the formal system and also provide follow up care. They have a willingness to treat.

What is the effect of these practices in Urban Areas: Veena Das

What are the policies about these practices?.

Indian medical council's laws do not allow alternate practices or cross practice but state governments allow them under exceptional conditions. The Supreme Court allows AYUSH practitioners to practice and there is a strong defense mechanism on the ground for the practitioners. There is a noted proliferation of degree granting institution to informal practitioners in Delhi and Allahabad.

The delegate's group went around and looked at the billboards of medical practitioners and conducted weekly morbidity surveys in Delhi, Allahabad, Mumbai and Patna around these practitioners.

What is the urban and rural availability of formally trained AYUSH doctors?

In Delhi they found that there are 17 doctors in a 5 minute walk, many of these have no formal training but even if they do have a formal training the quality of training varies widely because of a lack of quality control.

What happens in alternate practice? The practitioners spend about three minutes per patient. Symptomatic treatment is given by combination of pills antibiotics, vitamins and steroid unlabeled. After two to three days patients are asked to come for a follow up so there is diagnostic value in addition to therapeutic value in these practices. If you look at formal practice, biomedical doctors have more knowledge than untrained doctors but do exactly the same thing as untrained doctors. So the know do gap does not make a difference on the ground and outcomes are likely to be the same. Pharmaceuticals benefit from these practices.

Dr.Sainesh (name changed), a pharmacist who started a polyclinic with his informal training and now employs formal doctors. The surgeries were performed under unhygienic conditions. The long term implications of this staggering and formal doctors are also contributory.

Policy debate needs to take into account the large number of alternate practitioners. People in Kolkota and Andhra Pradesh are trained in the basics of Pharmacy and medicine before allowing them to practice as non-formal practitioners. Intervention needs to be more on terms of education than punishment.

Discussion:

Eagerness of Informal Doctors to expand their knowledge base:

The informal doctors trained by the delegate's group were keen and forthcoming to enhance their skills in Madhya Pradesh, similarly with traditional birth attendants. There was an eagerness to further their knowledge and skills.

Informal Doctor's role in Diagnosis and Monitoring of Tuberculosis:

Informal doctors collectedsputum in a bottle and referred positive patients to a center, the TB medicines were given to a medical store near where the patients stayed and the store used to give the medicines, this way the patients did not have to visit the hospital everyday and there was a way to track whether the treatment was being taken regularly and appropriately.

Who can tackle health issues best in underserved states?

Most of the health burden is on informal rural practitioners in places like Chattisgarh. Another key question is: Is the existing biomedical training good enough for the doctor to tackle issues in the rural setting? You can't paint all biomedical and rural practitioners in one paintbrush. There is a spectrum of skill in both which needs to be acknowledged. There is no getting away from the fact that a bulk of care will have to be handled by informal practitioners in some areas as there are no trained doctors in these areas.

Gender Inequity in Informal Practice

Other than ANMs and midwives most of the informal practitioners are male.

Penetration of Market Forces

A large number of NGOs in Maharashtra were working where the market penetration was not strong and they managed to convert these areas successfully. One would expect other actors to turn away or focus on other areas of need when an NGO or organization is doing well but 15 years later they found that the private system had really proliferated and encroached into the area they had worked with and converted.

Does the approach of this article do justice to address medical pluralism?

I am a bit disappointed about the title and the content it has put forward. Do the systems coexist or does it give a cafeteria approach? To me medical pluralism is the coexistence of alternate drugs on a prescription. This paper is all about delivery and franchising of system.

Organizations that train Informal Practitioners

In Uttar Pradesh there is an initiative called *Chikitsa* which trains untrained practitioners near the PHC or CHC for 6 months. Since the formal systems have failed to capture the practice of medicine so it makes sense to support informal practices in such a dysregulated system. The formal sector is too weak to penetrate the system.

This paper points to the chaos and problems in the Indian health system and it is disappointing.

A study of Azadabad Rasullabad Basti,Surat: Anuj

Culture is an important cross cutting determinant pervasive in all aspects of life emphasizing all values in a group. An urban slum is characterized by cultural diversity and balancing their native cultures to the cultures they are exposed to,

Azadabad Rasullabad *basti*, Surat. Surat has the highest inmigrant population in the country

Methodology:

He studied the *basti* as an External Observer with In-depth Interviews. It was Exploratory study.

Social Demography:

The migrants were from Karnataka, Andhra Pradesh, Maharashtra and were a mixture of Hindus, Muslims and Christians. Their cultural practices differed on the basis of their backgrounds.

Unique Identity within the populations

There were many informal leaders, while religious harmony existed for the most part the *basti* was dangerous during communal riots in other parts of the country.

Issues faced by people in the *basti*

1) Their daily wage was affected by monsoon
2) Long congested train travel was associated with health problems
3) People ignored health prevention because they believed diseases were the plan of god
4) Tobacco use was common between both genders
5) Gambling was common among men

Timings of private clinics suited the labourers

Cultural dimension provides important insights into disease burden

Solid Waste Management:

Solid waste is connected with health and Urban India produces 1 lakh metric tonnes per day (just collected waste), typically solid waste management is the responsibility of urban local bodies.

Primary communities: Ragpickers.

Occupational health hazards faced by rag pickers: Animal bites, Exposures to Toxins and other hazardous bio-waste, Musculoskeletal pains,

Urban local bodies, collectives and contractors connected to urban local bodies collect waste. Accumalated waste affects urban poor. Waste management happens only in the urbanized parts of the cities, in slums there would rarely be collection, The third animal emerging is where this waste is getting dumped. In Bangalore the police mobilized dumping trucks to a village to dump them. Waste disposal affects farming because the land area is affected with the dumping of waste which makes those areas unavailable to farm.

Issues encountered:

90% of the waste is through open dumping, rates of waste segregation are low, waste collectors are usually waste segregators, open dumping of waste pollutes land water and land Eg. Lalur area in Thrissur.

Who is responsible for Waste Management?

In Type 1 Mega Cities Health Officers are responsible for Public Health and the Social Determinants of Health. In Tier 2 Cities they are responsible for Social Determinants of Health and in Type 3 cities the office for health officer is found to be declining or absent leading to a disorientation of services pertaining to the provision of the Social Determinants of Health.

Constraints to managing waste purely with technology:

Technological interventions are constrained by finance. There are many technological solutions which don't really help the waste problem. Waste management needs to be context specific and there are only very few successful models in our country.

Waste governance is seen from a technological perspective and not from an equity perspective. Technical and financial support and segregation of waste are essential components.

There is a growing need to develop livable spaces for waste workers while affluent consumers discard over 20 crore phones a year as e-waste for recycling.

Sunil Nagraj: Anthony's Paper:Ensuring Entitlements and Identity of India's Poor

Slum Dwellers are treated as unwanted, undesirable and burdensome communities and are exploited every day. How do we bring about legitimacy to their existence to these internally dislocated populations?

The first step is to get people living in slums access to these basic documents:

1) Birth Certificates for the newborns
2) Voter ID for the older people
3) Aadhar Card
4) BPL Card
5) Caste Certificate

They require support in terms of filling up various forms, opening a bank account and help with savings and financial planning. We need to walk the extra mile and reach the unreached.

Approach Discussed:

Community groups need to be given information and education about these documents and be empowered with leadership to successfully seek their identity and entitlements. After mapping the habitation of urban poor and mapping out the resource centers, crime mapping needs to be done in collaboration with municipal groups and police. This needs to become a part of the national heath mission.

Discussion:

Portability of Identity

How to make it feasible for genuine cases?Also, If someone comes from a BPL family in his home state and he migrates and becomes well-off does he become a BPL? should he become a BPL just because he comes from a BPL household?

Awareness Campaigns In Mallapuram, Palghat

K.R.Anthony brought out a booklet which maps all the facilities, timings, and how to get access to 145 schemes related to health.

Stigmatization of Rag-pickers

Who is responsible for people in the slums? whose responsibility are people in slums? In ghettoized areas in Delhi even if people have a formal identity card just their identity of being a rag picker creates barriers.

What the identity system does is to say that if you don't have a property you are not deserving of living a life of dignity. What is the need of identity if these facilities and services were universal? It would break down boundaries and barriers.

Urbanization and Cardiovascular Risk: Moving forward from Framingham: Anand Zachariah

Presented by: Dr.Yogesh Jain

The cardiovascular epidemic in India is affecting particularly the urban towns in India. Epidemiological data shows that poorer communities are being particularly affected with increasing number of risk factors. (Kavita Singh, 2015). The focus of cardiovascular preventin in western countries has been individualized prevention based on screening, drug management of hypercholesterolemias, diabetes and hypertension and non-pharmacological management through diet, weight reduction and exercises.

In western countries a significant proportion of the entire population is on anti-hypertensives and statin therapy. The paper presumes heart diseases and Diabetes are more common in the urban scenario due to lifestyle.

The major four Chronic Diseases are:

1) Heart Diseases
2) Diabetes
3) Cancers
4) Mental Health Disorders

Other commonly occurring Chronic Diseases:

1) Sickle Cell
2) Thallassemia
3) Arthritis

Risk Factors:

Risk factors are chalked up from longitudinal cohort studies like the Framingham Studies, a small group of adults were followed for years on end until they died. The study started in the 1950s. This has become a milestone in the macro-epidemiology to find out the social determinants of chronic diseases.

The four measurable risk factors expressed by the body in the study:

Physical Indicators:

BMI

Blood Pressure

Blood Parameters:

Blood Sugars

Lipids

On the basis of these parameters they linked associationswith full blown diseases like Diabetes, Kidney diseases, Cardiovascular Illnesses and Neurovascular Diseases. This paved the way for epidemiological studies and intervention at an individual level.

Unfavourable Trends:

This study allowed not only the attribution of risk factor at an individual level but allowed some other changes at a macro socio-economic-political level. Over the last thirty years the cut offs for the various diseases have been coming down and new entities in risk factors like pre-hypertension and pre-diabetic are being used widely professionally in the economic interests of propagating illness.

Anand: The science of epidemiology cannot be faulted and blamed for what has happened with the management strategies of chronic diseases but it's rather its the political economy that has led it to become this way.

Any illness has to be studied in 3 levels by Individual Health Care Workers and Public Health Professionals:

1. Cellular or individual level – biomedically find out and intervene
2. Community Level
3. How Power Relations and the Basic Determinants of Diseases play out through resource allocation – the political economy of health

Ravi Duggal: Inequities in Healthcare in Mumbai

Private sector is unregulated. Mumbai's nursing home registration act was not implemented properly. The Primary and Secondary Care Centres are dirty and ill-maintained. Tertiary Care Centres are overloaded.

Challenges:

Just by living in an urban area one doesn't get access to health systems due to lack of coordinated public health activities and referrals. Social Exclusion reduces access. Lack of economic resources prevents people from accessing private facilities.

Challenges in Health care Delivery in Kerala:

Though Kerala is one of the best performing states in India, the health delivery system is not sufficient in the urban area, the state is in an urban-rural continuum. Migrant populations are not covered by healthcare. Urban poor have a poor coverage.

An effective primary care system may lead to reduced NCDs and out of pocket expenditures.NRHM supported urban areas through various means through funding support and strengthening district and block level hospitals. NUHM is to ensure that people living in districts and unregistered slums got health education, sanitation and clean drinking water

Problems with Health Infrastructure:

1) Absence of sufficient Urban Health Centres and effectively functioning Sub Centers
2) Top-down approach of Healthcare service delivery
3) Lack of converging mechanism and inter-sectoral coordination:Both the health service department and the municipal staff work without coordination and convergence.
4) Lack of community involvement
5) Lack of information and social exclusion prevents people from accessing care
6) Problems with reporting of data: Data is often inaccurate and true data is invisible.

Solution: A Technical Group for monitoring programs will help

Staff Allocation:

The NRHM tried to post junior public nurses now posted under NUHM as well. Posting of staff is on contractual position

Addressing health inequities through community-led advocacy in Bangalore- Experiences, successes and challenges: Sudha Nagavarapu

The paper is about the attempt by a group called SPAD through interface meetings there have been some results, abuse of Dalit women and Muslim women has reduced at the slum level and they have been able to improve some Social Determinants of Health. Some BBMP officials have become hostile to SPAD activists and are unlikely to investigate the matters being raised by the group.

Problems in Bangalore:

The major concerns with regards to healthcare are: Fragmentation, out of pocket expenditure, poor staffing and underequipped centers. In addition the NUHM has no clarity about where the medicines for NCDs will come from. There are challenges in building capacity on health issues and in overcoming adversarial relationships between hospital and community. This can lead to amplification of pre-existing problems.

Conclusions reached:

The challenge is to build effective partnerships between Confounders.
The Private sector is perceived as Dominant, visible, clean, efficient, friendly and everyone except the poor have abandoned the public system.

Problems in Mumbai:
Municipal Corporation Hospitals have *Dakshata samhitis* , there is regular political interference, there is violence against doctors in hospitals. Hospitals are often under the media scanner.

In response the Clinical Establishment Act and a Rights based approach (JAA/NHRC hearings) were discussed.

Sterilization Deaths in Chattisgarh:

Background:

In November 2014, in sterilization camps conducted in a particular block in Bilaspur 13 women died and this created a furor in India and abroad. In response, Civil Society, Media and The Human Rights Commission intervened. The Panelists shared their experiences within the judicial enquiry proceedings. The women who were hospitalized were given a compensation of 40,000 rupees with free follow up at Apollo Hospitals, the biggest tertiary care hospital in Bilaspur. To date women who attended these camps are facingphysical problems and issues waist down and are not able to participate in wage labour. They were reluctant to go to the hospital because it was a larger hospital and they were not sure if they would get free services, so they have been going to private and informal practitioners and have been paying out of pocket. There has been no formal system of ensuring the families are rehabilitated other than the WCD monitoring and ensuring that their children are going to the anganwadi. Most of the men have remarried in the last one year, there is no institutional mechanisms to give special support or services to their children. The Judicial Commission setup was a single judge judicial commissionand there was a lot of conflict of interest surrounding her appointment. The presenter, a women's rights activist from Bilaspurdirectly involved with the proceedings says the judge had very little awareness of what was going on, on the ground and that she made regressive recommendations in the Judicial

Commission Report. She addedthat there was no epidemiological enquiry into the death.Now, by government policy, only where there is a surgeon stationed will there be fixed day services.

Women are being told to go to the private sector with the RSBY card to access sterilization.

Report Findings:

All standard operating rules in these cases had been flouted.The Supreme Court wanted a Quality Assurance Committee at the District Level and State Level. In the Anita Jha report in atleast 6-7 instances she says there was a target for sterilization of women in Bilaspur District, She herself calculated that it was not possible for the 3 qualified people in the district to meet those targets, so a target based approach at the policy level contributed to the deaths.Men were not approached on spacing methods rather than Sterilization.Parallels can be made with the Bhopal Gas Disaster where the government made no effort to track the victims to redress and remedy the issues caused by the incident.How does the state approach the problems of accountability with this Amnesia?

Dr.Yogesh Jain:

We are forced to do 4-6 tubal ligations a day in a week because of the completely non-functional system, denial of care is a problem. Whether it was infection or faulty drugs that caused some of these issues is slowly fading away from the memory of people. I think infection is the more plausible reason and the drug argument was only to distract and hoodwink people by the drug lobby to win people over to their brands as they could be made to look safer.

Offering sterilization to women of PVTG Particularly Vulnerable Tribal Groups: Why was sterilization offered only to women?

Women's sterilization failure is very common where there is a poor quality of sterilization. When there is sterilization failure in men there is a huge uproar due to social cultural issues, so usually women choose to get sterilized to avoid this.

Myths on the Ground:

There needs to be a focus on clearing myths that exist on the ground in the community of fears of impotence andpoisonous drugs.

Camp Watches: SAHYOG

As Civil Society's initiative SAHYOG hasstarted camp watches, in 2014 they had a public hearing with regards to these deaths.

Dr.Binayak Sen: Atrocities in Bastar

He spoke about incidents and Activists in the Bastar area, in particular about lawyers working in Jaddarpur as a part of Jaddarpur Legal Aid Group. He quotes the example of an individualanonymized in

his report who was previously working with Red Cross Hospital shut down by Chattisgarh Government who shifted to Jaddarpur to write about issues in Bastar as a journalist, inviting the noticeof the government and the police.Dr.Sen says the people carrying out the violence in Bastar are often out of uniform and we don't know who they are. The situation is dangerous and tense not just for the activists but also for the people in the villages. Women's rights activists have gone into these villages and have presented a letter which Dr.Sen read out to the gathering. Sexual violence is a part of violence by paramilitary forces in various parts of Bastar, Prof.Elina Sen made a report to The Justice Verma Commission.

Discussions:

Shall we support these letters when the PM comes to Raipur soon after the mfc meeting? Shall we draft a new letter so it doesn't look like the same voice is arriving from a different source and put more pressure on that voice? Are there any strategies to involve the media?

Rohit Vemula: A Tragic Exit from Social Death and the Movement After

Gopal Guru, Anveshi

How do you transform the mindset of people that perpetuate discriminatory violence? How do you transform the victim's mindsets?

There is a National Campaign for Human Rights and Dalits play an important role in providing social support and academic empowerment in hostels so their roles must be acknowledged as equal to other castes. Ambedkar's thinking was urbanization leads to greater liberalism but what happens in reality is that there is an urban-rural continuum and there is a cultural lag even if there is urbanization.

The Anveshi paper ends with three implications on the politics of health.

1) The struggle against individualizing and psychiatricizing such suicides as personal and psychological flaws and advocacy towards a culturally rooted psychiatry that is aware of and actively engages with social discrimination.
2) The addressal of general problems in social health that arise in the tide of urbanization and migration to the cities. Many forms of morbidity and mortality, not only related to mental distress occur in relation to a deeper structure of social discrimination that perpetuates itself in modern urbanizing India. Medicine needs to find ways to understandand theorize thesocial determinants of discrimination in the pattern and scale of morbidity that characterize Indian populations.
3) Medical activists with a social conscience and political commitment must pay special attention to the political and administrative struggles of embattled students in medical and allied institutions and exert pressures to change the academic culture and administrative vironment. Activists also need to make a special effort to understand the larger political perspective and the context of the student's struggles so they can effectively support the students and help them cope with the social pressures they face.

It is such students who will develop a way of thinking about healthcare that takes into account the larger frames of distress in contemporary times.

Srivats:

There needs to be a strong political will and strength to change treating this incident as a kind of medicalized, individualized, psychological issue. Groups like MFC and JSA need to become way more proactive in raising these issues.

Swasthya Swaraj:Orissa

Learnings and Reflections:

Our trip to Orissa opened my eyes to the realities of rural and tribal parts of Malaria Endemic Orissa. The gravity of the word inequity stared us in the face as we came out of our CHLP classrooms to examine and experience first hand one of the most gross examples in the world in our own country.

At the TB clinic we learnt that giving medications and explaining them well isn't enough and there is a need to follow up hospital treatments with a social worker to check for compliance in the community regularly. Compliance is extremely poor in these areas even if people come to clinics, in a study conducted by a fellow traveller only 1 in 8 people he surveyed had complied to treatment.

My experience with Swasthya Swaraj oriented me on what it is to run outreach programs in remote areas, who are the key people to coordinate, how to account for medicines and equipment, and how to follow up with the implementers in the team. We also got a first hand view of the consequences of not following through with responsible people and how important discipline is in a team in order for each day of the program to be successful.

Anthropometry in Under-5 Clinics

Checklist for Outreach Programs:

Under-5 Clinics

1)Banner

2) Health Education Posters, hangers, thread and clips

3) Adult Weighing Scale

4) Salter Scale For Babies

5) Stadiometer

6) MUAC Belts

7) Infantometer

8) BP Apparatus

9) Thermometer

10) Physical Examination Set

11) Surgical Trays

12) Torches

13) Magnifying Glasses

14) PV/PR Trays

15) Gloves

16) C&D Tray

Checklist For the Registration Counter:

1) ANC Cards
2) Under-5 Cards
3) General OP Registration Cards
4) OP Tickets
5) TB Cards
6) OP Registers
7) Tally Sheet for Survey and Documentation

Checklist for Outreach Laboratory:

1) Microscope
2) Hb-CuSo4 Method
3) Spirit Lamps, Test Tubes and Test Tube Holders for Urine Albumin
4) RDT Kits
5) PS and MP Slides

Checklist for Medicine Kits:

1) Inj.TT
2) Inj. Iron,
3) Tab.IFA
4) Calcium
5) Anti-Malarials
6) Paracetamol
7) B-Complex
8) Vitamin A
9) Albendazole
10) Antibiotics
11) ITNs (Insecticide Treated Bednets) for Pregnant Women
12) Safe Delivery Kits

Checklist for Health Awareness Campaigns through Media:

1) Generator
2) Projector
3) Laptop

4) Interesting, Relevant and Palatable Audiovisual Material

Role Of Community Health Workers:

1) Checking BP, MUAC, Hb by CuSo4 Method, Urine Albumin, Physical Exam of Antenatal Cases, Health Education Through skits and talks
2) Follow up of Cases for Compliance and Health Education after the camps.

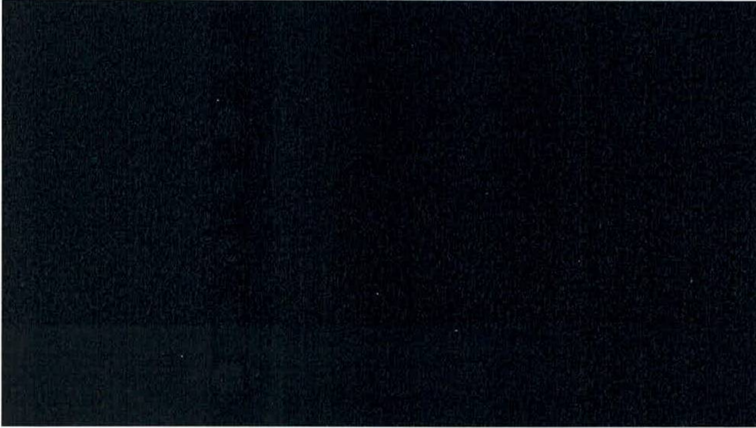
We learnt how to conduct outreach programs and Under 5 Clinics about the checklists required while conducting programs and the importance of regular follow up before the days of the program with the health workers responsible for execution of the program. We learnt how to account for medication after each day of clinic, how to prepare dispensing pouches with old newspapers but most importantly I had my first experience of a Focus Group Discussion on Health seeking behaviours of people in the region and this served me well as a primer to the Qualitative Analysis Workshop I attended soon after our return from Orissa.

Bare Necessities:

I learnt that life can be extremely pleasurable and fullfilling with the bare necessities and that all we need to live is a good purpose, a shelter, a clean source of drinking water, some food and good company.

Bathing and Washing in Kandhelguda

Solar Equipment is required to power outreach Programs:

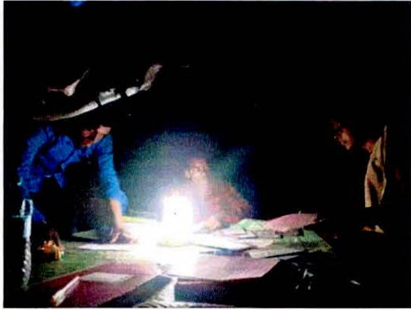


Since Open Defecation it is the only option it is advisable to carry a flash light or phone at night. Only, theres no electricity to charge the battery so come equipped with solar flashlights.

Abandoned Buildings make for Great Clinics and Overnight Resthouses:

Malaria and Under-5 Clinic in Kandhelguda, Rampura Taluk

The final Under-5 clinic of the week was conducted in Kandhelguda and was conducted in an abandoned school since the highest educated person in the village was a 3rd standard dropout and there was nobody available with the skills to teach the school lies abandoned and works as a makeshift hospital. We slept in the classrooms and conducted the clinic in the corridors. Schools have been a recurring theme in my journey and abandoned schools are capable of serving as good a purpose as a normal functional school.

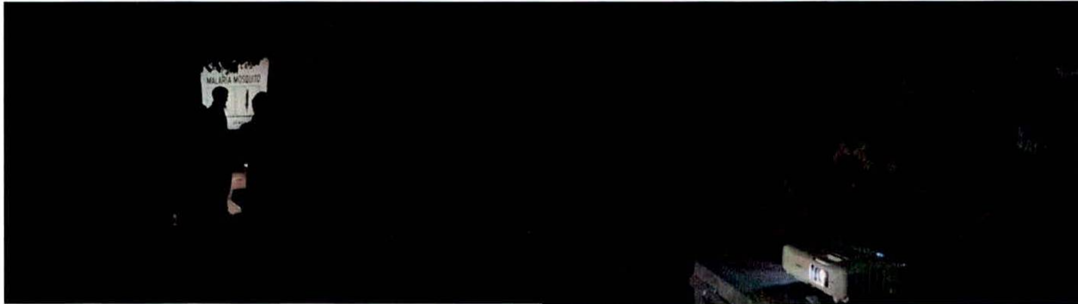


ANC and Under-5 Clinic in Silet at Midday: Solar Powered Lamps Charged the previous day power the clinic through the day. The communities are kind enough to lend us a home to conduct clinic, FGDs and Health Awareness Programs for Malaria.

Problems with Accessibility:

There are problems with accessibility not just with regards to access to healthcare but also with access to benefits being handed out by the government to the poor. There are difficulties with accessibility not just to patients but also to the doctors, nurses and health workers. Along with 4x4 Jeeps, talented drivers are needed to navigate the terrain. Equipment and passengers have to disembark on particularly difficult sections and vehicles have to be changed at sections inaccessible by 2x4 vehicles.

Cinema In Kalahandi: Curiosity and Flexibility of thePeople



There was a screening of a health awareness video on Malaria Mosquito, this was the first time I saw people from an entire bunch of villages around where a camp was conducted gather around a projector, the only source of light at night so happily to watch a rather dated visual experience of Malaria in English though they didn't understand a word. *Are there no movies in Odiya about Malaria?*

Kalahandi: A Window Into Blackness

Our trip to unreached villages in Kalahandi, Orissa with a group of friends from CHLP made me think about poverty. What is poverty? Can we limit it to exclusion through the scarcity of the quantifiable materials and services or should it include exclusion through absence of the unquantifiable, love, care, trust, respect, peace, hope and human values?

If you or I were to live neglected and forgotten lives in the darkness of a drought hit Kalahandi, in the rubble of a crumbled public education and health system, with little food, barely clothed, alien to the concept of electricity, ventilation or a world where open defecation isn't the norm, where the most enjoyable luxury is sometimes but not alwaysone clean source of drinking water that the entire village has to share, deprived of the right to read or write because you were deprived of the right to learn, deprived of the right to know that the money being allocated to your survival is dwindling or pilfered while people outside your world are being made to believe you are being helped, wouldn't you be satisfied with the prospect of dying to malaria while you are sipping a bottle of *mahua*because you have nothing to lose?

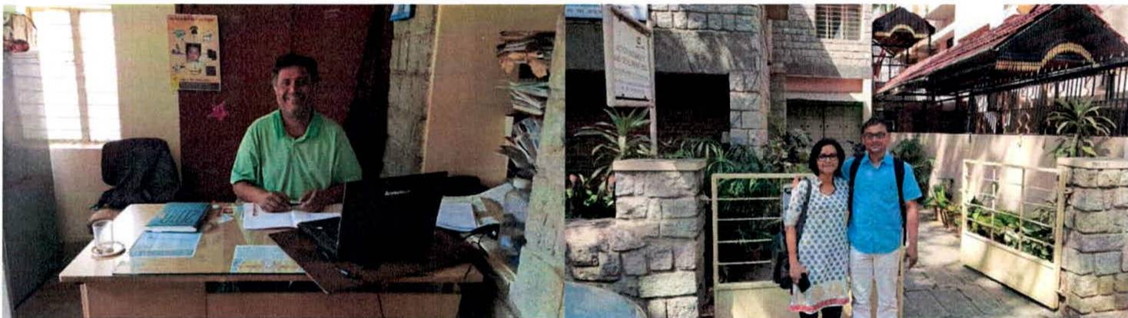
Once a month, 35 kilograms of rice is supposed to be handed out through PDS, even if we assume PDS is implemented perfectly, after distributing to the family, does the nutritional value break even with the nutritional losses of walking 30 to 40 kilometers barefoot on hot unpaved paths strewn with stones under the searing sun, crossing atleast a few rivers, some with no bridges, standing in line and then walking back carrying 35 kilograms of rice on the head across impossible terrain for the family? What is the energy and strength keeping these people alive if they don't have enough to eat? Is it a physical energy or beyond?

Malaria and Malnutrition were rampant. Of the 80 children who came to the clinic in just two villages, *Silet* and *Kadhelguda*- 62 had malaria. Not just the human beings, even the goats, cows, dogs and chickens in the villages looked underfed. Hunger prevails here to the extent that every time we stood or sat outside the homes or abandoned schools where the clinics were conducted, to serve food to the people in the village or to eat our lunch or dinner, we would always be accompanied and surrounded by hungry animals and they would sometimes fight with each other in the irritability of hunger.

I leave Orissa wondering what gives the people here the energy to carry their loved ones on their shoulders dying of a serious disease or going into labour for hours on paths across rough terrain and rivers, come sun, rain or darkness, what gives them the energy to walk back and face their families when they die on their shoulder?

This article is a tribute to Dr. Aquinus and the team of dedicated nurses and health workers of Swasthya Swaraj who have selflessly and tirelessly sacrificed their lives and comforts to quietly and persistently, through their passionate commitment spread their message of love, care, trust and hope through health and care to the unreached villages in Orissa.

Action on Disability and Development India



Interview with Mr.Ranganatha.N.V, Senior Program Coordinator, A.D.D, India

Contact: 9742831187

ranganathaddindia@gmail.com

Facilitated by: Dr.Ravi Narayan, Mr.Kumar.K.J, Dr.Thelma Narayan

Introduction

The Founder and President of Action on Disability and Development Mr.B.Venkatesh is visually impaired, He was instrumental in starting both A.D.D India and Basic Needs India.

A.D.D Organizes 2 training programs in association with Bethany Society, it used to be a 40 day training program, the program is now reduced to 20 days, divided into 4 phases of which currently 2 phases are completed in the current cycle as of 1st March 2016.

ADD has been working for over 25 year, empowering people with disabilities and enabling them to access their rights. They mainly focus on Capacity building - Training people with Disabilities and training personnel from various organizations, they produce Audio Visual Materials, Posters, Booklets and CDs in various languages (Hindi, South Indian Languages and English).

They can help blind people live a near normal life once they are oriented to some basic skills. The people with other disabilities are very difficult to rehabilitate to normal life. Mr.Ranganatha says that it is not the person who is disabled who is disabled or impaired, but the systems and people that are impaired to adjust and cater to a disabled person's needs to function normally in society.

Vision:

ADD India has a vision of a world where all persons with disability enjoy their rights and are able to participate as fully as they choose to at every level in the society.

Mission:

ADD India's Mission is to enhance the quality of life of persons with disability by their inclusion and participation in the development process,

This can be done by:

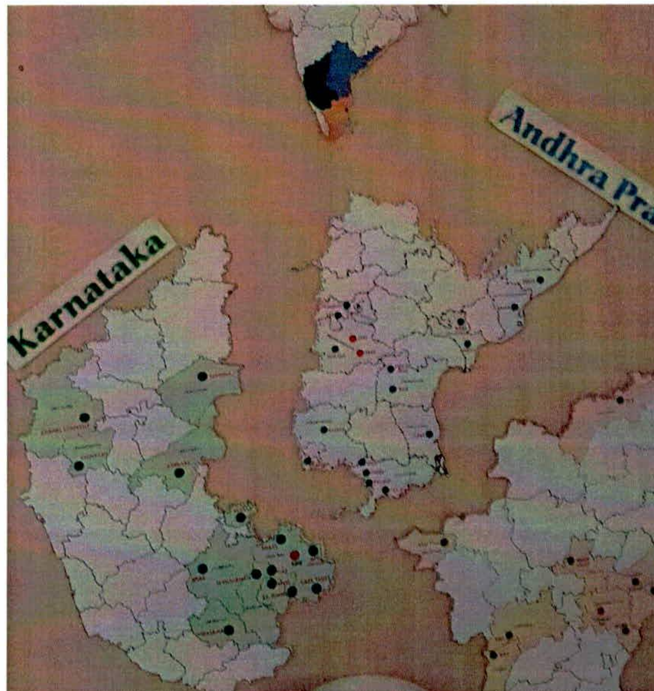
1) Addressing their rehabilitation needs, advocacy and empowerment
2) Facilitating organization of Disabled persons and strengthening their capacity to advocate for the social, economic and political rights
3) Being a resource and training agency to build the capacity of local NGOs to include disabled persons in their developmental activities

4) Paying particular attention to situations of disabled women and children as they are among the discriminated and marginalized sector in society.

Focus:

1) Building the Capacities of The Sanghas
2) The Focus is on Community Mental Health
3) Accessing Services through Networking
4) Communication and Awareness raising
5) Advocacy and Inclusion Policies
6) Training, Resource and Support

Direct Intervention Programs& Partner Areas:



A.D.D mainly works in South India, more recently, 4 years back A.D.D went to Orissa in areas in and around Koraput, Palakmundi (Gajapathi) and Baleshewar, there they are associated with 4 partners who are grass root development organizations. They aren't a funding organization. They Promote Direct Intervention Programs in Target areas in Andhra Pradesh, Karnataka and Tamil Nadu, They start SHGs, train people and hand over the program to them.

They mainly work in rural areas because the need is more and most NGOs aren't working there, They have around 30 partners in South India. Their partners are also mainly from the rural areas for implementation of programs, they have partners in the Urban areas as well but mainly for networking and training.

Sustainability:

The Groups that are trained may not work as they were trained but may modify to adapt to the issues and needs at hand. They give the groups some Financial Support and Technical Support. They also make Audio Visual Materials, Posters, Booklets and CDs in various languages (Hindi, South Indian Languages and English)

Laws Defining and Dealing with Disabilities:

1912 Lunacy Act, Renamed in 1987 as The Mental Health Act- Purely deals with Mental Health

Protects Legally people with mental health in the spheres of health, social inclusion, family life and property. By the Act, the Person is identified and immediately referred to treatment, even if the patient is destitute, the responsibility falls on Civil Society to seek help for the individual.

Rehabilitation Council of India Act 1992

The main purpose of this law is to build capacity and provide human resources especially in the sectors of Education and Vocational Training for the Disabled. The Act also has a provision on orienting Doctors, Lawyers, Teachers and other professionals to the sector and its needs.

Persons with Disabilities Act 1995

The Act has three components: Equal Opportunities, Protection of Rights and Full Participation of the Disabled.

Main purpose of the Act is to bring people with disabilities to the mainstream.

National Trust Act 1999

Focuses only on 4 Disabilities:

Autism, Mental Retardation, Cerebral Palsy and Multiple Disabilities

The Disabilities that A.D.D mainly deals with:

The SHGs consist of people with Cross Disabilities including people with:

1) Blindness
2) Low Vision
3) Locomotor Problems
4) Mental Retardation
5) Mentally Ill
6) Leprosy
7) Speech and Hearing Impairments
8) Autism
9) Cerebral Palsy
10) Multiple Disabilities

A mixture of people with more than one of the above disabilities is defined as a group with cross disabilities.

The Stigma Of Mental Illness

The stigmas associated with disabilities have reduced- beliefs among the disabled- that they are useless, need to be discarded or kept aside have reduced significantly.

Some people still believe in *Karma,* slowly, people are beginning to integrate biomedical reasoning to the answers to their questions but are sometimes left wondering why these things happened to them.

Approach in a New Place:

Representatives from A.D.D go to the Village Headman, Panchayat President, the Panchayat and Key People in the Village. Until today nobody has refused them when they have approached people in the Panchayat to help people with Disabilities because these groups and people don't know how to deal with people with Disabilities though they have answers and solutions to other developmental issues.

Training:

Dissemination of Skills

Route of Dissemination: RCI- Rehabilitation Council of India conducts more than 150 programs for different groups of people and professionals to produce professional competencies in the sphere of disability, Professionals disseminate knowledge to Semi Professionals, Semi Professionals to Parents.

Training Programs:

There are 4 Phases of training.

Each Phase of the Training Program is 10 days long, they train people in:

1) The Identification of Disability, Prevention, and Rehabilitation
2) Long-Term Management of Disability
3) Formation of Groups, Federation
4) Personality Development
5) Inner Learning
6) Local Administration
7) Disability Rights and Entitlements: Health, Education, Livelihood, Social and Empowerment

People who Help with Implementation on the Ground:

1) Anganwadi
2) Anganwadi Worker
3) Aiyahs

4) ASHAs
5) MRWs
6) VRWs
7) ANMs
8) Teachers in School

If one can link all the above people through one person they can easily work in these areas. If they don't get physiotherapists they mobilize from NGOs or organizations nearby, also they can train people for 6 months or 1 year to do follow up work but these people cannot plan activities. Skills are also disseminated to parents who take care of the disabled at home. DRC (District Rehabilitation Center in some areas) Cover entire districts.

DRC Professionals:

Physiotherapists

Speech Therapists

Occupational Therapists

Orientation and Mobility Instructors (ONM)

Special Educators for Mental Retardation

Monitoring:

They go to the field on surprise visits regularly and assess the competence of the trained people and their implementation, They check whether the trained people are giving the right inputs to parents, They monitor the files and the plan of action for each child and follow up with whether the plan of action is being implemented as per schedule, They check for compliance to the plan of action by the entire team.

They monitor if they are receiving interventions, instruments and entitlements in a timely, appropriate way.

With the Hearing Impaired: They check if the hearing aids are functioning are not, whether the instrument is switched on and if the volume is appropriate, if battery replacement is necessary or not.

With the Visually impaired: They check If they are guiding themselves i.e. whether the disabled person is adept with caning techniques to navigate themselves(through observation), whether the person is independent in day to day functioning and if they have any Health problems. Health problems are referred to doctors.

They check if follow up is being done properly, Cross Check with Teachers, Parents and Care-takers

Monitoring activities are tied up with motivation and guidance to workers on the field.

Frequency of Monitoring:

If it is their direct intervention program they visit every week or every once in 2 weeks, if it is with a partner located in a remote area they visit once in 6 months and coordinate as per the convenience of the partner by request.

Funding and Networks:

Financial Resources come from The Ministry of Social Justice and Empowerment

CBR Forum (Community Based Rehabilitation Forum): CBR Foundation is the Funding organizer working across the country. Bethany in the North East, Sanchar in the North and ADD India in South is part of the network responsible for training staff of their organization

Every 6 months a plan is prepared with a dialogue between the 3 implementing organizations (Training Agencies) and a budget is allocated by the CBR Foundation.

CBR Monitoring tools:

1) Case Files
2) Each Staff needs to carry a diary and you need to cross check what they did everyday
3) Travelling Bills are also a good monitoring tool
4) If the project is big sector-wise meetings are called for and a review meeting is required at least once a month, these meetings are important for planning at the project level.

A few Examples and Success Stories:

Bathina Arunada is a 10 year old boy with Cerebral Palsy from East Godhavari District, Andhra Pradesh. He and his family have been trained by ADD India. He is able to perform his Daily Activities and studies in the 5th Standard at a Regular School.

Pallavi Aged 9, suffers from Cerebral Palsy. The Home Based Education Program (HBE Program) is implemented by ADD India at Sidilghatta Taluk, Karnataka. Under this Program 60 children with disabilities get regular support. Home Based Education helps in transferring Activities of Daily Living Skills (ADLS) to parents and care-givers for better care of their children.

Nagarathna aged 24 years with Visual Impairment is a member of Sevasadan Karnataka. She was given a loan of Rs.5000 for fruit rearing from ADD India. Her Father helps her with this activity, now she is able to manage her life through this income.

Workshop on Qualitative Research

Reflections:

Research is not just an academic search but a contribution to the growth and prosperity of society. It is also a way to know one's own self better. Research today faces the crisis of outsourcing. Research in the social sciences is gradually being outsourced to firms, students or unemployed people and subject to market forces which demands more quantitative research than qualitative research. Once research is outsourced often the meaning of the research is lost as the firm conducting the analysis may not be the firm producing the thesis and neither of these maybe directly involved, investedor interested in investigating the issue at hand.

The theme of qualitative research is a year-long program in many universities and we have been oriented to it through this phenomenal workshop at Kristu Jayanti College in 2 days. There has been an fortunate separation of quantitative and qualitative research when both are important. When people are using one of the two methods they have the tendency to switch off their minds to the contralateral component when infact, Qualitative and Quantitative research have to speak to each other. There can only be a qualitative research of quality if there is a consideration of quantities.

Quantitative research has a spread of data but Qualitative Research lends depth to the spread. Qualitative research goes above, beyond, between and behind the responses and data. But in the real world it is always important to quantify qualitative statements to qualify them.

Qualitative methods can help you as a social worker, as a human being and as a doctor because it helps understand reasons, motivations and underlying factors in any scenario. It helps provide importance and organization to the artistic and social aspects of biomedicine, humanity, social work and justice. It helps lend organization to thought and to emotion, to the spoken and the unspoken. Qualitative research and

advocacy can help you clarify fuzzy scenarios into buzzy scenarios. It asks appropriate hows and whys keeping in mind the well-being and welfare of society.

Nice Quotations to randomize this report:

Appreciations can change a day or change a life. Feeling gratitude and not expressing it is like wrapping a gift and not giving it. Love and gratitude are the two most powerful emotions in universal creation so I want to thank Kristu Jayanti College and SOCHARA for giving me the opportunity to learn about qualitative research and broadening my personal and professional horizons through this program.

Learnings:

The workshop on Qualitative Analysis gave us an overview on Qualitative Research and also equipped us better to observe and experience events, to conduct interviews, meetings and focus group discussions and analyze these experiences after. The workshop gave me an idea of the tools used to arrive at hypothesis for new research, the tools used to arrive at results and how to check for authenticity of data in a system. Since the researcher is the tool in Qualitative analysis the workshop also helped us reflect and develop our interpersonal skills, which is the keystone to a successful qualitative research.

In order to observe and learn we need to know our objective categorically well or else we will come back flooded with excess baggage and more than what's necessary, we need to have a clear vision of what we wish to observe and have clear boundaries about where to stop to bind our research well. While we are observing we need to keep in mind two things What am I observing? and Who am I observing? The usual ethic is to become a participant in the group and inform people in the group that you will be observing them before starting your practice rather than be a voyeur looking at people without their knowledge and consent.

A preliminary observation of the field setting which we are going to be observing is required in as much detail as possible so that we can identify parameters to observe. Building a rapport with people requires empathy to be one amongst them so that they are one amongst you.

How to become a part of their landscape and gain acceptance:

In the Indian context and the human context collective learning starts with collective eating.Eat and drink their food with them, never ever turn down a glass of water or a cup of tea, Address women as they would be addressed locally i.e*akka, amma, didi or ma* and make extra time and space with elders to make them feel respected.

In order to become a part of their landscape we need to learn the spoken language and unspoken mannerisms and invest efforts to remember every single name to give people their identity. While doing so we must be careful not to add extra respect i.e call people as they are called by the others and be prepared to be called the same. Apart from language and mannerisms we need to be sensitive to the cultural norms locally at the place of study. Cultivating this sensitivity would also help us avoid taking

anything for granted. Anything spoken or unspoken, seen or unseen may be relevant, important or key to our findings.

A few important takeaways:

1) Know your capabilities
2) Allow your imagination to take a free ride but see that it stays in the orbit of your objective
3) Local explanations of local phenomena are important
4) No data can speak for itself, you need to make the data speak.

Interviews:Dr.G.V.Karanth

An interview can be:

1) Structured or
2) Unstructured

The sequence of questions will remain the same.

Precautions and Approach:

In your interview guide keep enough space for answers that may come up and questions and matters you never thought of, also be prepared for answers you were unprepared for and for unprepared answers, we may need some sensitivities in the matters being discussed to develop unprepared answers further. Write notes in a way that it makes sense to you at the end of the survey and study. Don't allow data to hang itself and become orphaned. Stay relevant and diplomatic through your interview.

How to elicit fluent, deep responses:

If something is not clear it is always wise to go back and ask, probe and tease out the data. Structure questions to elicit depth and keep the interviewee at ease at all times with your body language, your tone of voice and your personal investment.

PERSPECTIVE BUILDING
&
PHILOSOPHY OF QUALITATIVE RESEARCH

Dr. C.M.J. BOSCO

Principal

HOLY CROSS ARTS & SCIENCE COLLEGE FOR WOMEN

TIRUPATTUR 635 602

QUALITATIVE RESEARCH:

Qualitative Research is a group of methods dealing withNon Numeric, Textual data which after being

analyzedproperly leads to Authentic conclusions.

Similarities between Qualitative and Quantitative Research:

Both Qualitative and Quantitative methods are Empirical, Both methods are scientific and systematic, Both these methods can solve research problems, Both follow a similar procedure and both are used by researchers to add knowledge to the areas under study.

Differences between Qualitative Research and Quantitative Research

Qualitative Research	Quantitative Research
Not Controlled	**Highly Controlled**
Open system approach	**Closed system approach**
Description of a Dynamic Reality	**Measurement of a Stable Reality**
Researcher is the tool	**Standardized tools are used**
Gives an Inside View on matters	**Gives an Outside View on matters**
Looks For Explanations	**Looks For Predictions**
Gives hypotheses	**Starts with a hypothesis**

Possible Combinations of qualitative and quantitative:

1. Start with Qualitative and end with Quantitative

2. Start with Quantitative and end with Qualitative

3. From the beginning Qualitative and Quantitative research is planned side by side until the goals are achieved

Qualitative Research: Needs and Requirements

In Qualitative Research Face to face contact is needed coupled with good observation skills. The Researcher should have a good vocabulary and be capable of describing events which are difficult to measure.

Qualitative Research allows empathetic understanding. It never disturbs natural events and is based on triangulation.

Uses of Qualitative Research

- Sociology and Cultural studies
- Social work intervention studies
- Clinical settings

- Anthropology studies
- Pilot studies
- Autobiographies
- Evaluation studies
- Psychology
- Used in all scenarios where measurement is not possible or measurements are invalid

Qualitative Research Data Collection

Researcher is the tool of data collection through participant observation and non-participant observation,In-depth interviews and collection of artifacts.

Three Key People in Data Collection

Gate Keepers: These are the authorizing bodies in the field. Permission is given by these people to conduct research.

Key Informant : This person is the friend of the Researcher and helps to collect data.

Study Participants: These people provide data for Qualitative Research.

Records to be maintained in qualitative research

1. Field Log or Field work Note book
2. Descriptive Notes
3. Analytic Notes
4. Video Records
5. Photo Records
6. Documentary Records or Artifacts

Sources of subjectivity

Due to a researcher's identity his/her self is expressed through research. Alternatively, The researcher may seek justice during research or the Researcher may express subjectivity due to his community's influence or due to other personal interests.

Inanticipation of other's reactions subjectivity may be expressed. Subjectivity can also express itself due to personal relationships.

Ethical aspects of qualitative research

Ethical guidelines have been dealt in depth in the CEHAT ethical guidelines, I will just highlight a few key points which were important in this report.

- Protection of Study participants
- Respecting the dignity & privacy of study participants
- Objective of research is to be informed to the participants
- Right of stakeholders to remain anonymous must be respected at all times
- Pseudonyms can be used for confidentiality
- Study Participants may be remunerated properly for their time and efforts to contribute data

RISK INVOLVED IN QUALITATIVE RESEARCH

- Losing control of Emotions and Emotional Bracketing
- Physical risks in isolated places
- Emotional involvement with the study participants
- Witnessing dangerous acts and dangerous secrets
- Group clashes when the research participant is in a group conflict

HOW TO INCREASE TRUSTWORTHINESS AND CREDIBILITY IN QUALITATIVE RESEARCH

1. Prolonged Engagement

2. Triangulation (Verification)

3. Peer Debriefing(Peer questions)

4. Peer Review (Return to Field)

5. Negative Case Analysis (Playing Devils 's Advocate)

6. Research Auditing (Audit)

Roles of Qualitative Research

It is the duty of the researcher to play the following roles so the Qualitative research is of good quality

Artistic Role: So readers will enjoy reading

Translator's Role: The research must be translated to as many languages as possible for maximum penetration and dissemination.

Interpreter's Role: So people can know the real meaning of the research in a way everyone can understand and use the outcomes of the research to the benefit of the community.

Transformer's Role: To facilitate reflection and collective change to the object of study

Features of Qualitative Research

Certain aspects of reality which cannot be researched in quantitative methods are possible in qualitative method.Qualitative research is time consumingand is based on the personality and skills of the researcher. Outsourcing is not possible in qualitative research and funding is limited because funders off late popularly support quantitative research

Qualitative Research in Everyday Life

Observation in day to day life is a primitive method of data collection which is used even today by many people. It is one of the basic methods of qualitative research.

The Newspaper is an everyday qualitative record. It is descriptive with words and artifacts.All television interviews are based on qualitative research methods.All police records are qualitative. The most important avenues for application of qualitative analysis is in the Social Sciences and in Judgements and Litigations

Qualitative Research in Social Science

In Social Work qualitative research is suitable because many interventions cannot be measured but can be explained.In all social science subjects Qualitative Research is suitable. But, it is not given due importance due to a lack of experts in qualitative research.

Qualitative Research and Judgments: Application in Litigation

In cases requiring compensation, It is easy to assess the compensation for what is lost in terms of money. Accident claims are easily settled for loss. For emotional impact, mental agony and sufferings it is not easy for the Judge to compensate exactly in terms of money. Qualitative methods can give an answer to these aspects.

Counterarguments against the rejection of Qualitative Research in the current research scenario:

There is no substitute for qualitative research

Do not reject qualitative research because it cannot predict. Prediction is always conditional.Do not reject qualitative research due to the extended time it takes. Computers can be used for analysis and only data collection takes time.Do not reject qualitative research because it demands hard work. Hard work is always rewarded.

Numbers or Quality- What would you choose?A single gentle drop of nectar, or all the ocean water in the world?

FOCUS GROUPS IN SOCIAL WORK RESEARCH

DR. R. NALINI

ASSOCIATE PROFESSOR

PONDICHERRY UNIVERSITY

A brief introduction about the Faculty:

Dr.Nalini works with women with disabilities. In her last experience with doing focus group interviews she had a focus group with mothers of adolescent girls who are mentally challenged. She shared with us her dilemmas on how she formed the group such as, should she include men: whether to keep it homogenous or heterogenous. Though mothers were comfortable in a homogenous groups India is a diverse country and how do we have FGD with mothers. There are 700 children in the school how do we pin point whom to pick for the Discussions?.

Issues She Faced:

Autistic Children who were violent because they weren't able to handle puberty, She had to restrict the group of mothers to 10 and they had to give them a date and time that was convenient to them. Her objective was to slowly make them aware of the fact that their daughters could have been sexually abused. But they knew they couldn't jump into this issue because the mothers were not prepared for these issues, the mothers had the hope that the daughters could be cured and married off and this had to be addressed in the focus group interviews. If the objective is purely academic you can maintain the focus on the issue you go in with but if you want to do social work you have to be capable of adapting issues to your Focus Group Discussion.

FGD is a very enriching experience. When we go to FGD as an interviewer or moderator you need to go with an empty head so that we can take in and process what they have to say.

Introduction

Focus Group Discussions are a tool to gather data for qualitative analysis developed in the 1940s, it is used for a variety of purposes in various fields - market researchers historically have made the most use, it is a common method in evaluative research and it is useful in developing content of new programs.

Robert K Merton, a sociologist used it and popularized it in the 1950s

Differences from In-Depth Interviews

Data is generated in a group composed of the researcher and participants. Group dynamics can be assessed depending on how the participants are responding to each other. The event is dynamic producing a happening that cannot be replicated

On Repeating focus group discussions with the same participants the data gathered will differ because of the different conversations, due to the diversity and dynamicity in the method, this method reaches data that other methods cannot reach.

Key Features:

It is not a naturally occuring conversationas focus groups are always arranged by a researcher for the purpose of research. Priority to participants' hierarchy of importance, their language, concepts, frameworks can be analysed. The dynamic produced is called the 'group effect'.

Characteristics of a Good Focus Group

Participants are carefully selected :5-10 people per group, 6-8 is the ideal group size

Ensure there are similar types of people in a group in a comfortable environment with a circular seating arrangement. Ideally the conversations are recorded for analysis with a skillful moderator, skillful in handling groups and information.

The conversations are steered with pre-determined questions after ensuring a permissive environment with the appropriate choice of team which has a willingness to learn and demonstrate true respect for participants.

Characteristics of a Bad Focus Group

Interruptions by phone calls, Unfocussed interviewee, Unprepared Interviewer, Unfocussed questions, Leading Questions, Judgemental Questions, No context, Poor body language, Conduct or Listening, Making people uncomfortable.

Moderator Skills

Select the right moderator with the skills to exercise mild unobtrusive control

Make sure the Moderator has adequate knowledge of the topic, is familiar with questioning skills, has excellent listening skills and appears like the participants

Usually the Moderator handles logistics, Records the proceedings and monitors recording equipment making sure the recordings are free from any distractions

The moderator must have abilities to create a warm and friendly environment, involve shy participants and remain a neutral person.

Conducting the Focus Group

Make a smooth and interesting introduction. Welcome the participants, A brief introduction with an overview of the topic and the ground rulesbefore starting off with the first question. There needs to be a skillful usage of pauses and probes which comes with practice. Make sure you are recording the discussion and reactions to participants – verbal and non-verbal.

There was a note on handling of experts and dominant talkers and handling of ramblers

End with an appropriate conclusionsummarizing the discussion with a review of objectives, fill the missed gaps, thank the gathering before dispersing.

Important steps in focus groups

1. Decide whether the participants are appropriate
2. Decide who to involve
3. Listen to your target audience
4. Put your thoughts in writing
5. Keep the participants best interests in mind
6. Choose a common language

Guidelines to participants

Make sure the Participants understand a non-judgemental environment, that there are no right or wrong answers, only differing opinions

Since the discussion is being recordedthere can't be group responses and everyone has to listen respectfully to others as they share their views

Mobile phones need to be turned off or kept in silent mode and must not interrupt the Focus Group Discussion.

Explain the role of moderator

Have a small ice breaker if things are getting too hot.

Talk to each other.

How to Ask Questions

While asking questions: ask open ended questions and avoid leading questions

Avoid dichotomous questions and avoid asking "why?"questions, instead make people talk about their experiences and use questions that get participants involved. Your Role as moderator is limited to focusing the questions and using different type of questions such as all things considered questions, summary questions and final questions. Be cautious about sensitive questions.

Note taking:

Note taking is primarily the responsibility of the moderator. Make sure the notes maintain a clarity and consistency

Field notes contain Quotes, Key points and themes for each question, Follow-up questions that could be asked, Passionate comments, Body language and Non-verbal activity.

Types of analyses

Individual level of analysis: What each individual member has said, similar to interview transcript

Group level of analysis: Group narrative that emerges, group dynamics and interaction become a part of the data.

The focus of the analysis is: What is the research question? What information am i trying to get?At what level analysis occurred (individual, group or both?) and how best can this be represented accurately?

Systematic analysis

Systematic analysis must be started while still in the group, Draw a diagram of the seating arrangement, Spot check the recording equipment, Conduct a debriefing for the moderators, Label and file field notes, Make back-up copies of recordings, Send for transcription if needed to experts, Prepare report in a question-by-question format with amplifying notes

Share report for verification with other researchers who were present at the focus group and while describing findings- use quotes to illustrate your analysis. You could choose to represent your study in a narrative style or a bulleted style and sequence the study thematically or questions based.

How to analyse the data

The words used by participants need to be analyzed in the context and light of triggering stimulus. Interpret in the light of that environment and check for internal consistency – tracing shift in opinions by flow of conversation. Look for frequency or extensiveness, Intensity in ideas, depth of feeling and specific responses

You will find big ideas from the data by stepping back.

CASE STUDY

DR. R. NALINI

ASSOCIATE PROFESSOR in SOCIAL WORK

HEAD (I/C)

CENTRE FOR WOMEN'S STUDIES

PONDICHERRY UNIVERSITY

Case Study:

A case study is an intensive analysis and description about a single unit bounded by space and time. Researchers hope to gain in-depth understandingof situations through multiple sources of evidence. Context is important in this method.Case studies seek detailed investigation with the aim of developing theories and conceptual frameworks.

What is case study?

A case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a "real life" context. It is research based, inclusive of different methods and is evidence-led.The Focus is not on statistical generalization, but rather on connecting case study findings to a particular theory.

Rationale of choosing is usually based on the availability of a special case that seems to merit intensive investigation.The intensive study of a bounded entity i.e. a single case or a group of cases is an important form of enquiry.

When to use case studies?

According to Yin (2003) a case study design should be considered when the focus of the study is to answer "how "and "why" questions, when you cannot manipulate the behaviour of those involved in the study and when you want to cover contextual conditions because you believe they are relevant to the phenomenon under study.

Case studies are used when the boundaries are not clear between the phenomenon and context

Types of units

Case study is an idiographic examination of:

1) Individual
2) Family
3) Group
4) Organization
5) Community or
6) Society

Characteristics of Case Study

Particularistic: Focussing on a particular situation, event, programme or phenomenon

Descriptive: The final resultis a detailed description of the case/unit under study

Heuristic: Helps people to understand what is being studied

Inductive: Induces new relationships and new understandings about the case under study

Types of case study

Intrinsic: In this type of case study, the researcher wants a better understanding of a particular case because it is important, interesting, misunderstood or unique

Instrumental:A particular case is examined to give insight into an issue or to refine a theory. For Example, It is useful to learn about the 'typical' by studying the 'atypical'.

Collective: to learn more about the phenomenon, population or general condition by extending to cover several cases while exploring differences within and between cases. The goal is to replicate findings across cases. The cases have to be chosen carefully so that theresearcher can predict similar results across cases, or predict contrasting results based on a theory.

Explanatory: This type of case study would be used if researcher is seeking to answer a question that sought to explain the presumed causal links in real-life interventions that are too complex for the survey or experimental strategies. In evaluation language, the explanations would link programme implementation with programme effects.

Exploratory: This type of case study is used to explore those situations in which theintervention being evaluated has no clear, singleset of outcomes.

Descriptive: This type of case study is used to describe an intervention or phenomenonand the real-life context in which it occurred.

Conducting a case study

The researcher must have a prior understanding of the study contexts and pay careful consideration about the number of cases and number of participants in each case. The researcher must then decide the key participants to be involved and identify an overall strategy for the case study. Following this, key decisions on the study and analysis such as what data has to be collected have to be taken.

Binding the case

Once case is determined, researcher will have to consider what his case will NOT be. A common pitfall is the tendency for researchers to attempt to answer a question that is too broad or a topic that has too many objectives for one study. Hence placing boundaries on a case is important as it can prevent this explosion from occurring.

A case can be bound by time and place, time and activity, definition and context. Binding the case will ensure that the study remainsreasonable in scope.

Key factors to consider while conducting a Case Study:

Husserl defined phenomenology as How people describe things and experience them through their senses. Phenomenology studies conscious experience as experienced from the subjective or first person point of view.Philosophers Edmund Husserl and Alfred Schutz pioneered phenomenology in the 1900-20s. Other Contributors include: Martin Heidegger, Maurice Merleau-Ponty, Jean-Paul Sartre, *et al.*

Phenomenology- a common sense perspective

Phenomena are happenings, events, occurrences, episodes and so on.. These occurrences are studied for greater understanding. The studying and understanding have many shades and paradigms. In this approach we study the experience of a person in the given phenomenon in the natural setting of the person. To sum up,*Phenomenology is the study of conscious experience of various types as experienced from a first-person point of view. It studies the structure of experience and consciousness.*

Everything outside of consciousness is a Manifestation. If reality is assessed as is there are no boundaries in the Universe. Boundaries are illusions, products of the way we map and edit reality.

In this discipline we study different forms of experience *as we* experience them.

Components of Experiencing:

We characterize the experiences of the senses into seeing, hearing, imagining, thinking, feeling emotion, wishing, desiring, willing, and also acting, also under the umbrella of experience arethe embodied volitional activities of walking, talking, writing, typing, reading and other activities. However, not just any characterization of an experience will do. Phenomenological analysis of a given type of experience will feature the ways in which we ourselves would experience that form of conscious activity.

Phenomenology is, literally, the study of phenomena through:

(i) Things as they appear in our experience and

(ii) The ways we experience these things and the meanings things have in our experience with Logic.

Edmund Husserl established phenomenology at first as a kind of "descriptive psychology" and later as a transcendental and edietic science of consciousness.

The Structure of Consciousness:

Is generalization feasible in the case being studied? Case study is different from statistical inferences. Epistemologically it is in harmony with the reader's experience and so it can be a natural basis for generalization.

Intrinsic and instrumental case studies do not warrant generalization.

What can be generalized?: Theoretic Propositions, Knowledge Built, Causal Connections

In-depth studies make these generalizations feasible.

Understanding outcomes is crucial through narrative accounts of events, analytic induction and identification through comparative analysis.

There are differences of opinions among experts about use of theory. The case is explained as a bounded system relating to wider social context and what is going on in the case. Case study research is advocated on the basis that it can capture the uniqueness of the case and aim to represent the case authentically – "in its own terms". Authenticity of results is key to a good study.

Steps in case study

Data collection:

Data Collection is the process of assembling the raw case data: Data consists of all the information collected about and the person/unit for which the study is to be written.

Construction of the case record:

Condensation: Condensation of the raw case data into manageable and accessible records.

Write the case study narrative:

The case study is presented as a holistic portrayal of a person or a unit. It is a readable, descriptive picture of a person/unit making accessible all information necessary to understand the case and ispresented chronologically or thematically or both.

Analysis of case study data

Significant patterns are identified in the data

Few agreed upon tools for analysis, Pattern matching, Explanation building and Time series were touched upon.

Software for computer aided analysis

ATLAS.ti, HperRESEARCH, QDA miner, CAQDAS (They have a website where there is more information)

The software does not do the analysis but helps in organizing and retrieving large amounts of textual data

Media Analysis: ATLAS.ti, HperRESEARCH can also analyse audio data, video data and still imagery.

Case study template

Proforma for arrangement of a Case Study

- Title of the project
- Abstract
- Introduction
- Literature review
- Research design
- Data analysis & interpretation
- Summary and conclusion
- Bibliography and appendix

Skills and traits required by the researcher

Academic Inclination: The researcher must possess creativity and original insights in pursuing the research goal, Hence, Good scholarship in the relevant literature is essential.

Attitudes that help in research: Professional poise and a cheerful disposition even in the most difficult research circumstances is always an advantage. The ability to maintain a critical distance coupled with the ability to exercise restraint and a non-judgemental attitude helps immensely with theoretical sensitivity: the ability to think abstractly and give meaning to data is critical to bringing the unknown into the known and to make sense of the known.

Flexibilityis essential both cognitively and theoretically to appreciate different perspectives. The researcher must possess reflexivity which is the knowledge about one's own biases and prejudices and about how far these interfere with the study.

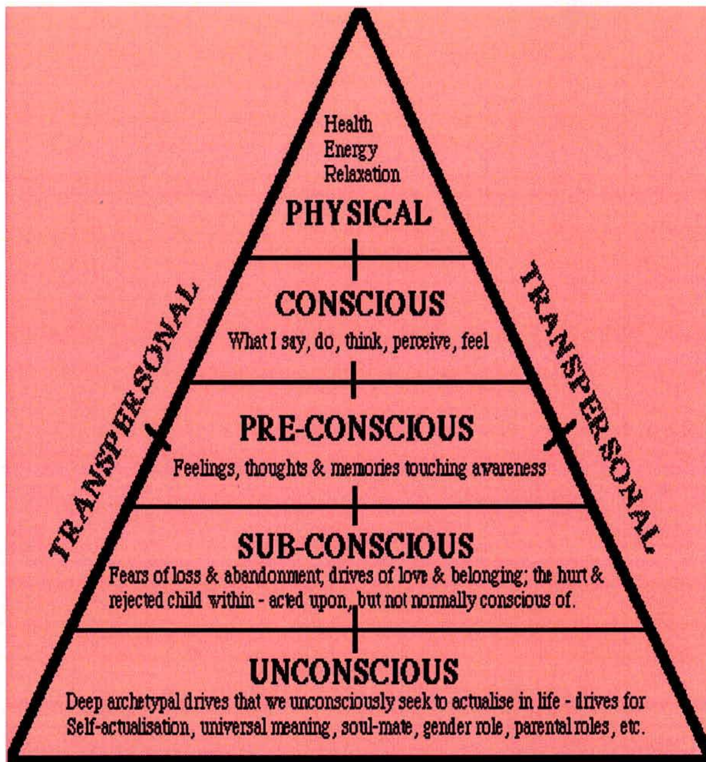
Phenomenology, Grounded Theory, Content Analysis:

Dr.M.Selvam, Professor and Head of the department of International Business and Commerce, Chairman, School of Management IQAC - Coordinator

Phenomenology:

PHENOMENOLOGICAL STUDIES

Introduction:



Consciousness is the state or quality of awareness, of being aware of an external object or something within oneself.

Consciousness is sentient awareness, Subjectivity in a state of alive wakefulness.It is the ability to experience or feel aliveness and wakefulness through a sense of selfhood.

Phenomenology and Philosophy

Phenomenology is a discipline in Philosophy, and a movement in the history of Philosophy. It shakes hands with other sub-disciplines of Philosophy like:

Ontology - the study of being or what is reality

Epistemology - the study of knowledge; its nature, grounds, limits and validity

Logic - the study of valid reasoning and

Ethics - the study of right and wrong action

Nature of phenomenology

Phenomenology rejects the concept of objective research. It adopts a process called *phenomenological epoche,* a process involved in blocking biases and assumptions in order to explain a phenomenon in terms of its own inherent system, a natural, subjective version of meaning.

Phenomenology believes that analyzing daily human behavior can provide a greater understanding of nature. People should be explored to understand them through the unique ways they reflect the society they live in. Phenomenologists gather *capta,* or conscious experience, rather than traditional data. Phenomenology is considered to be oriented on discovery. The methods adopted are far less restricting than in other sciences.

Importantterminologies in Phenomenology:

Intentionality: Intentionality refers to the notion that consciousness is always the consciousness *of* something.

Intuition: Intuition in phenomenology refers to those cases where the intentional object is directly present to the intentionality at play; if the intention is filled by the direct apprehension of the object, you have an intuited object.

Evidence: Evidence is the successful presentation of an intelligible object, the successful presentation of something whose truth becomes manifest in the evidencing itself.

Noesis and Noema: In Husserl's phenomenology, which is quite common, this pair of terms, derived from the Greek Nous (i.e., Mind). The real content, of an intentional act of consciousness is *Noesis*, and the ideal content is *Noema*.

Empathy and inter-subjectivity: Empathyrefers to the experience of one's own body as another, especially the subjectivity aspect, as well as our inter-subjective engagement with them. Your body is also experienced as a duality, both as object (you can touch your own hand) and as your own subjectivity (you experience being touched). If you extend the dualism to another you get inter-subjectivity.

Life-world: Lifeworld is the world each one of us lives in, the background or horizon of all experience, and it is that on which each object stands out as itself as different and with the meaning it can only hold for us. The lifeworld is both personal and inter-subjective.

The phenomenological reduction is voluntary sustenance of the awakening force of astonishment so that conceptual cognition or knowing astonishment is daily experience.

A unique and final definition of phenomenology is perhaps even paradoxical as it lacks a thematic focus. Phenomenology is not a doctrine, but rather a style of thought, a method, an open experience having different results, and this may disorient anyone wishing to define the meaning of phenomenology.

Phenomenon that led to 'phenomenology'

Europe was in ruins at the end of WWI.In the context of this ideological crisis, the German philosopher, Edmund Husserl (1859 – 1938) sought to develop a new philosophical method to mend the disintegration of civilization.

Transcendental phenomenology

Transcendental phenomenology studies the oneness of 3 consciousnesses:

1) The Physical factual unity of things and states of affairs,
2) The Eidetic unity of essences
3) The Living unity of consciousness as it flows along in a stream of experiences.

Phenomenological research practice

If we consider an example of the descriptive study of how individuals experience a phenomenon, such as flooded homes. The foundational question in phenomenology is: *What is the meaning, structure, and essence of the lived experience of this phenomenon by an individual or by many individuals?*

Phenomenological studies examine human experiences through the descriptions provided by the people involved. The researcher tries to gain access to individual's life-worlds, in their words which is their world of experience.

The goal of phenomenological studies is to describe the meaning that experiences hold for each subject. In phenomenological research, respondents are asked to describe their experiences as they perceive them. They may write about their experiences, but information is generally obtained through In-depth interviews or conversations to get access to an individual's life-world. The researcher next searches for the invariant structures of individuals experiences which are also called the essences of their experience.After analyzing the data and the invariant structures of consciousness the researcher writes a report that provides rich description and a vicarious experience of *being there* for the reader of the report. The phenomenon itself dictates the method including the type of participants.

An Example of phenomenological study

Phenomenological research would ask a question such as, "What is it like for mothers to live with their cancer, with grown up children looking particularly concerned?"

The researcher might perceive that particular mother, herself, would feel very hopeless and frightened. These feelings would need to be first identified and then put aside to listen to what the mother is saying about how she is living this experience while it is possible that this mother says she has discovered an important reason for living, not resorting to any untoward thoughts or feelings, but braving the illness as long as the Divine wishes, bearing the agony.

Parse, Coyne, and Smith wrote that the analysis of data from these types of studies requires that the researcher dwell with the subjects descriptions in quiet contemplation.

Methodology of phenomenology

1. **Choosing the research topics: Appropriate areas of study**

Topics appropriate to phenomenology are ones that are fundamental to the life experiences of the people being studied. Some examples were given to us such as:

1) The meaning of health/stress
2) The experience of bereavement
3) The quality of life with a chronic illness
4) Learning Experiences of a child having autism
5) Living through war
6) Moving from a village to a slum
7) Living in a State with Total Prohibition
8) Family Concerns of a Jailbird or history-sheeter
9) Mothers who Have lost their children in a Tsunami

A phenomenologic approach is especially useful when a phenomenon of interest has been poorly defined or conceptualized - or wasn't known to exist.

2. Goal focus

According to Van Manen (1990), the four aspects of lived experience that are of interest to phenomenologists are:

1) Lived space (spatiality)
2) Lived body (corporeality)
3) Lived time (temporality)
4) Lived human relations (relationality)

The aim of phenomenological research is to aspire to pure self-expression, with non-interference from the researcher. This means there must be no leading questions, as well as the researcher completing the process of bracketing in an awareness of their own ideas and prejudices about the phenomenon of interest.

3. Sampling

Small samples probably no more than 10 participants are most suitable for this type of research. Larger samples can become unwieldy.

4. Data collection tools and methods

Very open questions need to be asked to collect data on lived experiences through in-depth interviews and conversations. The data collection tools that are most often used are Interviews, Conversations, Diaries, Drawings, Observations, Gestures and Postures.

Four Steps of Phenomenological study

1) Bracketing

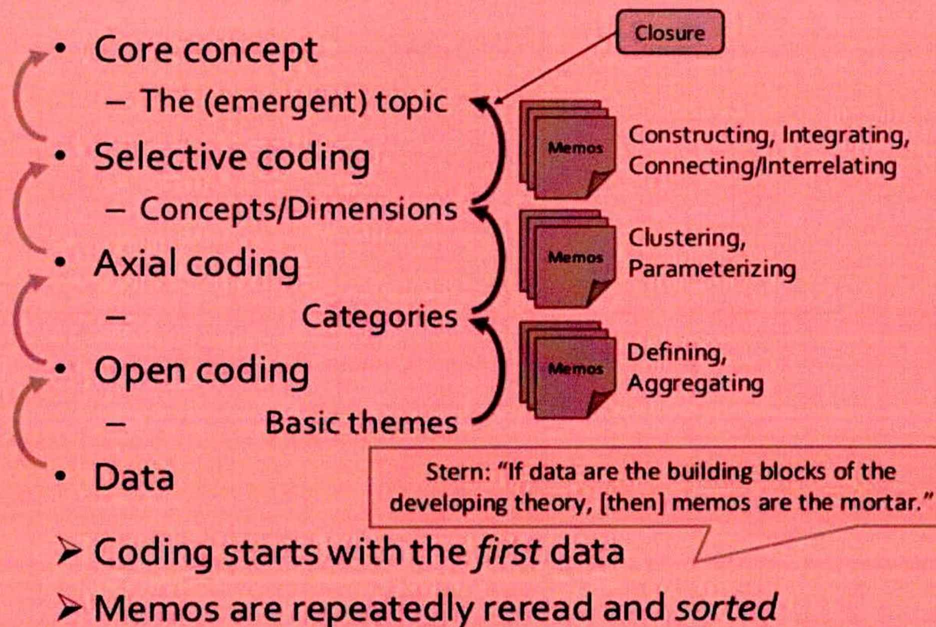
To understand the lived experiencefrom the vantage point of the subject, the researcher must block or bracket her or his own beliefs and feeling. Bracketing is the process of identifying and holding in abeyance any preconceived beliefs and opinions that one may have about the phenomenon that is being researched. The researcher brackets out the world and any presuppositions that he or she may have in an effort to confront the data in as objective a manner as possible. This procedure is called, *Epoche.* Only when the researcher puts aside her or his own ideas about the phenomenon is it possible to see the experience from the eyes of the person who has lived the experience.

2) Intuition

In Philosophy, it is immediate knowledge of something obtained instinctively. Intuition occurs when the researcher remains open to the meaning attributed to the phenomenon by those who have experienced it. This process of intuition results in a common understanding about the phenomenon that is being studied. Intuiting requires that the researcher creatively varies the data until such an understanding emerges. Intuiting requires that the researcher becomes totally immersed in the study and the phenomenon.Through Intuition the researcher tries to get to the essence of consciousness of the persons studied on the phenomenon.

3)Analysis : Coding

Analysis involves such processes as coding - open, axial and selective, categorizing and making sense of the essential meanings of the phenomenon.As the researcher works and lives with the rich descriptive data common themes or essences begin to emerge.This stage of analysis basically involves total immersion for as long as it is needed in order to ensure both a pure and a thorough description of the phenomenon.



Open Coding

In Open coding the collected data are divided into segments and then they are scrutinized for commonalities that could reflect categories or themes.Once the data have been categorized, then they are examined for properties that characterize each category.Properties are specific attributes of a category or they may be subcategories.The researcher will examine and identify the meaning of the data by: asking questions, making comparisons, looking for similarities and differences between the comments.Similar comments or incidents and events are grouped together to form categories. The open coding process reduces the data to a small set of themes that appear to describe the phenomenon studied.

Axial coding

In axial coding connections are made amongst the categories and the subcategories by exploring the conditions, context, action, interactional strategies, consequences, which influence the phenomena andthe social processes that are studied.

The next step is determining more about each category in terms of: the conditions that give rise to it, the context in which it is embedded, the strategies that people use to manage it or to carry it out and the consequences of those strategies.With further data available, the researcher moves back and

forth amongst the data collection, all the time coding them and continually refining the categories and their interconnections.

Selective coding

The Selective coding process involves selecting the main category, and then systematically relating it to the other categories.Next selective coding involves the validation of these relationships, and then filling in any categories that perhaps require to be further refined or developed.During this process the categories and their inter-relationships are combined to form a storyline that describes what happens in the phenomenon studied.The storyline or structure of phenomena is the major finding of any descriptive phenomenological inquiry. It is based upon the essential meanings that are present in the descriptions of the participants and is determined both by analysis and also by intuitive insights.

How to Analyze an Interview

Read the interview transcript in its entirety in order to get a global sense of the whole.On the second reading of the interview transcript, divide the data into meaningful sections or units.Integrate those units that you have identified as having a similar focus or content and make sense of them.Subject your integrated meaningful units to free imaginative variation.Elaborate on the findings, describing the essential meanings that were discovered through the processes of intuition or imagination.Revisit the raw data descriptions again to justify interpretations of both the essential meanings and the general structure. Make sure to substantiate the accuracy of all findings by reference to the raw data.

Through critical analysis of the work ensure that concrete, detailed descriptions have been obtained from the participants, the phenomenological reduction has been maintained throughout the analysis, that the essential meanings have been discovered, a structure or storyline has been architected and that the raw data has verified the results.

How to Analyze a Narrative Study

In a narrative, the data analyst must consider aspects such as the physical surroundings, the objects, the characters and aspects of the characters such as their relationships, the social interactions between the different characters or groups, the type of activity, the outcomes, the descriptive elements, or the time reference. If the narrative wouldn't keep its essential meaning when various of these aspects are changed, then those aspects are part of the essential theme. Only those elements that can't be changed without losing the meaning of the narrative contribute to the theme.The goal of analysis is uncovering lived experiences in the truest manner.

How to Analyze Artistic Depiction

The first principle of analysis of phenomenological data is to use an emergent strategy, to allow the method of analysis to follow the nature of the data itself. Artistic depictions of experience would have to be approached differently from narratives or interview data. In all cases, however, the focus is on an understanding of the meaning of the description. To get at the essential meaning of the experience, a

common approach is to abstract out the themes. Themes and patterns are sought in the data. These are essential aspects without which the experience would not have been the same.

5) Descriptive Stage: Drawing through Words, Imagery and the Fine Arts

After analysis, the descriptive stage takes effect. All Phenomena have something to say to us, Poets and Painters are born phenomenologists. Poets and painters, share their insights with others by means of word and imagery with the same artfulness as the professional phenomenologist.The researcher, with artistic spirits, comes to understand and to define the phenomenon to describe it vividly, all with subjectivist evidence and consciousness.The aims of this final step are to communicate and to offer distinct, critical description in written, verbal form or non-verbal form.

Specialty of Phenomenology

This type of research is used to study areas in which there is little knowledge (Donalek, 2004).Streubert and Carpenter (2002) contended that this research method is rigorous, critical, and systematic. They called for the beginning researcher to seek a mentor who has experience in phenomenological research.

Husserl's phenomenology began as a critique of both psychologism- viewing psychology playing a central role in grounding or explaining, and naturalism – our traditional scientific methods of understanding

Phenomenological research has sometimes been viewed as soft science.

Summary of the Process:

The first step is bracketing and phenomenological reduction.Each of the participants is given an account of their awareness of the phenomenon and confirmation.is got. Units of meaning are delineated. The units are clustered by meaning to form themes. Interviews are summarized and validated where necessary or developed further.The general and unique themes from all the interviews are extracted making a composite summary.

Grounded theory

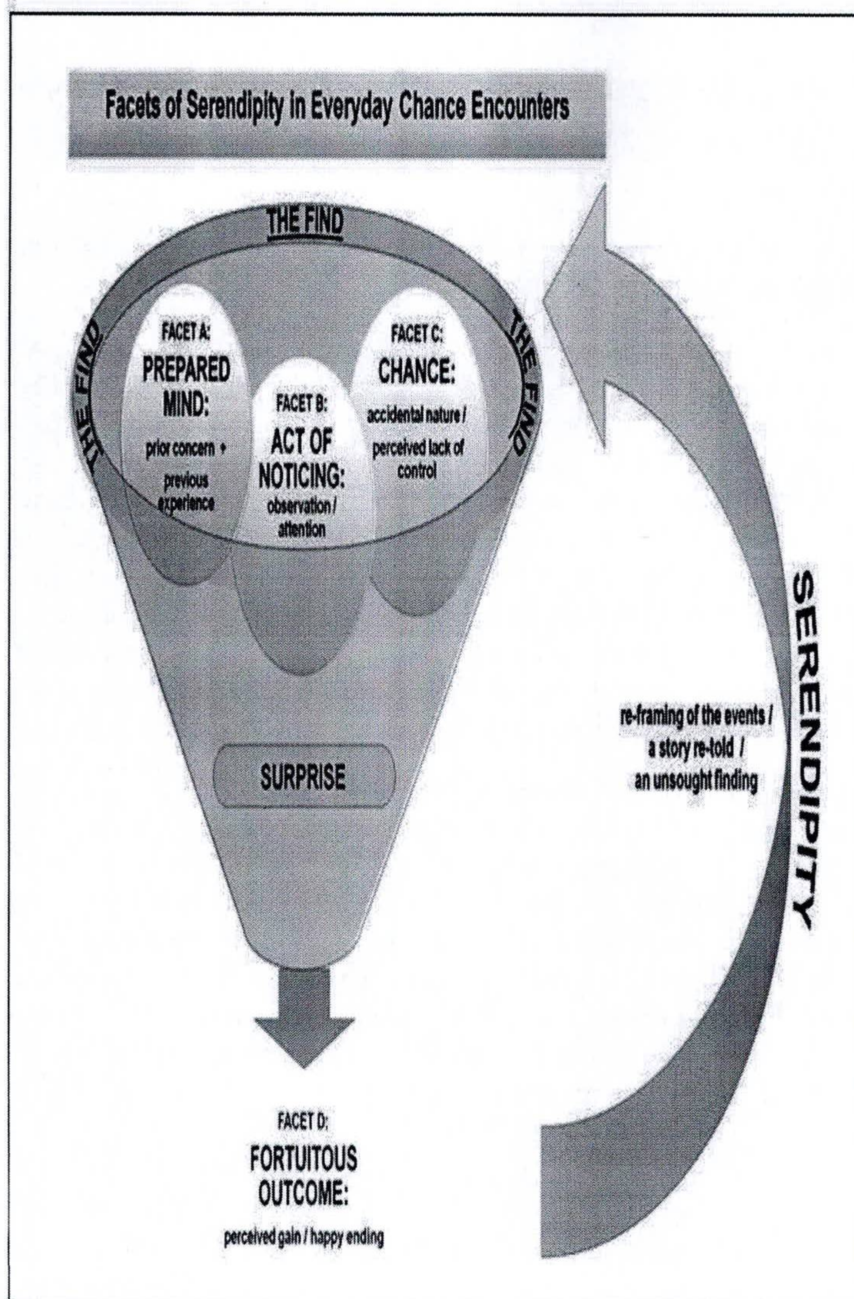
Definition:

Grounded Theory is a specific methodology developed by Glaser and Strauss (1967) for the purpose of building theory from data. In their book the term grounded theory is used to denote theoretical constructs derived from qualitative analysis of data(Corbin & Strauss, 2008).

Grounded Theory is a Qualitative Research Methodology.Grounded Theory is designed to generate theories, not verifications, tests or evaluations of existing theories.It is not hypothesis or problem oriented but is used to make ground breaking theories or to get net theories, rather than working on theories to make some incremental gains on pre-existing theories.

Grounded theory method connects with the data to get theories. In the data there remain hidden precious potential theories. It unearths them and refines them into well framed theories.Grounded

theory is a way of working with qualitative data to spot and mold hidden theories. It is interesting to me because it factors in serendipity.



Prominent early authors in Grounded Theory

Barney G Glaser and Anselm L Strauss Developed Grounded Theory in the late 1960s.

Their book, The Discovery of Grounded Theory (1967) is a monumental work on Grounded Theory Methodology, Grounded Theory is based on Induction, not deduction.

Later authors

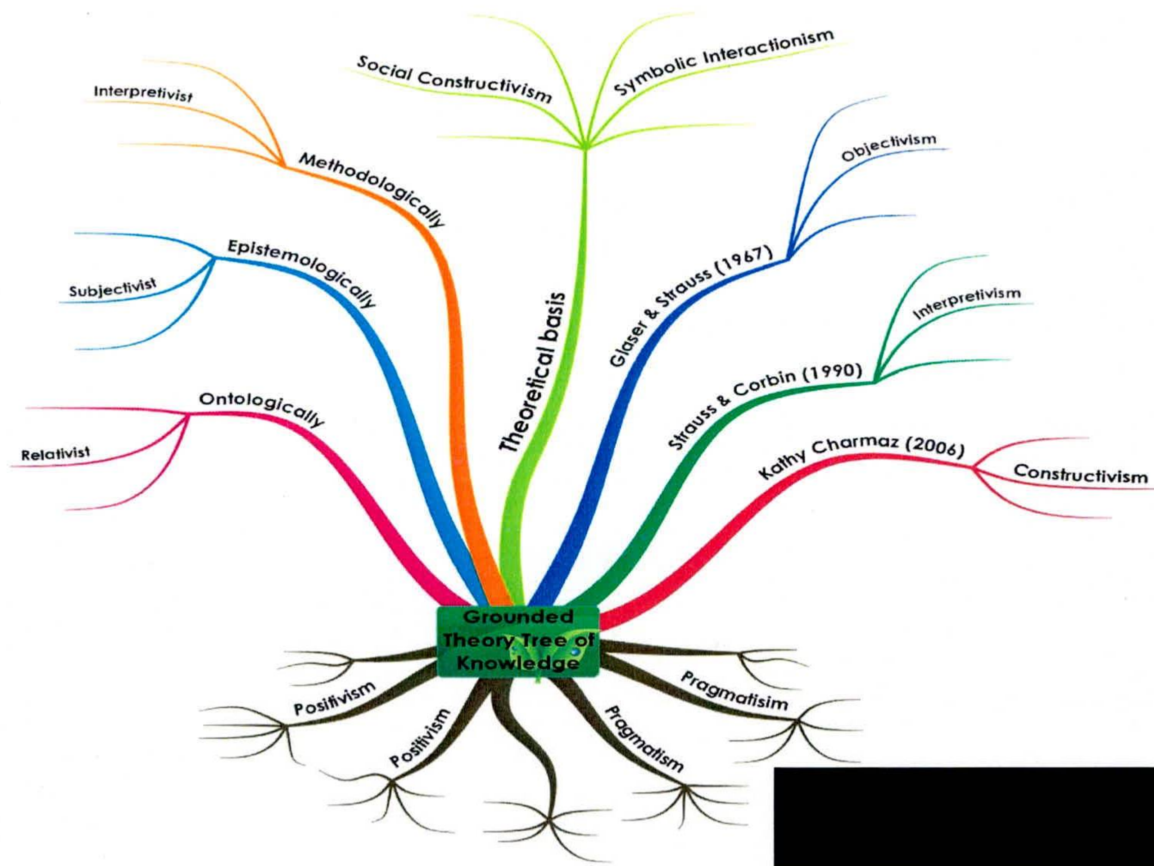
Barbara J Bowers, Juliet M. Corbin, Chantal D. Caron, Jane Mills, Antony Bryant, Ann Bonner, Karen Francis Leonard Schatzman,

Aim and Attributes of Grounded Theory:

The aim of the method is to produce theories and conceptual models through exploring empirical data on a topic, which has not yet been analyzed or theorized.

Grounded Theory as a method is suitable for various kinds of qualitative data. Although many call Grounded Theory a qualitative method, it is not. It is a general method. The concept of Grounded Theory sometimes refers to data-driven-immersion-insightful research. The concept may also refer to a form of research, which uses the particular practices and concepts of Grounded Theory method. The practices include various coding terms and coding practices, which enable you to conceptualize the phenomenon, formulate connections between the data and the concepts.It is inductive bottom-up theory that is grounded directly in the empirical data.All research is grounded in data, but few studies produce a grounded theory.It employs a set of rigorous research procedures leading to the emergence of conceptual categories. These concepts and categories are related to each other as a theoretical explanation of the actions to resolve the main concern of the participants in a substantive area. Grounded Theory can be used with either qualitative or quantitative data.

This method is a systematic generation of theory from data that contains both inductive and deductive thinking. One goal is to formulate hypotheses based on conceptual ideas.Others may try to verify the hypotheses that are generated by constantly comparing conceptualized data on different levels of abstraction, and these comparisons contain deductive steps. Another goal of a grounded theory study is to discover the participants' main concerns and how they continually try to resolve it. The questions the researcher repeatedly asks in grounded theory are "What's going on?" and "What is the main problem of the participants, and how are they trying to solve it?" These questions will be answered by the core variable and its sub cores and properties in due course. Grounded Theory method does not aim for the truth but aims to conceptualize what is going on by using empiricism.

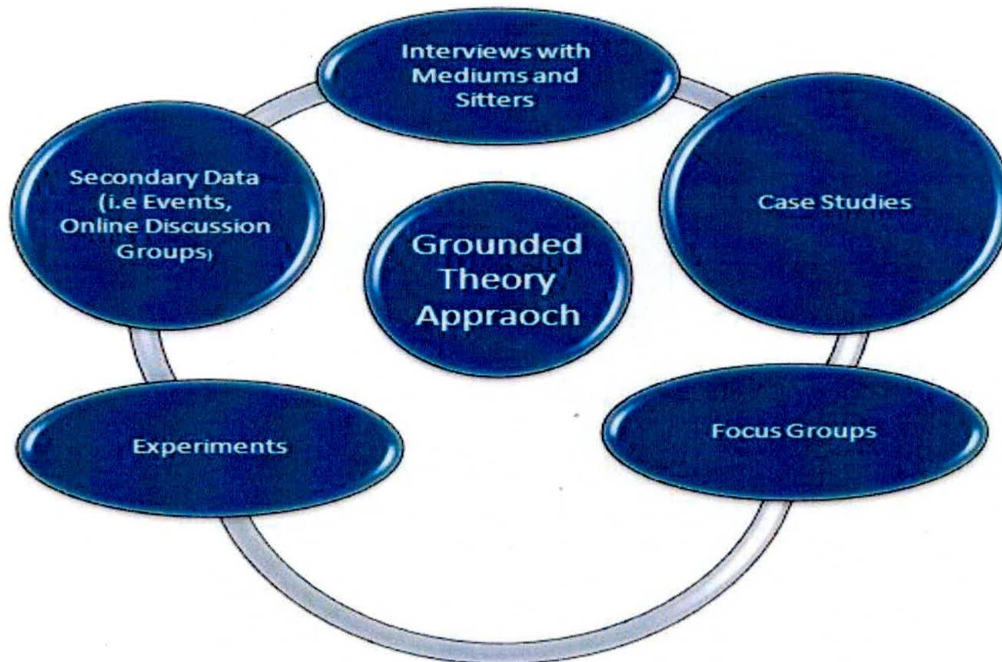


Source: Australian Journal of Nursing Volume 30, No.2:Discovering Constructivist Grounded Theory's fit and relevance to researching contemporary mental health nursing practice: Andrew Gardner BN, MMHN, MBus, Dip Medical Hypnosis. Lecturer - School of Nursing and Midwifery, Division of Health Sciences, University of South Australia, City East Campus, Adelaide, South Australia, Professor Helen McCutcheon Head, Florence Nightingale School of Nursing and Midwifery, King's College London, United Kingdom. Maria Fedoruk Lecturer - School of Nursing and Midwifery, Division of Health Sciences, University of South Australia, City East Campus, Ade

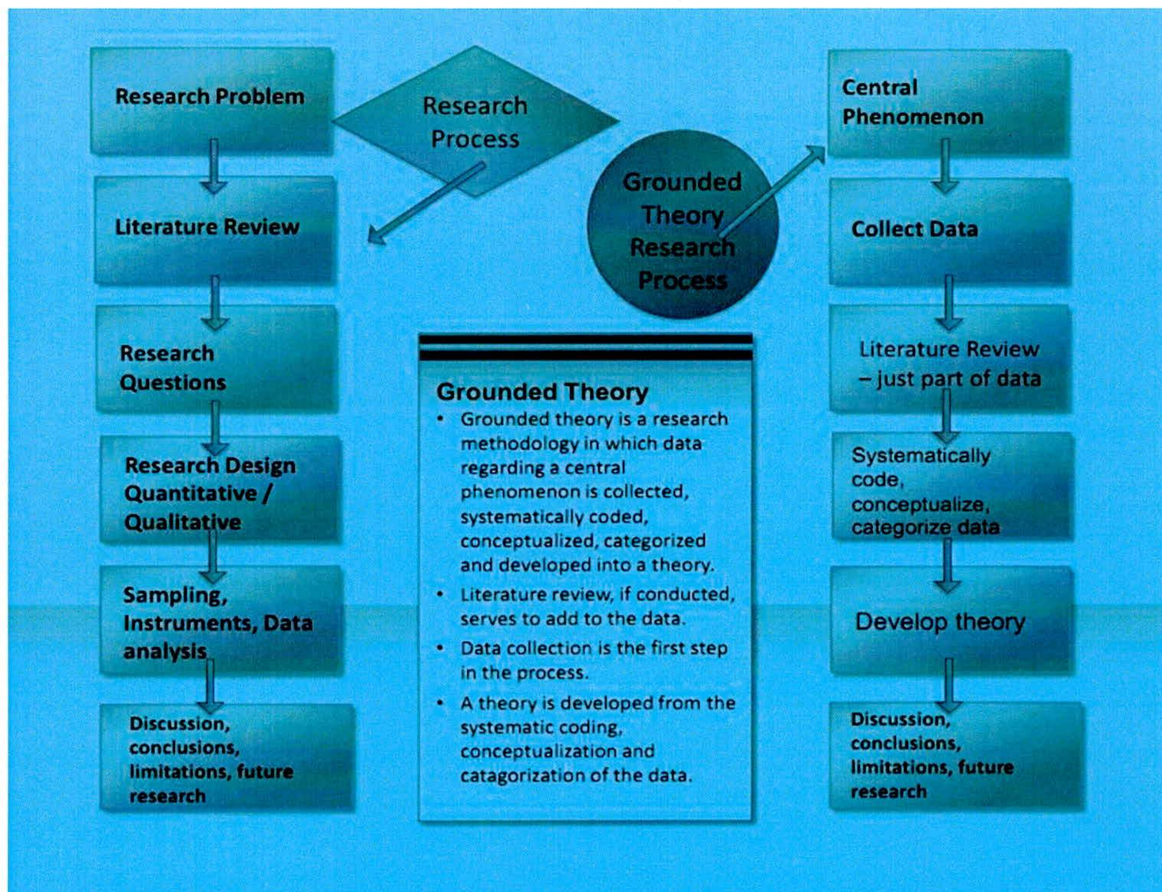
Grounded Theory is a research approach which has its roots in both positivism and pragmatism. Its theoretical base is derived from symbolic interactionism and social constructivism (Denzin and Lincoln 1994; Bowers 1988; Blumer 1969; Mead 1932). Symbolic interactionism is an interpretive methodology supported by pragmatism as the basis of the theoretical perspective (Blumer 1969) and (Mead 1932). Similarly Constructivist Grounded Theory takes an epistemological position of subjectivism, meaning that we understand that researchers cannot be completely objective, rather it is acknowledged that an interrelationship exists between the researcher and the participant (Mills et al 2006).

Ontologically a relativist position is assumed, meaning that we can only understand concepts such as reality and truth within a broader framework, which is contextually positioned within a certain time, place, and culture (Charmaz 2006). Methodologically Constructivist Grounded Theory is interpretive in nature, meaning that the notion of a shared reality is interpreted or discovered by the researcher and that reality arises from the interactive process and its temporal, cultural, and structural contexts (Charmaz 2000, p.523). Hence this perspective denies the existence of an objective reality, rather assuming that reality, society and the self are socially constructed and that we make sense of or world

by developing shared understandings through social interaction with others also known as social constructivism (Gardner et al 2010). This particular approach facilitates a researcher's understanding of how people negotiate and manipulate social structures; how a shared reality is created and how meaning is developed through the social interactions with others within defined contexts.



The Ideology of Grounded Theory is as an ever-developing entity, not a perfected product- Glaser and Strauss



Products of Grounded Theory: Substantive and formal theories

Grounded Theory may in the end produce, more often a Substantive theory and occasionally a Formal theory.Substantive Theory is a theoretical model that provides a working theory of action for a specific context. Substantive Theory is considered transferable, rather than generalizable, elements of the context can be transferred to contexts of action with similar characteristics to the context under study

In contrast formal theory is based upon validated, generalizable conclusions across multiple studies that represent the research population as a whole, or upon deductive logic that uses validated empirical theories as its basic axioms.

Components of a grounded theory:

1. **Elements of a Theory:** Concept, Conceptual Category, Conceptual Property.There must be ample diversity in concept categories- Concepts should be analytic, capable of being generalized to discern characteristics and have sensibility. Concept categories are indicated by data.
2. **Hypothesis Setting** –Relationships and extent of Relationships between conceptual categories and their properties

3. **Comparison of Categories and Properties of Concepts**Categories and Properties are compared for similarities and dissimilarities and patterns of similarities and dissimilarities, The differences enable generating theories.

Guidelines from the Pioneers-

Glaser and Strauss urge practitioners to ignore existing theory and work in areas where little to no literature exists- Data collection, coding and analysis should be done together as far as possible.

Constructivist or Charmaz Grounded Theory 2003, 2006.

Charmaz advocated a middle ground between postmodernism and positivism, and offers accessible methods for taking qualitative research into the 21st century

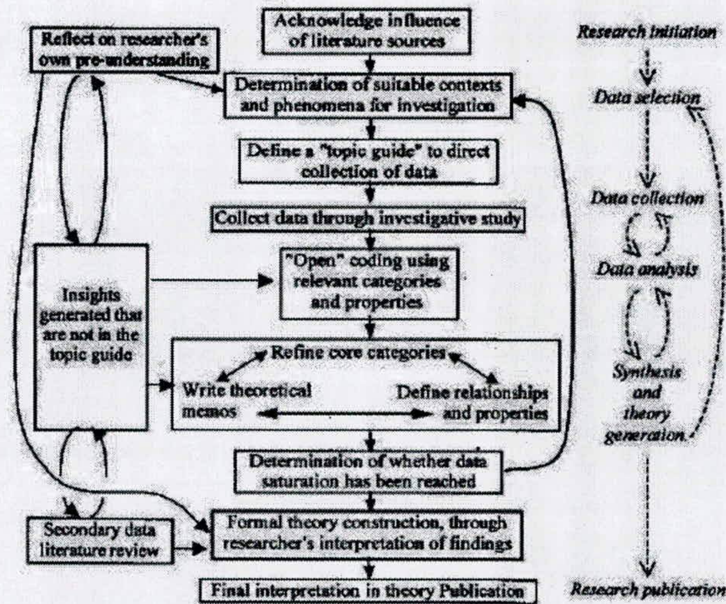
Charmaz's method appeared to value the inductive creativity of the classic methodology, and also resonated with the current popularity of constructivism within social research. As an epistemological stance, constructivism asserts that reality is constructed by individuals as they assign meaning to the world around them (Appleton & King 2002). From a constructivist perspective, meaning does not lie dormant within objects waiting to be discovered, but is rather created as individuals interact with and interpret these objects (Crotty 1998). Constructivism thus challenges the belief that there is an objective truth that can be measured or captured through research enquiry (Crotty 1998). Charmaz (2003) has therefore proposed a version of grounded theory that assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and viewed, and aims toward an interpretive understanding of subjects' meanings.

Process of grounded theory

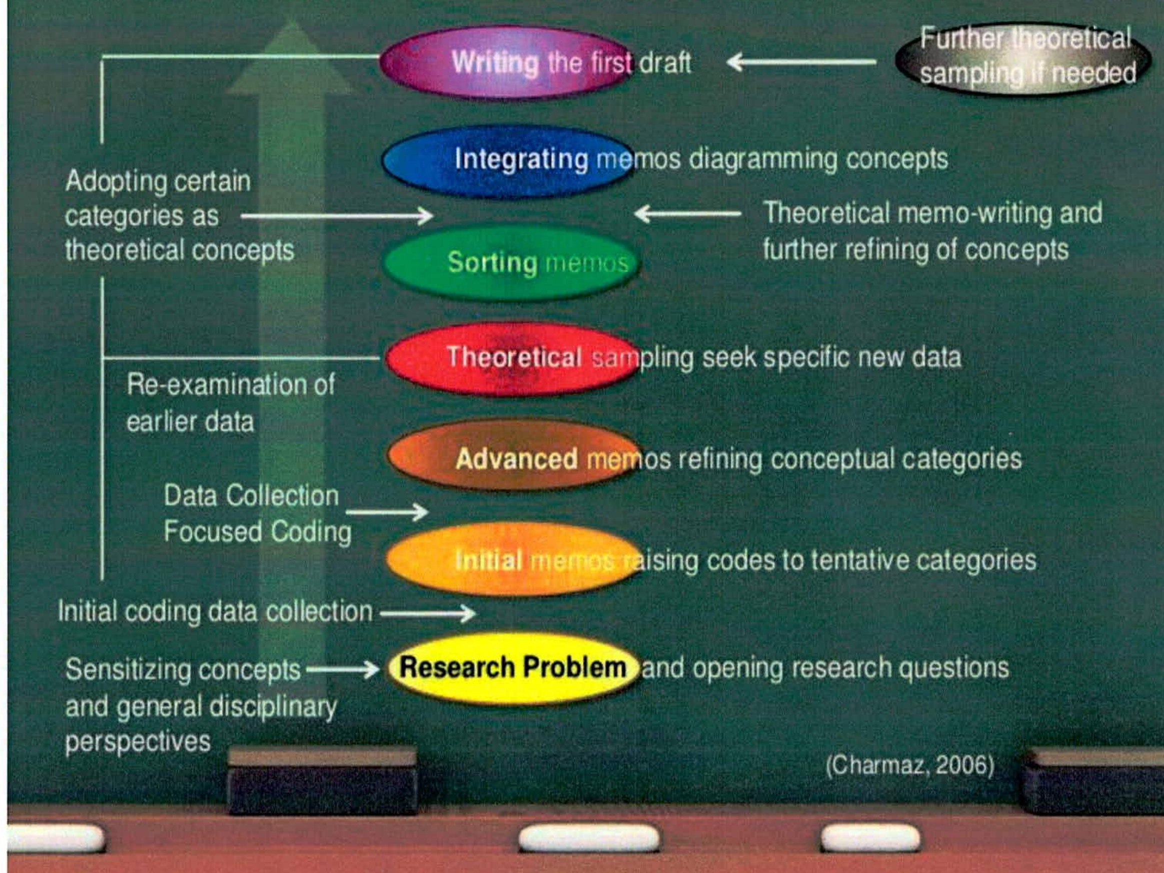
Grounded Theory involves the progressive identification and integration of categories of meaning from data. It is both the process of category identification and integration (as method), and its product as theory. Grounded Theory as a method provides us with guidelines on how to identify categories, how to make links between categories and how to establish relationships between them.

Grounded Theory as theory is the end-product of this process. It provides us with an explanatory framework with which to understand the phenomenon under investigation. To identify, refine and integrate categories, and ultimately to develop theory, Grounded Theory researchers use a number of key strategies, including constant comparative analysis, theoretical sampling and theoretical coding.

Grounded Theory Process



Gasson, 2003



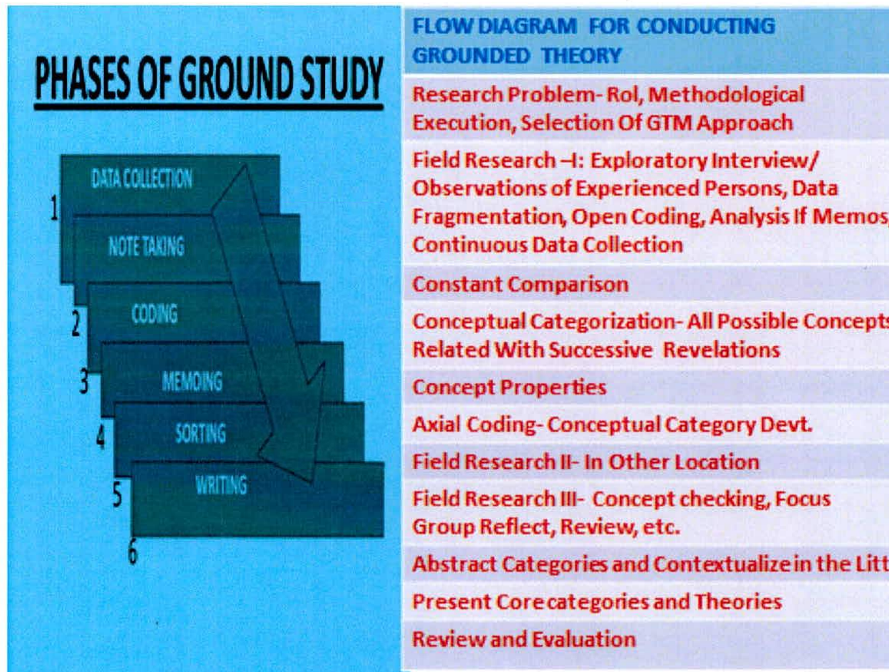
Here is the foundational question in grounded theory:

What theory or explanation emerges from an analysis of the data collected about this phenomenon?

It is usually used to generate theory like How and Why something operates as it does. Theories provide explanations.

Grounded theory can also be used to test or elaborate upon previously grounded theories, as long as the approach continues to be one of constantly grounding any changes in the new data. A study using grounded theory is likely to begin with a question, or even just with the collection of qualitative data.As researchers review the data collected, repeated ideas, concepts or elements become apparent, and are tagged with *codes*, which have been extracted from the data. As more data are collected, and as data is reviewed, codes can be grouped into concepts, and then into categories. These categories may become the basis for new theory. Thus, grounded theory is quite different from the traditional model of

research, where the researcher chooses an existing theoretical framework, and only then collects data to show how the theory does or does not apply to the phenomenon under study.



Stages of a Classic (Glaserian) grounded theory

Stages are generally sequential, but once research process begins they are often conducted simultaneously.

1)Preparation

Minimizing preconceptions. Do not conduct a preliminary literature review. Choose a general research topic, but no predetermined research problem.

2) Data Collection

Collect observations of the substantive area itself and activities occurring within the substantive area, Look at public or private records-photographs, diaries, paintings, sculptures, biographies, television broadcasts, news reports, surveys, government or organizational documents.Converse with individuals or a group of individuals, face-to-face or remotely synchronously via telephone, skype or text chat or even asynchronously via email or wiki.

3)Coding: the Start of Analysis

Constant Comparative Analysis is required relating data to ideas, then ideas to other ideas. When collecting and analyzing, the researcher needs theoretical sensitivity about what data is important in developing the grounded theory.

Data analysis starts with coding in three steps:

Open coding: Read transcripts line-by- line and identify and code the concepts found in the data.Open coding means code everything for everything.

Axial coding: Organize the concepts and make them more abstract.

Selective coding: Focus on the main ideas, develop the story, and finalize the grounded theory.

Eventually the core category and the main concern become apparent where the core category explains the behaviour in the substantive area i.e. it explains how the main concern is resolved or processed. For example in my study the main concern was finding time to study and the core category was 'temporal integration'. Axial coding is the disaggregation of core themes during Qualitative Research. Axial coding in Grounded Theory is the process of relating codes (categories and concepts) to each other via a combination of inductive and deductive thinking.

The basic framework of generic relationships is understood, with the use of a coding paradigm, to include categories related to:

1) the phenomenon under study,
2) the conditions related to that phenomenon (context conditions, intervening -structural-conditions or causal conditions),
3) the actions and interactional strategies directed at managing or handling the phenomenon and
4) the consequences of the actions/interactions related to the phenomena.

Ideally, category labels should be in vivo – that is, they should utilize words or phrases used by the participants. So, the researcher avoids importing existing theory into his. Theoretical coding involves the application of a coding paradigm which sensitizes the researcher to particular ways in which categories may be linked with one another.

In grounded theory, the researcher interacts with the data asking questions of the data, which are in turn modified by the emerging answers. Each emerging category, idea, concept or linkage informs a new look at the data to elaborate or modify the original construct. The researcher engages with the data by asking questions, making comparisons and looking for opposites. This may involve going back to the source to collect further data.

Examples of Coding

Informant Statement	Open code
From my perspective	• *Personal view*
the main challenge is	• *Assertion*
in changes in technology	• *Changes in technology*
or the product improvement	• *Changes in product*
done by the … supplier.	• *Supplier*
You	• *Pronoun shift*
can never guarantee that	• *Assertion* *Uncertainty*
if you are buying several	• *Procurement*
they will all be the same.	• *Product inconsistency* • *Necessary condition*

Microanalysis coding from a study of Configuration Management (CM) (excerpted from Allen, 2003)

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Data Components

- Core concept
  - The (emergent) topic
- Selective coding
  - Concepts/Dimensions
- Axial coding
  - Categories
- Open coding
  - Basic themes
- Data

Starr: "A code sets up a relationship with your data, and with your respondents.... a matter of both attachment and separation.... Codes allow us to know about the field we study, and yet carry the abstraction of the new."

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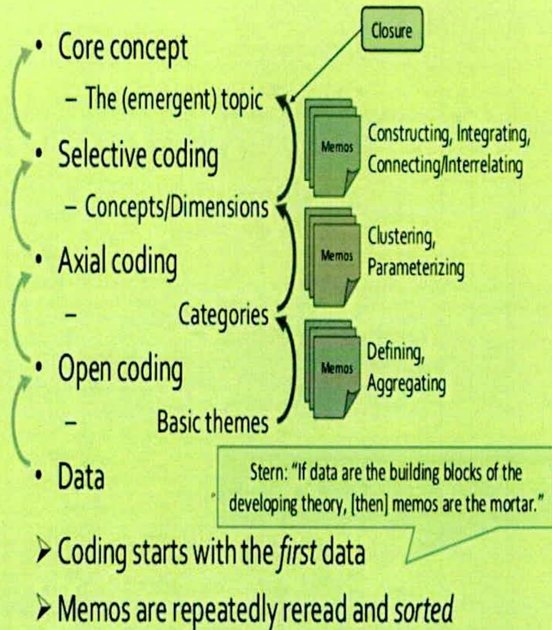
iv. MEMOING



Memos are the theorizing write-up of ideas about codes and their relationships. The development of your theory is captured in your memos; fewer memos means thinner theory.Data collection, analysis and memoing are ongoing, and overlap. Memoing should take precedence, because it is the actual write-up of what is emerging from the data and the analysis. Data are always available, and can be analyzed at any time. Ideas are fragile. They should be written down at the earliest possible time.

While writing memos, think and write theoretically, in a stream of consciousness fashion, with no concerns about grammar or spelling. This minimizes writers block. However make sure your memos are legible and coherent to you. Memos are always modifiable as you discover more about your topic.

Integrating the Literature: Once you are confident in your theory, you can begin to analyze and integrate relevant existing literature into it. Theoretical material from the literature must earn its way into your theory, just like any other theoretical construct.

5) Sorting and theoretical outline

Sorting refers not to data sorting, but to conceptual or memo sorting into an outline of the emergent theory, showing relationships between concepts. This process often stimulates more memos, and sometimes even more data collection.

6) Writing

The completed sort constitutes the first draft of your write-up. From here it is merely a matter of refining and polishing your product into a final draft.

Grounded theory is a general methodology, a way of thinking about and conceptualizing data. Grounded Theory begins with a research situation. The researcher should engage all their senses in simple observation which can reveal much. Data Collection Methods can be mixed and varied.

Unit of Data Collection is Individual. Longitudinal and cross sectional data, both collected for a moderate period. The task of the researcher is to understand what is happening in that research situation. This is called the core variable. Also the researcher has to concentrate on the actors role and their managing of their roles. After each hour of data collection the researcher takes 'notes of key data. This is called note taking. Constant comparison is made with the initial data to the theory. Comparison can land us on a theory that is grounded. Researchers compare the initial data to the theory and results of comparison are written on the margins of the notes. These are "codes". The researcher identifies categories and their properties from these codes. The researcher writes further notes about the theory, which is Memoing. The researcher groups the memo line by line and sequence them in order that will make the theory clearer. The steps or stages of the GT occur simultaneously.

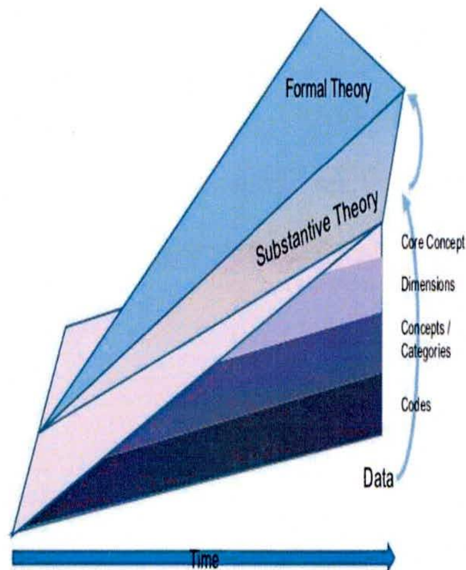
Characteristics of a grounded theory

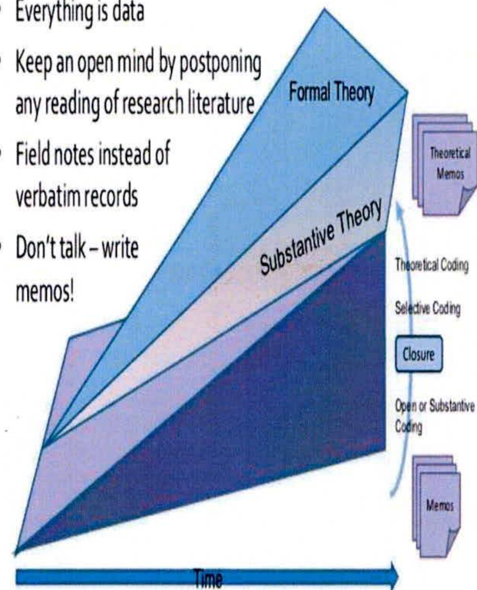
Fit: Does the theory correspond to real-world data?

Understanding: Is the theory clear and understandable?

Generality: Is the theory abstract enough to move beyond the specifics in the original research study?

Control: Can the theory be applied to produce real-world results?





Conclusion:

Grounded theory method is a systematic methodology in Social Sciences and Medicine involving the discovery of theory through the analysis of data. It is mainly used in qualitative research but is also applicable to quantitative data.

Grounded theory method adopts a reverse gear or reverse engineering method. Rather than beginning with a hypothesis, the first step is data collection, through a variety of methods. From the data collected, the key points are marked with a series of codes, which are extracted from the text. The codes are grouped into similar concepts in order to make them more workable. From these concepts, categories are formed, which are the basis for the creation of a theory, or a reverse engineered hypotheses. There is a constant comparison between the data and theory and an abductive disconfirmatory testing.

Uses of Grounded theory: Exploring new domain, leveraging the human tendency to interpret and theorize.

Strengths of Grounded Theory: It brings data into focus and depth and builds theory that is descriptive, abstract and powerful with discipline, rigor and quality

Content Analysis (Public Opinion Research)

Content analysis has proved to be a valuable research method in many areas of inquiry. Significant research ultimately depends upon substantive knowledge of one's field and creative imagination-indispensable qualities.Claus Krippendorff says, till late 1990s, content analysis was largely known in journalism and communication research, and, to a lesser extent, in the social and psychological sciences.

Today, content analysis has become an efficient alternative to public opinion research - a method of tracking markets, political leanings, and emerging ideas, a way to settle legal disputes, and an approach to explore individual human minds.

Margrit Schreiershows how to: create a coding frame; segment the material; try out the coding frame; evaluate the trial coding and then carry out the main coding; and consider what comes next. She also discusses software choices for doing qualitative content analysis.

Content analysis is a widely used qualitative research technique. It's not a single method, but a group of three distinct approaches: conventional, directed, or summative.

All 3 approaches are used to interpret meaning from the content of text data and, adhere to the naturalistic paradigm. The major differences among the approaches are coding schemes, origins of codes, and threats to trustworthiness. In conventional content analysis, coding categories are derived directly from the text data. With a directed approach, analysis starts with a theory or relevant research findings as guidance for initial codes. A summative content analysis involves counting and comparisons, usually of keywords or content, followed by the interpretation of the underlying context.

Nature of content analysis

The goal of content analysis is to provide knowledge and understanding of the phenomenon under study. Researchers regard content analysis as a flexible method for analyzing text data.Content analysis describes a family of analytic approaches ranging from impressionistic, intuitive, interpretive analyses to systematic, strict textual analyses.

The specific type of content analysis approach chosen by a researcher varies with the theoretical and substantive interests of the researcher and the problem being studied.Although this flexibility has made content analysis useful for a variety of researchers, the lack of a firm definition and procedures has potentially limited the application of content analysis.

Development of content analysis: A Context

Content analysis has a long history in research, dating back to the 18th century in Scandinavia.In the United States, content analysis was first used as an analytic technique at the beginning of the 20th century. Initially, researchers used content analysis as either a qualitative or quantitative method in their studies.Later, content analysis was used primarily as a quantitative research method, with text

data coded into explicit categories and then described using statistics. This approach is sometimes referred to as quantitative analysis of qualitative data.

Qualitative content analysis

Qualitative content analysis is a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns.Qualitative content analysis is one of numerous research methods used to analyze text data. Other methods include ethnography, grounded theory, phenomenology, and historical research.

Research using qualitative content analysis focuses on the characteristics of language as communication with attention to the contextual meaning of the text.

Sources of Qualitative content analysis

Qualitative content analysis uses text data which might be in verbal, print, or electronic form.The data might have been obtained from narrative responses, open-ended survey questions, interviews, focus groups, observations, or print media such as articles, books, biographies, Film stories, Speeches or manuals.

Aim & Focus

Conventional content analysis is generally used with a study design whose aim is to describe a phenomenon, like the case the emotional reactions of hospice patients. This type of design is usually appropriate when existing theory or research literature on a phenomenon is limited.

Researchers avoid using preconceived categories, instead allowing the categories and names for categories to flow from the data.Researchers immerse themselves in the data to allow new insights to emerge also described as inductive category development (Mayring, 2000).

Many qualitative methods share this initial approach to study design and analysis.

Conventional content analysis (CCA): Procedure

If data are collected primarily through interviews, open-ended questions will be used.Probes also tend to be open-ended or specific to the participant's comments rather than to a preexisting theory, such as "Can you tell me more about that?".Data analysis starts with reading all data repeatedly to achieve immersion and obtain a sense of the whole as we would read a novel. Then, data is read word by word to derive codes by first highlighting the exact words from the text that appear to capture key thoughts or concepts. Next, the researcher approaches the text by making notes of his or her first impressions, thoughts, and initial analysis. As this process continues, labels for codes emerge that are reflective of more than one key thought. These often come directly from the text and are then become the initial coding scheme. Codes then are sorted into categories based on how different codes are related and linked. These emergent categories are used to organize and group codes into meaningful clusters.Ideally, the numbers of clusters are between 10 and 15 to keep clusters broad enough to sort a large number of codes.Depending on the relationships between subcategories, researchers can combine

or organize this larger number of subcategories into a smaller number of categories. A tree diagram can be developed to help in organizing these categories into a hierarchical structure (Morse & Field, 1995). Next, definitions for each category, subcategory, and code are developed. To prepare for reporting the findings, exemplars for each code and category are identified from the data. Depending on the purpose of the study, researchers might decide to identify the relationship between categories and subcategories further based on their concurrence, antecedents, or consequences.

Conventional Content Analysis – A Case Study

What are the emotional reactions End-of-Life of terminally ill patients who are receiving hospice care?The Researcher decided to use a stratified sampling technique to ensure heterogeneity of the sample. The target sample size was 10 home hospice patients and 10 inpatient hospice patients, with 5 from each group being recruited within 48 hours of enrollment into hospice and 5 recruited 7 to 10 days following enrollment. In addition, the sample would include both men and women and both older and middle-aged people. The Researcher collected data through individual interviews using open-ended questions such as "What has it been like to be in hospice care?" followed by specific probes. All interviews were audiotape-recorded and transcribed verbatim.He began by reading each transcript from beginning to end, as one would read a novel. Then, he read each transcript carefully, highlighting text that appeared to describe an emotional reaction and writing in the margin of the text a keyword or phrase that seemed to capture the emotional reaction, using the participant's words. As he worked through the transcript, he attempted to limit these developing codes as much as possible. After open coding of three to four transcripts, The Researcher decided on preliminary codes. He then coded the remaining transcripts and recoded the original ones using these codes and adding new codes when she encountered data that did not fit into an existing code. Once all transcripts had been coded, The Researcher examined all data within a particular code. Some codes were combined during this process, whereas others were split into subcategories.

Finally, he examined the final codes to organize them into a hierarchical structure if possible. In the findings, the emotional responses of hospice patients were described using the identified codes and hierarchical structure. In discussion of the findings, the results from this content analysis were compared and contrasted with Kübler-Ross's (1969) model to highlight similarities and differences.

At most, the result of a conventional content analysis is concept development or model building. For example, The Researcher might find that patients who are new to hospice care express worry about how their social obligations will be met such as finding care for a pet, whereas patients who have been in hospice for long periods might express more anticipatory grief.

The Researcher might compare her findings to those of Kübler-Ross (1969) and conclude that an additional emotional reaction to entering hospice care is the process of tying up loose ends, which he might define as making both financial and social arrangements.

Advantages of Conventional Content Analysis

1) We get direct information from study participants without imposing preconceived categories or theoretical perspectives.

2) Knowledge generated from content analysis is based on participants' unique perspectives and grounded in the actual data.
3) Sampling techniques optimize diversity of emotional reactions

Challenges of conventional content analysis

1) It Fails to develop a complete understanding of the context and fails to identify key categories.
2) Findings do not accurately represent the data.
3) It can be confused with other qualitative methods such as grounded theory method or phenomenology. These methods share a similar initial analytical approach but go beyond content analysis to develop theory or a nuanced understanding of the lived experience.

2. Directed content analysis (DCA)

An existing theory or prior research about a phenomenon that is incomplete or would benefit from further description might make a researcher adopt Directed Content Analysis (DCA.)

Key tenets of the naturalistic paradigm form the foundation of Directed Content Analysis.The goal of a directed approach to content analysis is to validate or extend conceptually a theoretical framework or theory.

Existing theory or research can help focus the research question. It can provide predictions about the variables of interest or about the relationships among variables, thus helping to determine the initial coding scheme or relationships between codes. This has been referred to as deductive category application .

If data are collected primarily through interviews, an open-ended question might be used, followed by targeted questions about the predetermined categories. After an open-ended question, The Researcher uses probes specifically to explore participants' experiences of denial, anger, bargaining, depression, and acceptance. Coding can begin with one of two strategies, depending on the research question.

If the goal of the research is to identify and categorize all instances of a particular phenomenon, such as emotional reactions, then it might be helpful to read the transcript and highlight all text that on first impression appears to represent an emotional reaction. The next step in analysis would be to code all highlighted passages using the predetermined codes. Any text that could not be categorized with the initial coding scheme would be given a new code.

Directed Content Analysis – A case study: Method I

The Researcher designed a sampling plan to maximize the chance of recruiting participants at different stages. All participants diagnosed with a terminal illness constituted the population.Stratified Purposive sampling was adopted.1/3rd were receiving forms of curative therapy in a bid for a last chance.1/3^rd^consisted of those who refused further curative therapy but were not enrolled in hospice care.1/3rd were contemplating or had recently made the decision to enter hospice care.

In addition, the sample was recruited for gender balance and diagnostic diversity, specifically both oncology and non-oncology diagnoses. The target sample size was 18 to 21 participants. Interviews were conducted with individuals using open-ended questions, such as-what has your emotional journey been since being diagnosed with this illness? Specific probes were developed based on Kübler-Ross's model, such as- Have you felt angry since your diagnosis? After institutional review board approval, informed consent from all participants was obtained. All interviews were audiotape-recorded and transcribed verbatim. The Researcher developed operational definitions of the five emotional responses. He then reviewed all transcripts carefully, highlighting all text that appeared to describe an emotional response.All highlighted text was coded using the predetermined categories wherever possible. Text that could not be coded into these categories was coded with another label that captured the essence of the emotion. After coding, The Researcher examined the data for each category to determine whether subcategories were needed for the anger category such as anger towards self, anger towards doctors, anger towards a spiritual being.

Data that could not be coded into one of the five categories derived from the theory were reexamined to describe different emotional reactions. Finally, The Researcher compared the extent to which the data were supportive of Kübler-Ross's theory versus how much represented different emotional responses. The report of study findings described the incidence of codes representing the emotional stages suggested by Kübler-Ross with those that represented different emotional responses by comparing the rank order of all codes. The Researcher summarized how the study validated Kübler Ross's model and what new perspectives were added.

Directed Content Analysis: A Case study: Method II

The second method is to begin coding immediately with the predetermined codes. Data that cannot be coded are analyzed later to determine if they represent a new category or a subcategory of an existing code. If the researcher wants to be sure to capture all possible occurrences of a phenomenon, such as an emotional reaction, highlighting identified text without coding might increase trustworthiness. If the researcher feels confident that initial coding will not bias the identification of relevant text, then code immediately. Depending on the type and breadth of a category, researchers might need to identify subcategories with subsequent analysis. For example, the Researcher might decide to separate anger into subcategories depending on whom the anger was directed toward.

The findings from a directed content analysis offer supporting and non-supporting evidence for a theory.

Merits: The main strength of a DCA is that existing theory can be supported and extended. The directed approach does present challenges to the naturalistic paradigm.

Demerits: Using theory has some inherent limitations in that researchers approach the data with an informed but, nonetheless, strong bias.

1) Researchers might be more likely to find evidence that is supportive rather than non-supportive of a theory.

2) In answering the probe questions, some participants might get cues to answer in a certain way or agree with the questions to please researchers. In the study, some patients might agree with the suggested emotive stages, though they didn't experience the emotion.
3) An overemphasis on the theory can blind researchers to contextual aspects of the phenomenon. In this study, the emphasis on Kübler-Ross's stages of emotional response to loss might have clouded his ability to recognize contextual features that influence emotions.

Remedy: To achieve neutral or unbiased results, an audit trail and audit process can be used.

2. Summative content analysis (SCA)

SCA typically, starts with identifying and quantifying certain words or content in text with the purpose of understanding the contextual use of the words or content. This quantification is to explore usage. Analyzing for the appearance of a particular word or content in textual material is referred to as manifest content analysis. If the analysis stopped at this point, the analysis would be quantitative summative content analysis, focusing on counting the frequency of specific words or content .

A summative approach to qualitative content analysis goes beyond mere word counts to include latent content analysis which focuses on discovering underlying meanings of the words or the content.

In the Researcher's study, the initial part of the analysis to count the frequency of death/die/dying is viewed a Quantitative Approach. However, The Researcher went on to identify alternative terms for death and to examine the contexts within which direct versus euphemistic terms were used. That is qualitative summative content analysis.

Summative Case Analysis - a case study

The Researcher designed a sampling plan to maximize the diversity of the sample around demographic characteristics of both the clinician and the patient/family. Patient characteristics included gender, age, diagnosis and ethnicity.Clinician characteristics included gender, discipline, and specialty. Two types of communication events with patients who had received a terminal diagnosis were sampled. One was discharge teaching for hospitalized patients who were being transferred to home hospice, inpatient hospice, or skilled nursing facilities for end-of-life (EOL) care. The other communication event was clinician-patient/family conferences in an OPD or inpatient settings to plan EOL care. Fifty separate communication events were sampled for 50 different clinicians and patient/family pairs. All clinician-patient conversations were audiotape-recorded and transcribed verbatim.

Data analysis started with computer-assisted searches for occurrences of the terms die, death, and dying in the transcripts. Word frequency counts for each of the three death-related terms in a transcript were calculated and compared to the total length of the communication event. The Researcher also coded the identity of the speaker, such as physician, nurse, patient, or family member.

Frequency counts by type of speaker were calculated and compared to the total number of terms coded. Next, The Researcher tried to identify alternative terms or expressions used instead of death, die, or dying. Occurrences of these terms were counted both as a total number and for each alternative

term. Frequencies of euphemisms versus direct terms were compared for type of speaker, demographic characteristics of clinician, and demographic characteristics of patient within each communication event and across the total sample.

Some Applications of Content analysis:
Content Analysis is used in Marketing and Media Studies, Literature and Music, Ethnography and Cultural Studies, gender and age Issues, Sociology and Political Sciences

Sources of Content Analysis:

Textbooks, Chapter Writing, Essays, Interviews, Discussions, Newspaper Headlines and Articles, Documents, Speeches- Any instance of Communicative Language

Conceptual Analysis:
Conceptual Analysis can be thought of as establishing the existence and frequency of concepts most often represented by words of phrases in a text.

Steps for Conducting Conceptual Analysis

Decide the level of analysis and how many concepts you want to code for. Decide whether to code for existence or frequency of a concept. Decide on how you will distinguish among concepts and develop rules for coding your texts

Relational Analysis:

Relational Analysis seeks to explore the relationships between the concepts identified.

Theoretical Influences on Relational Analysis:

Linguistic Approaches: Focuses analysis of tects on the levels of a linguistic unit, typically single clause units.

Cognitive Science: Includes the creation of decision maps and mental models. Mental Models are groups or networks of interrelated concepts that are thought to reflect conscious or subconscious perceptions of reality.

Subcategories of Relational Analysis:

Affect Extraction: This approach provides an emotional evaluation of concepts explicit in a text.

Proximity Analysis: Concerned with the co-occurrence of explicit concepts in text

Cognitive Mapping: Allows for further analysis of the results from the previous two approaches

Steps for Conducting Relational Analysis:

Identify the question. Choose the sample for analysis. Determine the type of analysis. Reduce the text to categories and code for words or patterns. Explore the relationships between concepts keeping in mind

the strength of a relationship, sign of a relationship and direction of a relationship. Code the Relationships, Perform statistical Analyses and Map out the representations.

Reliability:

The reliability of a content analysis study refers to its stability, or the tendency for coders to consistently re-code and reproduce the same data in the same way over a period of time.

Validity:

The validity of a content analysis study refers to the correspondence of the categories to the conclusions, and the generalizability of results to a theory.

The Kolar Initiative

Objectives of the Initiative:

1) To support infrastructure for service provision to improve the Primary Health Center
2) To improve accessibility to PHCs
3) To raise health awareness through media

The PHC being strengthened:

The PHC is in Thailur which is in Mulbagal Taluk, which serves a population of about 12,000 and covers 12 villages The PHC has 2 buildings, the older building has 12 rooms and the new building has 11 rooms. Both buildings put together have 13 beds. Each PHC has 9 ASHA workers covering around 6104 people in Thailur village and 3 sub-centers. 100-150 people come to OPD every day. Yearly 7500 patients access the facility. RNTCP reveals 14 TB patients. Many migrants from Andhra Pradesh access the PHC due to its proximity to the Andhra Pradesh border. In April around 360 deliveries were conducted. There are 4 Anganwadis. The toilet is used as a storeroom. There was an RO plant for drinking water which has been kept aside. They are asking for another RO plant.

The SOCHARA team had a good cooperation at the PHC with the doctors and ASHA workers. The PHC caters to a 15,000 strong population.

Improper allocation of VHSNC funds: Nobody knows about VHSNC and the funds aren't being used appropriately.

Corruption: The Doctor takes money from all patients: 20 rupees.

Under-reporting of cases:

Registers are not maintained properly and cases are under reported because reporting results in problems from the THO and DHO. PHC employees sometimes don't report Infant Mortalities so that they don't get hauled up. Anganwadis don't report malnourished children because it will speak poorly about their work.

Training Programs Conducted at the PHC:

BESCOM arranged a training program to find out what problems happen due to current problems and electric hazards from power lines. FRLHT organized a training program to setup a herbal garden in the PHC and sensitize people to herbal gardens and what their uses are. Aruna from our SOCHARA team spoke to the community for 20-25 minutes about SOCHARA, Sanitation and Personal hygiene.

Street Play:

10 villages were chosen for the program to conduct a street play about communicable and non-communicable diseases under each PHC. Identification was done with the help of members of the Gram Panchayat and Community. The team for the strengthening of the PHCs was supported by 5 SHG members, 8 ASHAs and 2 ANMs.350 people gathered around Thailur Bus Stop for the Street Play and the play was replicated around 10 villages. It was easy to mobilize people for the Kala Jata initiative in Adgal because there were willing musicians in the village. There was a rescheduling on the last day. The program was ultimately successful in meeting its goal of raising awareness at the community level.

Challenges faced while conducting the Health Awareness Campaigns:

The ASHAs and ANMs did not get permissions from the THO (Taluk Health Officers) and DHO (District Health Officer) to attend the training program.

Aruna got information from 2 members of the Gram Panchayat to attend the program but they called early in the morning of the program and cancelled their plans. Despite these setbacks she was able to enlist 5 women for the program.

The availability of a mic and audio system would have helped make the play even better than it was. It was excellent. Another Challenge was bus facilities were not available regularly.

Though there was cooperation from the PHCs the initiative and engagement from people in the community could have been better with some people skipping meetings and not staying engaged with the material being acted out.

Learnings and reflections:

Observing the projects and interviewing friends who worked in-depth with the projects around Kolar gave me an orientation to team management, how to deal with different people and manage a team, to adjust to changes in schedules in peoples plans, how to talk to people. There were difficulties in accessing and talking to the THO. Managing and giving importance to gatekeepers and authorities is very crucial while doing visible work else non-cooperation could potentially impede a project. As in the case of this project, the THO employed evasive tactics and red tape and refused to think of plausible flexible solutions possible under the given set of circumstances in the interests of a greater good without allowing services to be compromised. There needs to be a sensitization of public health workers during their training with an orientation to the Social Determinants of Health and creative approaches to tackle these. Permissions would keep getting referred to the DHO and a sort of back and forth up and down the hierarchy happened until the meaning of the permissions in the context of the project was lost due to a disconnect between the decision makers and key implementers on the ground. The THO also moves around the Taluk a lot in his supervisory role and may have genuinely been busy but creative solutions could have been employed to address all stakeholders requirements in the context of the project more equitably. A creative approach to health will not only help healthcare systems but other sectors as well. For example, Herbal Gardens don't necessarily need to be restricted to PHCs but can also be created in schools to complement to mid-day meals which can add to the nutritive value of schools.

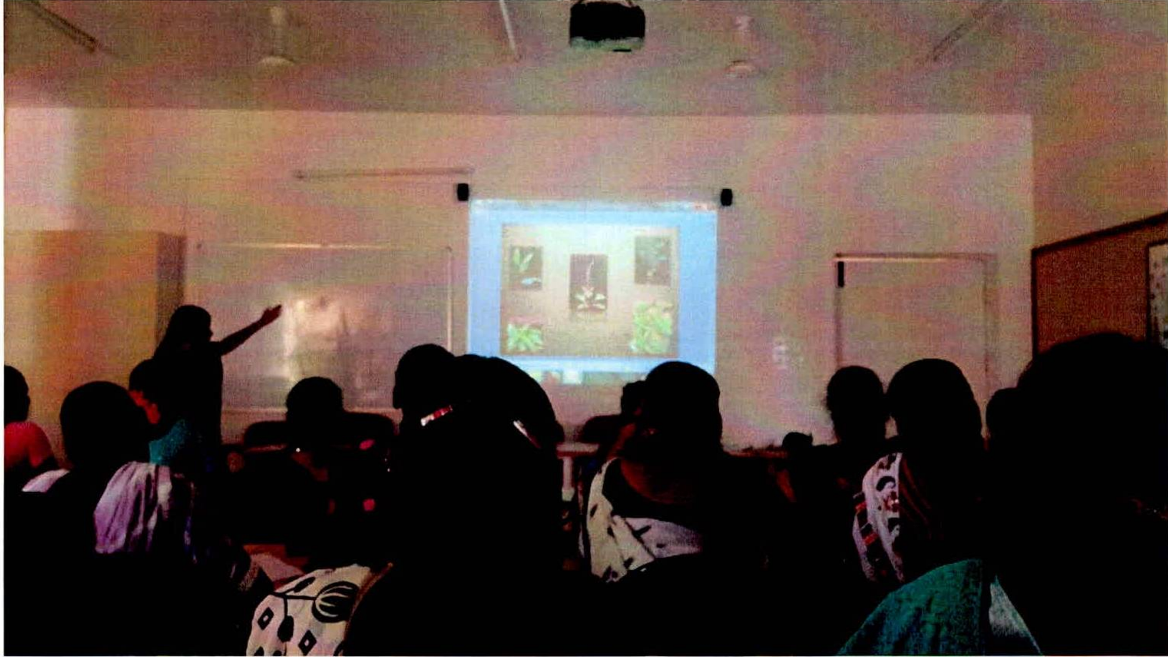
Herbal Gardens at PHCs in Kolar with FRLHT:

10 villages were chosen for the Herbal Gardening Initiative. There were no problems with cooperation. 8 ASHAs 2 ANMS 5 SHG members participated in creating the garden with the support of SOCHARA and FRLHT. Anjineyalu got to meet the Panchayat Development Officer and to attend a meeting with gram panchayat members in the current MLA's village: Mr.Ramesh Kumar.

Issues of concern that surfaced through the field visits and meetings:

1) In Adgal Alcoholism is rampant, even among children.
2) Dog bite is another common problem in this area.

Training Program at FRLHT:



A training program was conducted in FRLHT with the PHC workers and members of the Self-Help Groups.

The meeting started with a prayer and song by Geeta from FRLHT. The meeting was conducted in Kannada.

Purpose of the visit:

To orient ASHAs and PHC workers to Ayurvedic and Herbal remedies and to train ASHAs and PHC workers to grow and medicinal plants around their PHCs for herbal remedies. Through the training program FRLHT faculty insisted to the women to get professional medical attention for major problems and to make home remedies at home with these plants for minor problems.

Other agendas that were met at the meeting:

1) **Location of Gardens:** They decided on the space near the PHC to establish the herbal gardens.
2) **Dimensions:**How much room was required for the herbal garden was discussed and decided upon.
3) **Nutrition:** Women were taught how to make herbal drinks of nutritive value in addition to getting trained in herbal remedies.
4) **Livelihood:**A note was made on how it is possible make Hair Oil as a source of livelihood. The FRLHT staff also promised to conduct a workshop near the PHC for the community in the future on how to produce hair oil with local herbs.

Potential Areas for conducting workshops with FRLHT in the Community:

1) Vermicomposting

2) Capacity Building for making herbal gardens with medicinal plants
3) Nursery and propagation techniques
4) Semi-Processing and value addition techniques

Method of finding participants:

A Baseline Survey is conducted to find out interested women in villages in the target area. Currently programs are being conducted in 8 villages around Yelahanka by FRLHT staff near the institution.

FRLHT's Activities:

The focus of FRLHTis mainly research, High Performance Thin Layer Chromatography and Phytochemical studies are done to analyse the chemical fingerprints and DNA fingerprints of plants. An Example: Ginger's main constituent is Gingeral, they can also find out how much gingeral is present in ginger.

They work on Anemia and are coming up with revitalizing drinks. Herbal Drinks are a cost effective solution to energy drinks. Some plants have been found for Helmenthiasis. They are currently working on Alzhiemers and Diabetes.

They fed fruit-flies pomegranate juice and proved that it increased their lifespan.They are involved in conservation of endangered plants.

Home remedies and plants shown to the participants at the training program:

1) *Tulsi* for common colds, coughs and fever
2) *Ashwagadha* for generalized weakness
3) *Aloe Vera* for Skin Problems, particularly wounds and burns
4) *Brahmi/Aamla* consumed for memory and used to make Oils for the scalp and hair,
5) *Amrita Bali* to mitigate Diabetes Mellitus and boost immunity
6) *Hongane Soppu* is used for Anemia and can be incorporated into a vegetarian diet with the vegetables or the stew.

The women were also introduced to concepts such as *Topiary* which is an artistic way of cutting shrubs and bushes they were briefed on how to maintain the plants, Watering needs to be done daily or once in 2 days, the women were taught how to maintain the consistency of soil and how often to manure the plants.

Minor Issues and Solutions:

Fencing was needed to protect the herbal gardens from animals. The problems in the beginning of the herbal gardening program were that the plants were not being watered properly but through Prahlad's intervention the watering is being done now.

Implications of The Union Budget 2016-17

Budget History: Some Important Milestones:

First BudgetIn Indian History: on April 17, 1860 was by James Wilson, from East India Company to British crown

First Budget of Republic of India: by John Mathai on Feb 28, 1950 at 5 pm

Gita Sen: Implications of the Budget on the Social Sector

I agree that Mr. Jaitley had a difficult task this year but he is not the first Foreign Minister to face these challenges and the UPA has faced these challenges in the past, and that's where the question arises about how you take an economy with a massive rural and poor population and turn it into a silk purse. The core economic challenge is. How do we invest? In physical infrastructure and capital or invest in human beings. Those who know NREGA know that the claims that the policy makers make are not true and that the budget was cut during their term. It is at the same ratio to GDP as it always has been and there have been years where it has been higher, and in years of drought if this is all there is to NREGA there is going to be a lot of problems we are not going to be able to deal with. The poor people in the rural areas are going to feel the pinch. There is a sleight of hand. Funds of 15000 crore rupees have been shifted from the Finance Ministry to the Agriculture Ministry to show a boost in the agriculture sector without an increase in expenditure.

There is a rise in cesses and surcharges levied by the centre, in terms of rural growth 14% agricultural growth in 5 years is not going to happen and its hot air that we are going to see anything of this kind since these numbers have been well in the negative till last year.

Last year was a disaster to the budget for the Social Sector. Women and Child, Health and Education saw massive cuts, there was a prolonged denial of what was happening in the social sector, it took a long time for the *Niti Ayog* to come together and think about how to help critical programs to the social sector because of a 60:40 division between Centre and State and a policy paralysis because of a lack of clear role clarity. Who is going to ensure the state government will ensure they come up with their 40%. We have to wait and see how much money actually comes out at a time when agriculture is in serious trouble.

If we look at the Education budget and the Health budget there is no real increase. Education as a percentage of GDP is at about 0.48 (nominal and not translated to real numbers) *Sarva Sishya Abhyan* reduced by 100 crores. The draft national health policy which has been put together by coming together

of multiple stakeholders was stuck and there was no money forward coming for it. The policy is a policy and cannot pull a budget.

1,00,000 insurance with 30,000 top up for insurance, is insurance the right way to go? the increase in *Jan Aushadhi* has gone up from 16.9 crores to 39.9 crores how many centres are going to be able to come up with that money? The insurance route is not the best route in our country to take. RSBY is not helping in primary healthcare or prevention neither is it sustainable financially.

Growth Estimates:

These Growth Estimates make no sense, 7.2% doesn't jibe with anything, steel, industrial credits and exports. Look at R.Nagaraj's piece in the Hindu the middle of the last month. The growth numbers are not reliable, if these numbers are not reliable what are we going to know about the money that's there and how much of it is being used?

Narendar Pani: Dynamics and Trends (Expert and Author on Inclusive Economics and Gandhian Economics)

When we talk about economic strategy we need to look at the dynamics of the economy and not at specific sectors the way the budget is approached every year.

Jaitley has set ambitious targets but its good textbook economics through quiet measures by forcing public sector to push up non-tax revenues

Sustained Growth:

Why the mismatch between the growth rates and what's happening on the ground? (Answer: Black Economy and skewed accounting practices)

Mr. Jaitley couldn't afford an increase in fiscal deficit because of a massive increase in demand, there is nothing in the budget to make our production competitive when exports have been slowing for 14 consecutive months and this has serious consequences on the economy. There is a seeming insensitivity to clear economic thinking and macroeconomic dynamics. Direct Cash Transfers do not take into consideration the bigger picture of the economy and do nothing to help the economy. Moreover, they are not sustainable.

Agriculture focus is exaggerated. *Pradhan Mantri Kriti Sanchar Yojana* is exaggerated and NREGA is well below the peaks reached by the previous governments.

Discussion:

No talk about defense in the budget

There is a freeze in the defense budget due to the shift of rhetoric to agriculture and a difficulty in getting deals from abroad.

Decline in subsidies:

Reasoning: Because people who are undeserving get in and the deserving get anyway left out

How Economists Calculate GDP: They look at production and they look at the market price and both the numbers should match but because a large number of companies are declaring income with no production due to return of black money or various reasons. The numbers don't match and are badly skewed. This is a huge problem due to the black economy.

Impact on the small farmer:

Particularly in the north and east people are moving away from agriculture in a massive way, so we have to look at not the farmer, but at the real poor and what does the budget do for them. Nothing.

Any good news at all?

Instead of looking at 30 countries he should have looked at 30 villages. We wish the Ministry had looked inwards rather than outwards before coming up with the budget.

The Excise Duty on tobacco products has gone up from 15% to 30%, so this is good from a public health perspective, but they never tax beedis so does it really help in an absolute sense?

Reasoning for non-taxation of beedis: It is a source of livelihood for the poor.

Should the 60:40 be more flexible:

If you make it flexible the states may not need to come up with their 40

How is 100% food processing FDI going to help the farmers?

The logic is that a lot of food generated gets lost due to lack of cold storage facilities and will also help with exports.etc

Someone from the Finance Commission at the Talk:

He Compliments the finance minister for creative accounting

Though money has been pumped into infrastructure he talks about capital expenditures, 1% has been mopped up from falling petroleum prices and the gap between the price per barrel and the market price and also by subsidies and higher taxes to maintain the fiscal deficit at 3.5%

Fertilizer Subsidy:

Fertilizer subsidy goes to fertilizer companies and not to the farmers. Urea is being pilfered to Bangladesh and other countries because urea is cheaper here in India. Year after year government after government has been unable to deal with the problems arising from the incorrect administration of fertilizer subsidy.

Tax Administration:

Dispute resolution, the amount of money collected is 25 Lakh Crores

It is important to reform the GST and the union government could have done a lot more in harmonizing and unifying the tax rates. They have taken very superficial measures.

Tax Amnesty for black money:

Amnesty is not going to deal with the process of dealing with black money. So will this really reduce the black economy?

Even if 5% of the people come forward this is great but does it really deal with or solve the problem at hand.

Increase in Transaction Tax and Dividend Tax

If you want to tax the rich tax all the rich why only rich shareholders?

The government has done some degree of undoing of what the finance commission tried to do by increasing cesses and charges

Conclusion: Budget loses the big picture and we were better off in 2014-2015

Charan Singh: Overview of the Budget 2016

Context and Highlights:

We are a $2 Trillion dollar economy competing with the $17 Trillion economy of USA and the $12 Trillion economy of China.

Key Features of his Talk:

100,000 Crore rupees is siphoned off by tax subsidies to the well-off.

Enhanced female participation can lead to 1.4 % to GDP Growth Rate,India has the largest number of undernourished people in the world, at 195 million people.

By next year the value of the rupee could fall to 83 rupees to a dollar

Focus on Rural Area and Rurban clusters

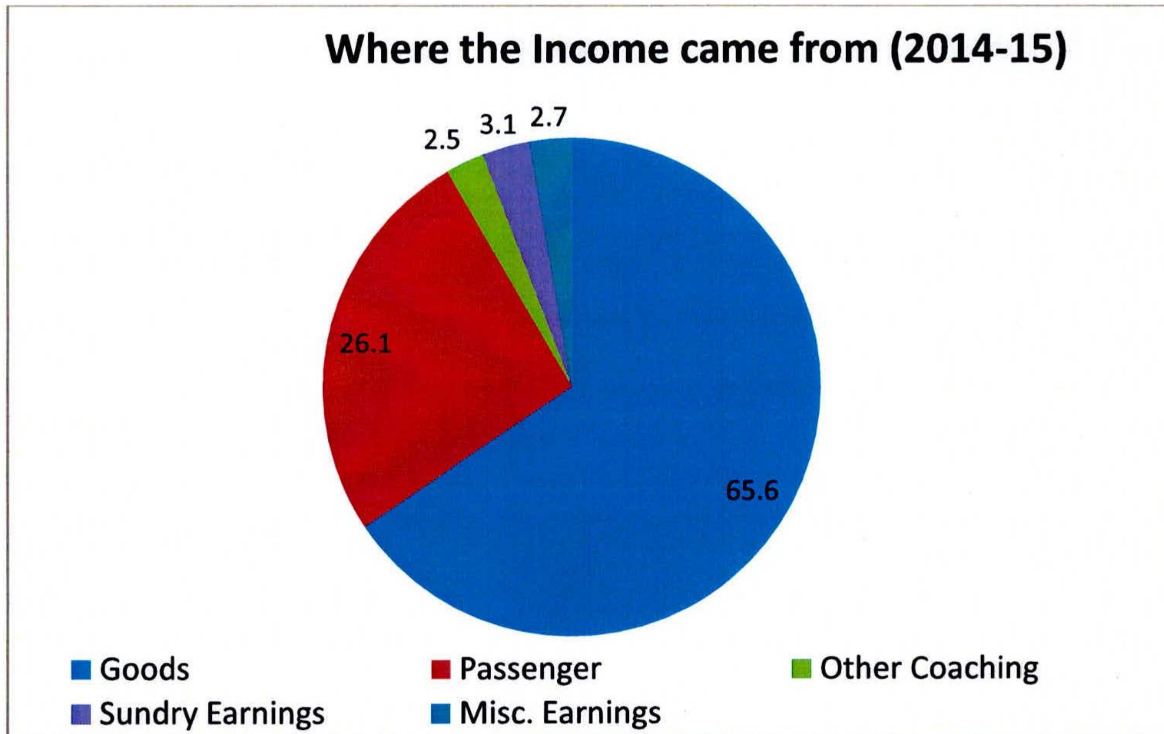
Is Voluntary Disclosure Scheme a good strategy?

Recapitalisation of Banks – too less and too late

Railway Budget: A Separate Budget

The railway budget is presented separately because the railways, was not a national enterprise when it was started by George Clark in 1843, but was a commercial enterprise and hence had a separate budget. There is an ongoing debate that the railway budget needs to merge with the rest of the budget.

A large chunk of railway revenue comes from freight.



We have had a Separate Railway Budget since 1924, The First Rail Budget in India was presented by John Mathai in Nov 1947. The Computerized Reservation System was established in 1986.

The Railways is the Largest Employer in the country and employs 14 lakh people and operates about 65,000 kilometers of track.

Railway budget Hits and Misses

Hits:

Improving freight traffic

Women: Sub quota for 33% women's reservation

Establishment of a Railway University

Geospatial technology

Reorganization of the Railway Board.

Misses:

Depreciation fund and safety fund have a lower allocation

Public-Private Partnerships focus on murals rather than public amenities like toilets and escalators

The Union Budget:Economic Survey:

Is an important policy document for analysis:

Revelations:

Growth in agriculture is in trouble and is lower than decadal average.

Growth in industry is accelerated on the strengths of manufacturing.

Growth in services sector doesn't show much change.

Economic Survey suggests: Growth in 2016-17 is in the range of 7 to 7.75 percent. (this claim is rubbished by economists)

Muted flow of credit to industry is a cause of concern

Banks will need to improve their capital positions.

Estimated capital requirement: Rs.1,80,000 crore by 2018-19

Mining, iron and steel, textiles, infrastructure and aviation sectors contributed more than half of stressed assets. A prudent fiscal target of 3.9 percent seems achievable in 2015-16, partially because of decline in petroleum subsidy and buoyant indirect tax collection.

Low taxation base – Only 4 percent of voters pay Tax. Tax payers to voter's ratio should rise to about 23 percent.

Economic Survey calls for review and phasing out of tax exemptions. It identifies property taxation as a potent area for attention.

Well-off people enjoy government subsidies of Rs. 1 lakh crore.

Exports have declined by about 18 percent in the first three quarters.

Services exports have been more affected than manufacturing.

Economic Survey suggests introspection on five major issues – providing support to farmers, mitigating impact of errant trade policy on farmers incentives, reconciling the "big but poor' dilemma that confronts India in trade negotiations, dealing with stresses due to external environment and engaging more broadly with the world, on trade issues.

India mid-way through its demographic dividend, needs to create enough good jobs.

It suggests enhancing the share of contract workers to limit the threat of labour regulations.

Enhancing female participation can lead to an additional 1.4 percent of GDP growth every year.

Declining educational outcomes, reflected in lower reading levels in both public and private schools.

Reveals India has the largest number of undernourished people in the world, at 195 million people.

Exchange Rate of the Indian Rupee:

Rupee is sliding from 62-70

Wholesale price index is dipping down

Exports and Imports there is a global slow down and exports are suffering imports are mainly oil and it's a happy scene

By next year the value of the rupee could fall to 83 rupees to a dollar

Key Debt Indicators are Very high

Tax and Non-Tax Revenue: trending up marginally

Main Sources of Tax Revenue:

Corporate Tax

Income Tax

Customs and Excise

Main Sources of Expenditure:

Subsidies, Defense and Interest Payments

Interest payments are in very big amounts and they are coming up with the following ways to rationalize and reduce the interest rates:

Food Subsidy is going to be hit

Petroleum Subsidies

Deficits

The gross fiscal deficit has been contained. You could give up fiscal consolidation and keep the deficit but the finance ministry chose not to take this route and chose fiscal consolidation

The Budget is a Policy statement rather than an accounting exercise- how the policy is going to unfold remains to be seen.

According to the Finance Minister, the Budget was made in difficult times, the domestic economy is slow and sluggish same with the external economy.

In this situation the finance minister said the agenda was to transform India by development of the rural sector and that he wanted to do the analysis under 9 pillars:

1. Agriculture and farmer welfare
2. Rural sector
3. Social sector
4. Education skills and job creation
5. Infrastructure investment
6. Financial sector reforms
7. Governance reforms and ease of doing business
8. Fiscal discipline
9. Tax reforms to reduce compliance burden

Features at first glance of the Budget unfurled:

- Focus is on Rural Areas
- Employment Generation
- Strengthening National Pension Scheme
- Start-ups in Rural Areas
- Voluntary Disclosure Scheme
- Recapitalisation of Banks
- Encouraging Housing
- Infrastructure Impetus on roads
- Bank Bureau to be operationalised

Missing Issues:

Women Participation in the workforce is very small (31%)

MSMEs: 5 crore MSMEs employing 12 crore people, adding 15 million people to the workforce

Social Security is important but not spoken of 11 crore elderly only 3 crore get a good pension. We need universal pensions if not for all elderly then for the females

Conclusion:

It's a Mixed budget that's Not Big Bang but slow moving

The budget lacks focus and the reforms are fragmented

There is a Lack of research in the Formulation

Missed Micro, Small and Medium Enterprises

No Social Security – Universal pension

There is Nothing on Gold Monetization schemes

There is Nothing on Debt Management

Vishwanathan: Manufacturing Sector's Perspective: Background of the budget:

The global economy is in slowdown mode fall in growth from 6% to 3% particularly in growing markets commodity based markets, even china is facing struggle, Brazil, South Africa.

Concern Area: Ration

Exports- huge drop, manufacturing exports as well as service exports :Employment generation and foreign earnings are under pressure

Manufacturing Sector has fallen from 8-12% to Static and decline, despite statements of Make in India.

Factors: Dull international scenario + Lack of competitiveness in India, Inability to identify thrust areas, poor demand manufacturers are sitting on excess capacities.

On the ground- There are reduced investments from within the private sector because of the above reasons though government is pumping in.

Corporate Profit is under stress despite very advantageous commodity price situation due to poor demand internally and externally

Key Core Sectors are under tremendous stress so they are affecting the banking sector resulting in a deadly spiral affecting the entire viability of the banking sector.

Unemployment is growing creating a vicious cycle of low disposable income and low demand and this budget has not adequately addressed these issues

Recommendations are discussed:

Increase in Public Spending is a good start but whether this will help other sectors outside infrastructure should be seen.

Manufacturing: Corporate Tax has come down only for those companies having a turnover of not more than Rs.5 crores per annum and big corporates are excluded.

Raghavan:

He feels the budget has addressed the rural sector quite well.

Good allocations for the rural sector- largest amount in the last five years with irrigation and water given a major focus. We have the most Arable land in the world. Good to see.

National Highways and Roads are a huge investment and this may generate some employment

1.25 lakhs crore for railways may not get allocated

No major steps for the industry, only help to new starters.

Recapitalization on banks is a major requirement and there is no movement in that angle. They have restricted it to 25,000 crores. In the course of time after consolidation of banks there won't be many banks left.

Negatives in the budget:

High dividend taxation + Divident restriction tax, any dividend above 10,00,000 is going to be taxed.

Contribution by employers above 1.5 lakhs will be taxed. PF amount will be completely taxed at above 30%.

No clear mention about exit policy. Cannot be done without labour reforms. India suffers from a birth defect. Poor Labour Laws and we live with this to date.

Too many cesses and surcharges above the divisible pool.

He rates this budget as a 5/10 because of dishonest centralization by some policies

Ramu Sharma: Stock Market perspective on the budget:

Stock markets across the world have been on a roller coaster ride because of fears of Chinese slow down spinning out of control and there is a spectacular collapse of Oil Prices.

How is India:

India Fortunately is looked at as a bright spot in a dark pit because we are growing at around 6%, we will have to see how many of the initiatives of the government are put into action:

Make in India

Digital India

Smart India Program

Issues of importance:

Stock Markets Trending Down

Recognition of bad loans by Indian banks, something is seriously wrong with the banks

Uncertainty of GST implementation schedule

ARE WE ON THE CUSP OF A GLOBAL RECESSION?

There is a sovereign debt crisis in Portugal, Ireland, Italy and Greece

Chinese economic bubble about to pop

Student loans at $1.2 trillion dollars just in the US

Unemployment

Central banks have little room to maneuver, banks across the world have been printing money to absorb debts.

Foreign Direct Investment has been made easier.

Foreign companies can own up to 15% up from the previous cap at 5%.

Privatization of Government Insurance Companies

Security Transaction Tax: Options trading and turnover at the highest and is going to increase the cost of trading

Excise duty on tobacco is increased by 10-15%

No tinkering on taxability of capital gains on shares – this is a huge relief to stock markets

NIFTY's Reaction to the budget:

When Jaitley spoke about Welfare initially in his speech the market hit a 52 week low.

When he spoke about fiscal discipline and that he's not going to borrow there was a 900 point upswing on the SENSEX and the NIFTY sprung back.

Because of state of world markets they swung back down.

ITC is the favourite whipping boy of the market during the budget.

The prices of automobiles is going to go up.

Centre for Budget and Policy Studies:

Food Security and Agriculture: Implications of current policy and budget:

Madhura Swaminathan

Indian Statistical Institute, Bangalore

Introduction by Narendra Pani:

Dilemmas in empirical work:

If we study a village how much is it representative of 1/6th of humanity?

You may not have complete information when its time to make a policy so do you make half-baked information or do you let leaders take the wheel? It takes time to collate empirical data to policy because of the complexities and dilemmas of the empirical data itself

The quality of reports leading to decisions depends on the quality of the person conducting the studies

Dr Madhura Swaminathan

What is food Security?

When all people at all time having physical and economic access to sufficient safe and nutritious food to meet their dietary needs and preferences – FAO and World Food Summit

She spoke about:

National Level food Security:Production

Individual as Consumers: Are they food secure?

Production:

History of Production:

There has been a period of very rapid increase in production but the concern is only with food security and not all agriculture.

Food Security and Sovereignity:

The rate of growth of food production more or less exceeded the rate of growth of population. For a country of India's size and population food security is very important to maintain sovereignity. But in the last decade food production has fallen behind the rate of growth of population.

Projections:

Last year food grain production was 252 Million Tonnes of which cereals production was 225.5 Million tonnes.

The requirement ranges from 237 Million tonnes to 296 Million Tonnes. We are barely making it to the lower range of the production so there is no room for complacency in production in the upcoming years.

Projection vs Income:

Producers: The farmers and cultivators are barely able to survive, if more farmers leave food production the growth rates will be further threatened.

We have very good data on food grain production by region and district for many years but we hardly have any data on incomes of cultivators and farmers. If we look at income of producers there was only two by the National Survey in 2003 and 2013 but they project monthly income of agriculture households was 6200 per month but in 17 states it was under Rs.1700 a month

A proportion of households in every village has negative incomes the well-off farmers make 25 Lakhs to 36 Lakhs. In Gulbarga 47% of villagers made a loss. Majority of the cultivators have 2-5 Acres and barely make Rs.2000 per months.

Price of farm inputs are going up but price of value of outputs are not going up. The minimum support price was one of the pillars of policy to increase food production in the 1960s.

Farming in India is not in a good state: What has the budget to offer to farmers?

Big claims, but very little for farmers, Every paper carries the news of huge increase in Agriculture but it is just statistical jugglery. Interest Subvention is a subsidy which goes to banks and not cultivators which will reduce the loan percentages. Interest Subvention has been added discreetly. If you look at the actual increase its only 22,000 to 29,000 crores and not 22,000 to 35,000 crores. The actual budget for agriculture is 29,000 crores not 35,000 crores. If you look at the number as a percentage of union budget or the percentage of GDP it has gone up from 2.20 to 2.5 percent, so there is very little to talk about. The only increase is increase in agricultural credit. Agriculture credit is what is given out by banks and banks are being asked to give more loans.

Who is going to benefit from these loans:

Most agriculture credit goes as indirect finance to the corporate sector and not to small and marginalized farmers.

Allocation of the current budget is in no way addressing the profit squeeze in agriculture. If we look at sustaining food security or livelihoods of farmers the present Union Budget does nothing to address these issues.

To the Consumers:

Tables from phone

Inadequate food because of inadequate access

Incomes

Prices

Quantity

Quality

Increasing research that food security is related to sanitation

Reasoning: There is no point in having food and having diarrhea.

PDS:

It is the only one intervention to improve direct access to basic food. It started in Kerala. There was a very big change in the 90s with targeted PDS.

Targeting Errors:

Given the lack of data in the country theres going to be errors of identification.

Errors of wrong inclusion: as a result of non-poor being included there is a huge cost of error and the government spends money on people who aren't in need which it could have saved.

Errors of wrong exclusion: The genuinely poor are excluded and the cost of this error expresses itself in Nutritional Status, Health Costs, Productivity Costs, Life Costs and the accumulated costs are at the cost of the next generation's health.

Are the two errors equivalent: these two errors need to be treated differently.

Weighting of errors

All governments have only focused on reducing the financial costs. Wouldn't the outcomes be better if wrong exclusion was focused upon?

Targeting has led to a very high exclusion of needy people. 33% of the households don't have ration cards. In Bihar and in UP 71-73% of agriculture labour households have no ration cards. Southern states and particularly Kerala has done well in distribution of ration cards.

80% of rural households and 60% of urban households are poor.

Moving from cash transfers versus kind transfers.

Cash transfers doesn't solve the structural problems of our economy and aren't fiscally viable in the long term. The economics of direct cash transfers isn't sound and could lead to a rise in the cost of living for all in the future. There is an absolute reduction of the food subsidy allocation. It is now less than 1% of GDP when 40% of people are malnourished.

Conclusions:

The policies of the Union budget doesn't address the problems and distress of small and marginal farmers and doesn't address malnutrition and food security. Direct Cash Transfer is disastrous for Price index when there is no scope for distribution there's no scope for procurement.

The PDS is about 5 lakh ration shops has been very critical in maintaining stability as far as food grains is concerned and keeping prices down. So if we take away the PDS and step into open market systems the prices are going to shoot up

Physical and Economic Access to food may increase if there is a shift from kind to cash transfers.

Slum Eviction: Our Journey through the Passages of Hope

All the darkness in the world is not enough to put out the light of even one candle. She stood defiantly and skillfully unified crowds years after she stood in disbelief before the shell of her former home demanding her rights as a human being born on our soil to live a life with her children in a safe place. Character and Creativity comes from braving and swimming through difficulties. Character transforms

from the intangible to the beautiful and the prominently evident when you witness people living on the streets years after their homes were taken away from them, living with hope, inspiring others with moving stories, stirring words, lyrical songs with profound meaning, dancing past their troubles with their friends in an unshakable solidarity.

Sharada (anonymized) was picked up with her children by a JCB and thrown far away like garbage while her home was smashed to bits because she chose to trust the people who dished out gifts and money to her when they wanted votes, she chose to trust that the very least they would do was treat her and her children like human beings rather than the refuse she picks everyday while the people she works for take credit for her efforts and raze down her home.

If someone doesn't exist on paper should they cease to exist? Should they cease to deserve to live with respect and dignity? Four years after she was uprooted from her home the only benefits she has been honored with after multiple attempts to get supports for her family have been empty promises, Yet, She still stands bravely not unlike a rock smoothened by the harsh waves of an unjust world, as a defiant picture of hope addressing a crowd in an inspirational, emotional and powerful speech fostering friendships and the unity of one voice among diverse groups of women facing a common problem. Only this time, she stands not alone in disbelief but with a massive gathering of equally determined and hopeful friends by her side.

If Sharada and her friends decided to leave our city because they didn't have the security of knowing if their homes would still be there when they came back from work, we wouldn't have a city, we would have a barren and filthy wasteland, it is the hands of people like Sharada that built the buildings that protect us from the elements and allow us to sleep peacefully in our beds at night while they are left naked to the exposures, discomforts and the dangers of the night because they don't exist on paper, it is

the sacrifices and difficulties they endure that allow us to breath freely, to live. I wish every privileged citizen in our city acknowledge every breath of fresh air they breathe is at the expense of Sharada or her friends getting themselves drunk to numbness before they lower themselves into the sewage for maintenance with minimal or no protective gear, before they come home to no home. That she was never accepted by the people she sacrificed her breath, blood, sweat and well-being for. Must we not acknowledge the pains and miseries of the very people who bless the lives of people like you and me with the convenience of a normal life? Do they deserve to be forgotten or taken for granted for making our lives livable?

Sharada has demonstrated to me that it is only circumstances which appear to defeat people that kindle a relentless undefeatable spirit. The wounds that hurt our souls are the ones which give hope and strength to many. Every sentient being deserves a place in our heart and in our city and everyone who contributes to the well-being of others expecting nothing in return deserves not just to be accepted and acknowledged but to be embraced and celebrated.

Learnings:

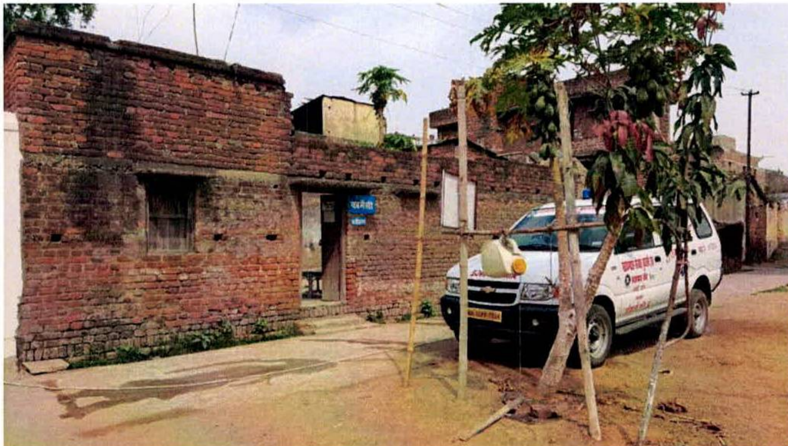
I was told that health is not healthcare and I agree. Also, Health is not just electricity and water and roads and education and sanitation and livelihood. Health is to sing and dance with your friends when they are down and you have none of these things.. To stand by their side and clap for them when nobody is clapping or worse, when nobody is bothered enough to look. Health is to fight darkness with light and hope. To make sorrows fade into the shadows of hopeful and helpful collective action. Health is to fight apathy with friendships beyond time and distance, beyond religion, class, caste or colour. Friendships with no judgement or condemnation. Health is to believe and to make others believe that the impossible is possible and to live on that belief collectively until it becomes a reality.

Across my field training I have learnt that in order to unify groups it is important to keep the spotlight and inspiration on the common cause and the common problem affecting the group when dealing with groups with individuals from diverse backgrounds who may not share a common set of values. Emotionality, human stories and versatility of expression is extremely important when engaging with and mobilizing groups into a collective ideology and action. The person who has experienced the problem is always the best person to engage with the group because they have a deep experiential understanding of the problems, related issues and solutions to the problems, and it is easier for members of a group to connect with someone who shares their problems and empathizes more understandingly. However problems such as infighting are possible within groups while unifying them. They must be anticipated and dealt with skillfully overtly or covertly before they amplify or blow up to antagonize the movement. While I am a very direct person, ours is a rather indirect culture so in the field I choose to engage more indirectly with strangers, to put across my point and this has helped me walk away from unfairness without burning bridges in some of my field visits which is a huge improvement from say 3 or 4 years ago. The field visits have made me a more diplomatic person. Sharada told us about the problems she faced that put her in jail because of a lack of unity in the group

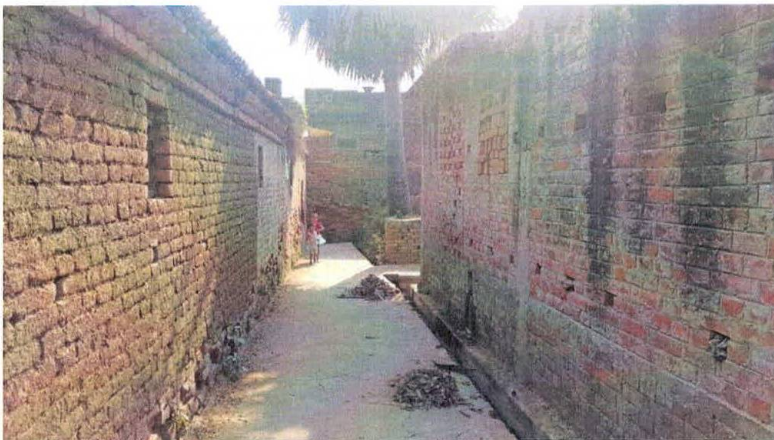
and urged the gathering to learn from the mistakes that cost her time and delayed the efforts and best interests of the group for a better tomorrow.

DFY-Bihar: Centre for Peacebuilding through Community Empowerment

With inputs from Jacob Oommen Arikupuram, Manoj Paswan, Rinku Chakroborthy, Dr.Taru Jindal



Musarhi is a village about 30 km from Patna.The DFY Community Development Initiative is run out of a handmade thatched shelter built by the people in the community in exchange for clothes and other gifts.



Geography of Operations:

The Program Operates in 4 Panchayats:

Musarhi Panchayat:

Bindoli

Satauli

Bibipur

Nandachak

Daolutpur

Mahaddipur Panchayat:

Bankipur

Bijrukh

Shreerampur

Abdullapur

Kismiriya

Saidanpur

Kharbaiya Panchayat:

Mustafapur

Kundli

Aimanbigha

Jamalpur

Tope

Sarthura

Madarichak

Kharbaiya

Niyamatpur

Parshanbigha

Soahpar

Navhiyapar

Sigrriyawan Panchayat

Kazibigha

Chakrajja

Jiwanchak

Arei Dih

Areiinformally - Eatwaari Tola

Siggiyawan

Rationale for placement of Programs:

The Program is headquartered in Masarhi which is the ancestral village of Dr.Ravikant Singh, the founder of DFY.

There is an Ultratech Cement Plant upcoming in the area and Ultratech is the primary funder for these programs as of now though the finances are dwindling and not meeting the need of the programs. DFY is experiencing difficulties with sustainability due to this. The programsare conducted in areas around the Cement Plant.

Interview with Jacob and Rinku Chakraborty

When you come to a new place how to go about finding out what to do:

When you are an outsider you will see a lot of kids, we used to talk to kids and connect to them through sports badminton, cricket, volleyball, they would come out with their issues during the drinks break and lunch break, semi-structured questions would be asked informally. For Example: Do they go to school, Do they have a school, What are their experiences and expectations with schools?

In this area the children had observed many English speaking people coming in from outside the village and they too wanted to learn English. Teaching the children English and playing games with them before and after was one of the most satisfying experiences in this trip. Way more satisfying than seeing patients.

The government lower primary school, middle primary school and high school were examined by the group.

These are the issues in schools around Masarhi:

1) Absentee teachers
2) Lack of teacher training
3) Single Teacher schools who have to go to other activities
4) Low Teacher Student Ratio 300 students to 3 teachers in lower Primary, 220:1 in some schools (which schools unknown)
5) Lack of segregation of subjects and structured curriculum
6) Limited Midday Meals where the meals that are prescribed are not available
7) Though there are Sarva Siksha Guidelines, they are not followed
8) Absence of a proper curriculum
9) No proper evaluation,the fellow was told during his interviews in the community that in some cases some children in the 8th standard don't know the alphabet.
10) Poor infrastructure, seating on floor

English classes were started by DFY late 2015 with one keen student Raghavendra, who is sitting in the front row in the above photograph the next day onwards his friends came along, within a few days there were 200 students in front of the health centre looking for an education, now they have 414 children

Water :*Chapakkal* is used (handpumps) soaps are not available for handwash, sand and ash are used instead. The water is subsoil water and is available in plenty but is contaminated due to the common practice of open defecation.

The programs are customized based on community demand. Quality is based on Social Audit through community meetings.

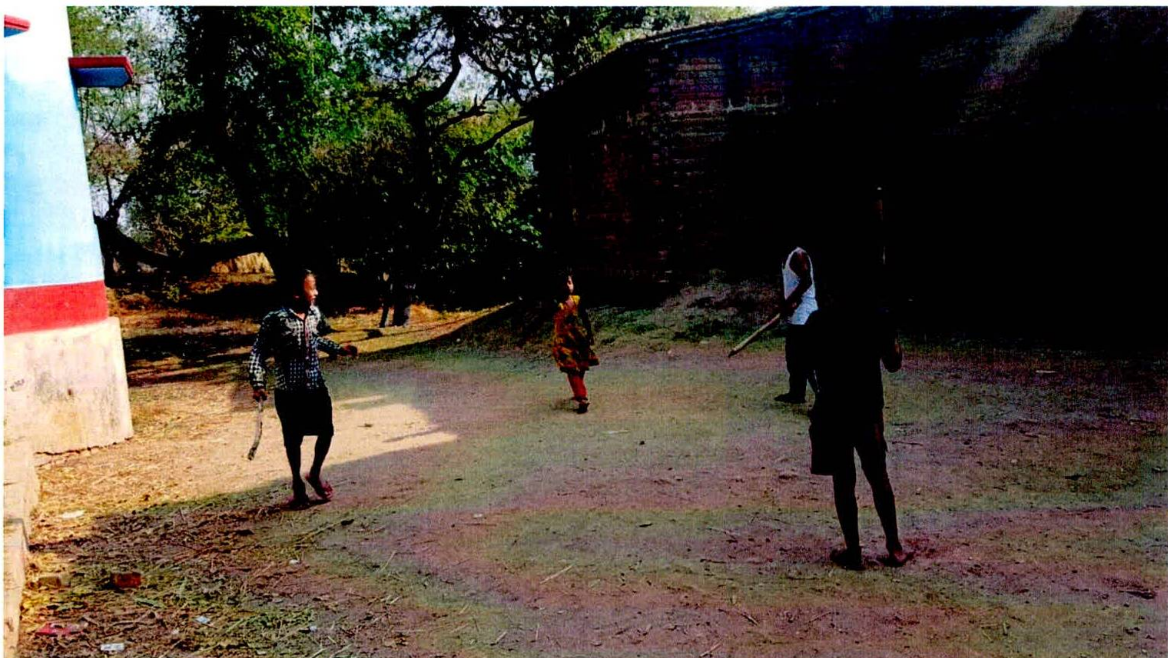
EducationPromotion Activities:

1) After school support for classes 1 to 10

2) English Classes and Story Sessions : they read stories write stories and make stories on certain themes to build mental capacities for students of Standards 5 and above
3) Computer Classes: 80 students per batch, they have 10 computers, 10 batches
4) SSC and Public Service Commission exam training.

Involvement of Parents:DFY-CPCE organizes parents meets for the families of kids studying in their learning centers. Through this meet they plan to bring guardians close to the learning process of the kids. On 25th March, 145 families assembled in front DFY-CPCE office to assess the progress made by their children. The community is included in planning and now they do the audit.

Sports Promotion in Tandem with Education:



Indoor and Outdoor equipment is available at DFY and the staff engage with the children in sports in tandem with the educational activities in the village.This is a morale booster to both the students and the staff and builds community-ship within the organization and the community.

Livelihood Cycle:

Training is given to women in the Community to tailor clothes. Clothes and gifts are given to people to build buildings. Buildings are built to teach children and train more women.

Capacity Building:

1) Anganwadi workers are trained to work better in Maternal and Child Health.
2) 64 housewives and girls were trained in tailoring and opened a tailoring centre in Masarhi of these 16 were trained by experts.
3) DFY plans to start a skill development centre for hygiene.

Earth Day:

4) Solid waste Management of the hospital: Training was given to convert solid waste from the hospital to manure and Utilization of the Waste Disposal of the Hospital in fields on Earth Day.

Since it was Holi everyone played Holi together and inaugurated this program.

Malnutrition: Community Based Management of Acute Malnutrition Project:

The method used for determining malnourished children is anthropometry through MUAC tape and height and weight measurement plotted on a growth chart. Those who fall under SAM category are admitted to the Centre and Ready to Eat Therapeutic Food (RUTF) is given to them. There are also health promotion and health education activities involving mothers in the villages on nutritious diet, hygiene and breastfeeding.

Women from the community are being trained to become health care workers in the Health Centre.

An example of a training program in malnutrition:

1) Demonstration was made on measurement of weight
2) Demonstration of measurement of height
3) Demonstration and explanations on Plotting of Growth Chart
4) Demonstration of Measurement of MUAC

Following the demonstrations the training nurses and health workers are asked to counter demonstrate the procedures one at a time.

Counselling and treatment was discussed. There was a general discussion on nutrition and micronutrients and doubts were clarified.

How DFY prepare questionnaires for Research and Audit:

They discuss within the team about the objective on three issues: health, education and livelihood because these three things are interconnected. According to the issues which come out they prepare the questionnaire.

There is a Cement Plant being built by Ultratech Cement in the surrounding villages they start doing research for programs. They make sure there is equal distribution of males and females so there is no bias. Opinions of community members are recorded on a graded questionnaire

The tools DFY uses to get information:

Rapid Assessment is by mixed method.

Special Social AuditDuring Festivals: There was one Social Audit called *Holi Sammelan* for Health Centre and the Community Development Initiative, First day there was registration of adolescent girls they were dewormed and given Vitamin A and they were followed up. The second Day was a Health Awareness Campaign. ASHAs, Anganwadi Workers, Adoloscent girls, nursing assistants and students, their families, staff, interns played holi together.

The Holi Sammelan was also an opportunity to spread awareness about the WASH program. Open Defecation is a major cause for malnutrition in the Musahar community. The community is extremely vulnerable to diarrheal disease due to the contamination of subsoil water through this practice.

Personal Learnings

The visit to Bihar was truncated prematurely. While I am keen to discuss the reasons for the truncation of this visit the successes of the action must be examined. This trip has given me the confidence to establish contact with key personnel in an NGO and to negotiate entry into a project, it has also given me the confidence to walk out of a project without burning bridges and to salvage relationships while doing things on my own terms against the wishes of other people involved when there was a need to. I feel action must always be taken in a hostile scenario in order to improve relationships. When you take assertive action and sprinkle some smooth diplomacy with the help of grey haired mentors who back you up you will notice a change in the demeanors of the people making a situation unpalatable and they may not repeat the mistake with the next person. A conflict is often times a fertile ground for a long term sustainable relationship for mutual respect especially when values or causes are aligned.

Diplomacy and Cultural Sensitivity while opting out:

While I am a very direct person, ours is a rather indirect culture. We chose to engage more indirectly with the stakeholders to put the point across and this has helped me walk away without burning bridges or ruffling too many feathers. This CHLP field visit has made me a more diplomatic person. Previously I would have engaged very directly and the relationships would have been compromised, but I chose to give a personal reason to exit the trip because I felt the contacts established through the flood response

on this visit were important and on a common good mission. We made sure that the hosts didn't feel guilty after I left and that personal differences was addressed with reassuring and positive affirming emotions rather than guilt. CHLP with inputs from my mentor Dr.Ravi Narayan and another friend in the personal realm has made me a more diplomatic person in all the experiences that followed this and it is beautiful because I have been educated into a more smooth assertiveness. I do believe this one education is going to help me for the rest of my life. We must sometimes fight fire with water and not with fire.

Citizen Journalism: Oorvani Foundation

Timeline- Bangalore: Some important happenings reported over the last few years

2000: Rajkumar kidnapped: fans bring city to a halt, riots in the city and chaos 2001: Reva Launched, Radiocity Launched First private radio station

2002: NASSACOM opens office in Bangalore, Bill Gates Visits, BATF Task force created by the CM since the city started booming

2003: Air Deccan launched, The whole saga of flyovers started, Hebbal's flyover is supposedly the longest in India

2005: December: IISc shooting, 1 killed 4 injured

2008: July Serial Blasts; 9 bombs, 2 killed, 20 injured

2008: December Fake bills scam

2009: Midnight tender case

2009: TVCC BBMP call centre shut down

2011: Namma Metro launched

2012: Garbage issues, Sectarian discrimination against people from the north east populations- thousands flee from Bangalore, Government allocates funds for SURE roads on a pilot basis

2013: Karnataka Tourism Vision Group formed, City broken into smaller municipalities

2013: KGIAL: 15 million passengers transit via just 1 runway

Governance: Key Issues:

Formation of BBMP from BMP which is now talking of breaking up

Intelligentia and activists are talking about devolution of power- they want a say in what happens in their wards and communities. Regional Governance Bill was passed. Regional Metropolitan Planning

committee. 12 corporators resigned in protest. That was supposed to be the coordinating body for the whole city. There is much chaos in Local Governance. On all Civic Issues finally at the end of the day the way the centre shares funding with the state government the state govt does not share with the BBMP. Unless we have a more empowered city council theres not much we can do in the city.

Does the city have a disaster plan if we have floods like Chennai, these things are difficult to find out and cases of dengue and chikungunyaare underreported.

Infrastructure:

Flyovers and underpasses: 100+

Water: 30-40% of Cauvery water is lost. Govt. is talking about getting water from the Western ghats but the people there have a problem with that.

Electricity: Shortfall of electricity is a Karnataka wide issue.

Why all Urban Hydrology is Social Hydrology. Evidence from Bangalore, India

Consumers and Citizens are different categories and we are both consumers and citizens, the role of citizens conflict with the roles of consumers.

Social Hydrology in Bangalore

Bangalore Background Drivers:

Short Term Average rainfall: around 850 mm/year

City Area: 740 Sq. Km.

Total Rainfall: ~1700 Million Litres a day. But human intervention impacts the water cycle.

Primary water utility:

We import 14000 Million Litres a Day ~82% of Rainfall from a source 100 km from Bangalore

Bangalore as a living organism:

Circulatory System: We understand a lot about Bangalore's circulatory system: the flow of the rupee

Metabolic Flows:

Food (organic waste and sewage)

Energy (Air Pollution)

Water (BWSSB)

Metals and Plastics (Solid Wastes)

Three ways to categorize metabolism:

Social Justice: How are the flows distributed b/w diff people in the city?

Ecological Sustainability: What volume of flow is sustainable?

Economic Efficiency: How are the flows distributed between different activities in the city?

Bangalore as a living organism is sick on all three counts

1) The political economy of distribution is fraught with inequities in multiple dimensions
2) Most metabolic flows are unequitable and not sustainable as well

The population of Bangalore in 2011:A Malignant Growth

In 2011,the population of Bangalore is the population of Bangalore in 2001 plus the population of Chennai in 2006. No infrastructure can keep up with the pace at which the city has grown. A study published a few years ago that looked at the pace at which Asian Cities have grown and researchers asked the question what else grows at this pace they could only cite specific instances of Leukemia cells. The city has uniformly grown in all directions. In 2001 not a single ward had 40,000 people and in 2011 ***every ward*** had over 40,000 people.

Water:400 MLD is the maximum we can tap out of Cauvery. The surface water we get from Cauvery is obviously not distributed evenly. On an average across Bangalore 100-150 Litres of water is used per capita per day with an upper limit of 300 Litres per capita per day. Lakes are a big part of the ground water system as well. In 2013 BWSSB moved formally from the outer peripheral areas.

Inequitable Distribution of Piping:

The piped network is concentrated in the center of the city while the people in the periphery do not have access to this extensive pipenetwork, so this is the cause of the conundrum of inequities in water distribution and sometimes the most populous regions have the least access to water. Example: Electronic City.

An example of Biophysical Links: Bellandur Lake-Yelahanka Lake

The Water Balance:

Drivers are the People and the Ecosystem. 80% of rainfall evaporates, 10% flows as stream flow and 10% percolates into the ground in the absence of people. Once you add people to the equation all these numbers change because the city is built up and we have roads and concrete which don't permit percolation and add factors of contamination resulting in an altered state of Water Balance.

Altered State if Water Balance:

We have rainfall and external water supply (some leaking out of the system) providing the surface watershed. Two sources of leakages are technical leakages and commercial leakages.From the Surface

watershed 10% percolates to the ground water aquifer. The actual recharge of groundwater is 63 mm per year without leakages. The leakages are 157 mm per year but there is some return leakage which is unfortunately contaminated but if you include that we have a recharge of minus 19-20 mm per year. In the Center of the city the groundwater is rising because of leakage of pipe water. This is fairly common across the world. Eg. Tokyo. Tokyo has leakages to the extent that it does bulk pumping out of water into the sea to keep the underground infrastructure safe.

The most water stressed months in Bangalore are the Winter Months but the algorithmic models deviced by the academics in IIMB were not converging in the months of May and June, they were missing large chunks of ground water. They had a hunch it was because of the *Kalyan Mantaps* (Wedding Assemblies) and after they added up the consumption of the *Kalyan Mantaps*the models started converging.

Water Quality: how potable is the water in the aquifers?.

The government monitors the depth in 13 wells across the city which is scarcely enough to know the levels of water across the city and BWSSB employs 0 ground water hydrologists.

Slum types and adaptation strategies

Reference: Identifying policy relevant differences in Bangalore: M.S.Sriram

What explains social mobility in the city. There are certain slums in which it is possible to escape and be awkwardly mobile. If you started your life in Bangalore where groundwater is available that has a huge impact on your mobility. There is not a single water utility in Bangalore but there are 100s of other utilities.*One of the principal drivers of internal migration in the city is the availability of water.*

Simply pricing something right does not make a difference only a fraction of people have an idea about how much water they use and how much they pay. There is a huge inequity in what people pay for water in Bangalore. 30% of the city depends on tanker water, nobody knows the quality or source of this water.

What can you and I do as Citizens:

Collect Data: We need to be monitoring more than 13 wells, we have divided Bangalore into grids.

Quality of Groundwater: Grab sampling vs. Hourly Sampling

In theory there is no problem of pollution and all the affluents are treated if you ask the Karnataka Board who are following certain protocols. But practically all the water has heavy metal contamination Chromium, Copper, Lead and Manganese: because instead of doing a grab analysis they just do 24 hour monitoring once in 12 months in the Vrishabhavati river across 12 points and the rest of the year

measurements are made at 9 a.m in the morning which does not account for the night time industrial discharge. Neither are these studies are able to point out which are the industries making the discharge.

Uncertainties: Where we need Citizen Involvement

When we Juxtapose Democratic problems with Centralized Technocratic Governance, experts are good at looking at trends and variations, where you need citizen involvement is in the critical uncertainties, to know the unknown unknowns. This requires citizens to deliberate.

How it fits into Citizen Matters:

They would see reports and repeats in newspapers but there was nothing to connect the dots on the whys and hows and they felt there was a need for an in-depth media which would look at the city and come to solutionswith involved citizens. They provide background data, discussions, success stories and failures to make people make their own call. Journalism is information for self-governance. To engage the citizens in the process is problem solving.

Story-telling: Vasanti

Divided into the following segments:

1) Context of the changed newscape of India
2) The Context of where you and I find ourselves today as citizens: the relevance of citizen journalism
3) Forms and Formats of stories. The journalist of today cannot just afford to be a journalist but needs to be a trans-journalist.

Context: Traditional Journalism vs. Modern Journalism:

When she entered her job in Indian express Office, each section had a huge space allocated and the editorial was such a large space, the noisy section was the reporting section, next to the editorial 6-7 people with glasses would sit in a semi-circle pouring over copies, there was a section of proof-readers who would work in shifts nowadays they are washed away by spell-check. She was assigned the job of checking letters published to the editor. The letters to the editor of that era was largely the citizens journalism of the time. Outside the news room there was only Doordarshan and Radio-*Dooravani.*

Cut to 2016 , from that point to now we have 800+ channels on satellite television of which we have 300-400 news channels.

New forms of Story Telling:

1) Blogs
2) Social Media: twitter, Facebook, WhatsApp
3) YouTube
4) Radio/ Podcasts
5) Print Media

6) Documentaries
7) Vlogs
8) Shorts-Short Films
9) Citizen Media
10) Alternate Media
11) Posters

News Aggregator

InShorts- Its a news aggregator which accumulates news of not more than 60 words from across the world.

Hyper-local magazines in Bangalore and Chennai:

Bangalore Gyan

Dainik Jagaran

Jayanagar Times

Adyar Times

Mylapore Times

Frazer Times

Why is a hyper local newspaper actually important:

In westernsociety everyone is always tuned into what is happening in their neighborhood or block or ward. For a hyperlocal newspaper to sustain itself it needs credible news gatherer. The strategy is two pronged, you need some amount of subject expertise and presentation skills.

Examples of how hyperlocal news can be presented in various formats:

The village voice is a reputed hyperlocal outlet in New York, very populist though Manhattan is small.

Challenge in India

Hyperlocal news outlets cannot sustain themselves in India because of funding.

Solution:

One easy way to break the funding barrier is to go on social media. Get video documentation for your story. You just need two lines below your pictures for a photo story. Just ensure your camera is on and audio is on, superimpose text on it. Bear in mind, people of this day and age would rather watch media than read text. You can tweet the story as text and additionally you can tweet the story as a video. Divide up the story so that dissemination is easier.

Software, toolsand links you can use:

www.wevideo.com

www.loopster.com

www.mp3cut.com

Contact and Source: Raksha Kumar

kumar.raksha@gmail.com

www.rakshakumar.com

Elements of Story:

Keep the Story Multi-Dimensional. Fairness and accuracy and who is saying it matters. Gaze matters-bias, beliefs ,A slant will always be there in a story towards where your heart is. Foundation has to have facts, emotions can be built on facts of where, why,when, what and how.

Keep in mind all the stakeholders and talk to them. Humanize the angles. Juxtapose two interesting pieces of statistics to tie elements in a story. Simplify everything to a level it can be understood.

Photojournalism: Citizen Journalism:

He has done more than 200 photowalks in the city. Documented Bangalore Lakes extensively. He has been a professional photographer for 11 years. He is a Chemical Engineer by training.

What is a Camera?

We have the best camera in our eyes and our souls but we cant show it to the world so as a photographer it becomes very important to use this tool as a recording medium. It is not the quality of the image but the content that matters more, if the quality is good you can show the images better to the world.

When you have a camera you must not have any fear to record anything. Photography is a language that can be understood anywhere in the world. Anyone with a mobile camera is a photographer. As a photographer keep shooting. Every dog has its day try to get your best shot on every day

Importance of Pictures

1) It gives you a reference of how things were and how they have morphed.
2) Documents things which are disappearing
3) Documents Cultures which are disappearing
4) Documents changes
5) Creates Contexts for the future

6) Tells Stories
7) Pools information from different media to make a story: Curates a story

Photography: A Lesson on Configuration:

Aperture:A smaller aperture gives better focus (F16, F11, F8) if you want to shoot only a subject and not the background use B4, B5, B8

Shutter speed: Your shutter speed has to be fast if you want static image. If you want a blurred motion image use a slow shutter speed.

ISO: Sensitivity of the film: When you are in a darker situation increase the ISO so the camera can capture the picture.

Importance of Captioning Visuals for Stories:

Individual images that tell a story but sometimes images can lie so you need two lines of caption to explain the image.

With technology and social media and citizen journalism every rock that used to be unturned has been flipped, lit and put on TV. –Granderson

Popular Genre of News Stories:

1) Social
2) Art and Culture
3) Heritage
4) Science and technology
5) Political
6) Business
7) Fashion
8) Lifestyle
9) Education
10) Economy
11) Celebrity
12) Health
13) Crime

Tips for citizen journalists

1) Have the camera at all times
2) Be ready with the camera
3) Use a compact unit
4) Look for interesting subjects
5) Talk to people
6) Understand their moods and focuses

7) Respect your subjects
8) Build your portfolio
9) Put it up on media

Data Journalism: Nisha

Every big project needs a clearance from the government. She gave us an overview on: What is Data, Where do you get it, How do you manage it, How to interpret Data.

www.Datameet.org

In open data we don't trust the narratives of people and don't listen to what the government publishes. We want raw data. Don't be afraid to get raw data.

Data:

Data is just a value assigned to a thing

Two major types of data:

Qualitative and Quantitative

Types of Data

1) Categorical
2) Discrete
3) Continuous

Where do you find data:

1) Government Sources
2) Websites: Data.gov.in
3) RTI
4) Purchase data from intermediaries
5) India Stats: http://datameet.org/wiki/catalog
6) Private Sources
- World Bank
- CKAN
- Socrata
- Knoema

Urban Data Sources

1) Transparent Chennai
2) Open Bangalore
3) Hyderabad Open

Sector Data

1) India Water Portal- water
2) Biodiversity Portal – species Data
3) Karnataka Learning Partnership – Education data
4) My Neta – Election data

How do you manage small data sets:

1) Excel
2) Open spreadsheets
3) Google docs

Databases:

Data Management systems are warehouses of structured and unstructured data

Unique IDs and Standardization:

Unique Identifiers:

The data has to be cleaned up, unique identifiers sort and visualize data. Each row must be a data point

Standardization

If there are multiple ways to name something you have to standardize it.

How to interpret data:

1) Averages
2) Base Rate Fallacy: When our assumptions overestimate probability. The only way to negate this is to know that you have a bias.

Donts:

1) Overcomplicate representations
2) Oversimplify Representations
3) Be afraid of data

Do:

1) Make sure your visualization adds on to your story

Tools for Citizen Journalism:

RTI as a tool for Journalist:

In 2005 RTI Act has given us so much information to Journalists. The information you gather could be documents, emails, MOUs.etc

How to Apply

Application is to the public information officer of a department and pay a fee of Rs.10. You don't have to give reasons for asking for information. There is no fixed format. Do not ever ask open ended questions

Tips:

1) Write to and from address clearly
2) Write to and from address clearly
3) Make sure you have paid the fees

According to the act you need to get the reply in 30 days if it is addressed to the assistant information officer you need to get it 40 days, after this you go to the appellate Authority- the DySP

Evasion Strategies experienced by journalists: The onus is put on another department, documents have been burnt in fire accidents.

Filing RTI online:www.RTIonline.gov.in for Central Government.

You can check the status of the RTI in the state website.

Provision to inspect and take notes

Section 2 (j) I and ii of the RTI Act allows citizens to inspect and take notes

Tools for Journalists/Citizens

There is no substitute for Legwork you have to go to the field and get the facts if you want to report from the ground, capture audio and video with your smartphone

You can use various tools in google and verify authenticity of search results in private mode

encrypted.google.com

Google reverse image search: If there is some image going viral and you doubt its authenticity you can use this tool

Lessons on Google Searches

Google Maps

Google news : the news aggregator

How to check ownership of registered companies

To check elevation/ height violations: www.freemaptools.com/elevation -finder.htm

Environmental Clearances: seiaa.kar.nic.in/appraisalcom.htm

Crowdsourcing tools:

Google Forms: Simple Surveys, volunteer registraitions, event RSVP

Screen Door: Useful for Newsrooms

Check Plagiarism: www.copyscape.com

NIMHANS Department Of Psychosocial Work: An Overview

An Interview with Dr.Janardhan

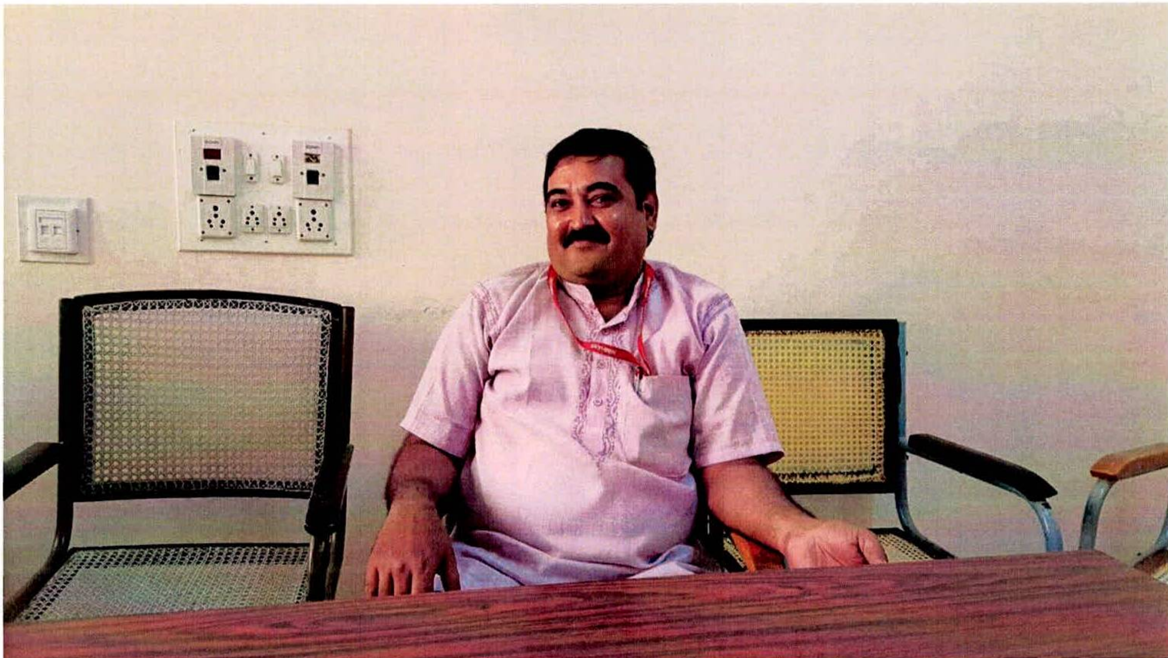
Following his MSW, Dr.Janardhan did his M.Phil in Psychosocial work.

He started his career in Samraksha after finishing his M.Phil, before moving back to NIMHANS and completing his PhD.

He has experience in the Government Sector and the NGO sector (BNI).

He has 26 years of experience as faculty in Psychosocial work.

Contact: janardhannimhans@gmail.com



Prevalence of Mental Illness:

10.2 Million people in India Suffer from severe mental illness. Studies say 60 Million people have common mental illness which requires the attention of mental professionals. Organic Mental Health Disorders: Delirium and Dementia account for 0.5% of the total population which is 5 to 6 Million people. Mental Retardation is at 2%, Epilepsy which a psychiatrist would treat is at 1%:

A total of 8.5 Crore population require mental health professionals in India.

Infrastructure and Resources in India:

42 Government Hospitals deal with Mental Illness, In addition Medical Colleges and District Hospitals have 5 beds each for mental health, if the allocated beds are not occupied, patients from other departmental specialties occupy the unoccupied beds.

Total Bed Strength in the country is 20000 beds in the government sector and 10000 beds in general hospitals so a total of 30000 beds of these in the government sector 10000 are admitted chronically and we are unaware of where their families are and where to send them when we are discharged so in reality we only have 20000 beds.

One study was conducted around ten years ago which says per day the government. spends 500 rupees per head per mentally ill.

This made WHO think and similar situation is seen in developing and underdeveloped countries. In Laos there are only 2 psychiatrists. In order to deal with this problem WHO wanted come out with an experiment which came out as development health report across 23 countries. This experiment was conducted in Bellary, a 5 year program where people in the community were trained to treat mental illness at the community level itself.

In India there are 4000 psychiatrists, 2000 psychiatric social workers and 2000 clinical psychologist.

Need for Basic Mental Health Intervention or Inputs in PHCs:

30% to 40% patients who come to a PHC to a General Physician require mental health intervention or inputs but the training is not adequate to address this. WHO is predicting that by 2020 Depression is going to be a major problem with 121 Million people globally suffering with this illness alone. Experiments have shown that mental illness is treatable. A person walking in the streets without clothes can return to normal life in 2 to 3 months. In the case of Schizophrenia 70% have a chance of recurring comorbidities and 30% will not have comorbidities. Intellectual Disabilities take a long time to treat and can be treated in the community itself.

Reasons for General Physicians in PHCs not seeing follow up:

1) The training is not adequate for severe mental conditions.
2) The medicines have many side effects.
3) Families expect dramatic changes and prefer to go to the private sector where they try out many combinations of anti-psychotics to meet the family's expectations.

Protocol followed for Admitting Destitute People with Severe Mental Illness at NIMHANS:

A Magistrate Order is required to admit a patient to Psychiatric Facility in the case of destitute patients. After the magistrate order is given Psychiatric team needs to make an assessment and write a report to the magistrate. Only in the case of severe mental illness will they be admitted. If person is not willing to get admitted and is not destitute but is severely violent the family can make an appeal to the magistrate and have him admitted.

There is a 10 symptom checklist for people with schizophrenia to admit patients called ICD-10. Even a severely mentally ill person can be treated at home or community and may not require inpatient care for a long time. They are classified into positive symptoms and negative symptoms. The positive symptoms are treated by medications, negative symptoms are treated through psycho-social intervention. The family will be trained, counselled and supported to help the person.

How do you start a program for inclusion?

They meet field staff. Address their issues and fears regarding mental illness, challenge them if necessary till they are comfortable to talk to the family first and then the person.

What are the main diseases NIMHANS are treating in decreasing order of frequency ?

Depression

Anxiety, Phobias

Psychosomatic Illnesses

Severe Mental Disorders

Three features that differentiate between mental illness and common stress:

1) Symptoms must persist for one month
2) Behaviour must affect the family and people around the person
3) Affects the day to day functioning of that person

Challenges Dr.Janardhan faced as ayoung mental health professional:

1) He was not comfortable to share his skills with field staff he had to overcome his urge to compete with people on the field. He later learned their work is different from his. His skill is to build capacity. Their skill is to do home visits as they already have an acceptance. He spoke about the stigma of mental illness.
2) Making field workers talk to the person with the illness rather than the caregiver. Often Mental health workers ask all the questions to the family and ignore the patient. So the person feels neglected and invalidated and this breaks down respect and trust between the patient and the Health Workers.
3) Follow up would be superficial and quantitative rather than qualitative.
4) Families preferred to go to temples, churches, *dargahs* and mosques rather than approach a mental health professional to avoid being stigmatized.
5) Inaccurate presentation of data by family can lead to wrong dosing and needless increase in dosages.

Challenges with Follow-up:

NIMHANS gets a lot of patients from Ananthpur Medical College but when they are sent back, there is no appropriate follow up and patients prefer to come back to NIMHANS.

Many are not aware that District Hospitals have departments and that they can go to these and get access to treatments.

Schedule of the Psychiatric Departments in NIMHANS

They have six units in the institute each unit is allocated one day of OPD in a week. They alternate their OPDs with one day for new cases and one day for follow up cases.

Multidisciplinary Team Structure in NIMHANS:

200-300 people are seen by the team per day which consists of 15 Students, Psychiatric social workers and 3-4 Psychiatrist consultants, 1 consultant and junior consultant, clinical psychologists and psychiatric social workers .

They also have psychiatric social workers in neurology and neurosurgery to prepare families for surgery and difficult procedures so there is no need for interdisciplinary coordination.

Family therapy gets referrals from all the units.

How teams in NIMHANS approach Family Conflicts and Marital Conflicts:

During Assessment they decide whether they need to go with a Systems approach or a Strategic Approach. In a systems approach there are units called subsystems, parents are one system and children are one subsystem, they see the boundaries of this system and see if they are open, closed or diffuse boundaries. They have to strengthen the bonds between the people by making them understand they have responsibilities with each other and they should not pass on their difficulties to their children. The alignments in the system have to be broken and differences have to be respected.

Central Social Welfare Advisory Board under the government have Family Counselling Centres whose job is to provide counselling to people. This has been given to NGOs. Now, Crises Centres have been started in District Hospitals with a counsellor, legal advisor and police officer for people facing Domestic Violence.

Financial Structuring:

BPL cardholders have to pay 5 rupees per day and are given free food

APL patients have slabs, Families above an income of rupees 4000 have to pay the full amount.

Patients and Families with an income 2000-4000 rupees have to pay 25% of the charges.

Higher socio economic status people rarely come because they have a stigma to NIMHANS and they go to the NIMHANS Wellness Centre.

Training Programs Conducted by NIMHANS:

1) Training program on International Classification of Functioning
2) Workshop on recent trends in Psychiatric Social Work

3) Consultative workshop on women and children in sheltered homes
4) Workshop on family enrichment program
5) Sensitized care of children affected by drug abuse
6) Workshop on Psychiatric Social Work
7) Specialized Care for children affected by drug abuse
8) Regional level training program on Social Defence among Social Work Professionals
9) Workshop on Stress Management
10) Seminar on psychosocial aspects of children with epilepsy
11) Workshop on Psychiatric Social Work to update the previous workshop
12) Workshop on Psychosocial care of the elderly
13) Workshop on School Mental Health Program
14) Workshop on Psychosocial Orientation for Community based Rehabilitation Workers
15) Workshop on Spirituality and Mental Health
16) Workshop on Family Interventions in Mental Health
17) Workshop on Livelihood of persons with mental illness
18) Psychosocial aspects of sexual minorities
19) Workshop on Skills Education
20) Workshop on Research Methodology in Psychosocial issues
21) Workshop on Effective Parenting
22) Workshop on Medical and Psychiatric Social Work- An Update
23) Workshop on Empowerment of Student Youth
24) Workshop on Psychosocial Rehabilitation

Inter-Organizational Collaborations

In addition to the above workshops which NIMHANS conducts independently, NIMHANS also conducts the following regular Workshops in association with external groups and institutions:

1) Suicide Prevention Workshop for Mentors of Indian Airforce Airmen – 6 per year at the institute of Aerospace Medicine
2) Basic Counselling Skills for College Teachers – Department of Education
3) Psychosocial Support in Disaster Management – ATI, Mysore
4) Stress Management, DTI Bangalore
5) Women's Mental Health, All India Women's Conference- Bangalore Chapter
6) NISD Collaboration for Sensitization Programs in Social Defence among PRIs, Specialized Care for Children Affected by Drug Abuse, Regional Level Training Program on Social Defence among Social Work Professionals.

NIMHANS has MOUs with the following institutions:

1) Richmond Fellowship Society India on Psychosocial Rehabilitation and Therapeutic Community Services and Training
2) National Institute of Disaster Management – MOHA, GOI, New Delhi

Policy Initiatives by NIMHANS Department of Psychiatric Social Work:

In December 2009 they published the National Disaster Management Guidelinesfor Psycho-Social Support and Mental Health Services in association with the National Disaster Management Authority, GOI

Books Published by the NIMHANS Department of Psychiatric Social Work:

Changing Marital and Family Systems: Challenges to Conventional Models in Mental Health, Bhatti et al, NIMHANS Publication No.49, 2003

Handbook on Psychiatric Social Work, Sekar et al, NIMHANS Publication No.67, 2008

Current Areas of PhD Work:

Current areas of PhD work revolve around the following Topics:

1) Psychosocial Issues in Mental Illness, Neurological and Neurosurgical conditions
2) Psychosocial Services in Disaster Management and Disaster Preparedness
3) Group Work With Families and Adolescents
4) Parenting Skills, Marital and Family Life Education
5) Psychosocial Rehabilitation of persons with Mental Illness
6) Preventive and Promotive Mental Health Program for School children
7) Developmental Disorders among Children
8) Family Centred Social Case Work Interventions
9) Sexuality and Mental Health: Impact of HIV/AIDS on Mental Health
10) Effectiveness of PSC and Yoga Therapy
11) Gender and Other Psycho Social Issues in Alcohol and Substance Abuse

Programs Dr.Janardhan is associated with:

With the support of the Govt. of Karnataka they work with:

1) **Personnel working with children from difficult circumstances** : street children, runaways, HIV AIDS, Romantic Relationships .etc
2) In 2000 a Legislation, **Juvenile Justice Care and Protection Act** was passed . By the Act the word delinquent was removed it got amended in 2006 and 2010. In 2010 they came out with a policy of care and protection of children and Government of India came out with the ICPS and societies have been protected all over the country by the Government of India under the ministry of Women and Child Development
3) The Ministry of Women and Child Development has started the **Integrated Child Protection Scheme (ICPS)** which takes care of children from difficult circumstances at the district level.

There was an institutional team and non-institutional team under district child protection officer. Under the act juvenile Justice board members and child protection committee members who would develop a curriculum to train people at the community levels to work at the Panchayat level to identify people with mental illness and get all the supports available from the governments.

He is capacitating NGOs through training programs on how to include children in psychosocial support and enroll them in government schemes

His current work is focused on Family Mental Health. Family Mental Health deals with how family contributes to mental illness and psycho educating the family so that they would make a change to their lifestyles. They also help with Marital Conflicts.

Silver Jubilee Reflections

The Faded Pants Experiment

My father told me at a very young age that people will judge you by how you dress and accessorize. In a way this is true. The people of our world who are rooted in material judge themselves and others by their externalities and will judge you by how you dress, how you accessorize and how you look to others. They will behave according to how you are dressed and the titles you or your relatives own, it is a reassurance to attach your ego directly or indirectly to anything that "looks good" without reflecting if the beauty is skin deep or more. My father told me before an international meeting that I helped organize with a group in Chennai in 2014 "dress so that people will know who you are". Who am I? I have wondered ever since is this the way to garner love and respect? By dressing well? Is this the matter of priority and relevance to the world- How you dress? So I decided to conduct an experiment. At the Silver Jubilee Meeting, on the first day when we would meet and interact with many new people for the first time, I wore my most faded and torn pants and made sure that they didn't go well with the colour of my shirt or with my dusty *chappals.* Also, I drove to St.John's in a very old beat up second hand car that was scratched and dented all around.

What I learnt is that true friends and new friends do not care about whether your pants are faded or torn nor are they concerned the with the car you choose to drive, true friends and new friends are more concerned with how you feel and how you make them feel, how authentic, engaged and connected you are. New acquaintances feel more comfortable talking to you when you don't dress *"up"*, They reveal their true selves to you and trust you more freely and willingly. I never once felt anyone at this national level meeting respected me less or loved me less on the first day. My friends and I sang songs to the gathering in my faded torn pants and never once did I feel anyone was judging me by my clothes. The warmth of the community did not fade with the colour of my pants. Nobody noticed nor cared if they did. In fact for the evening song before the *Kala Jata* performance, Kumar and two strangers, professionals who I have never met before agreed to come and sing along with the fellows when I invited them though I was wearing faded and torn pants. On the road while I was driving back people didn't compete for space around the car like they would with a nicer car. Dressing *up* and driving

*up*garners attention and fosters competitions with other people who like to dress up and drive up. It *doesnot*foster love, trust or respect. If it does, it garners the respect of the kind of people you don't want in your life and the wrong kind of respect.

I also think about the people who judge others exclusively by the clothes, the titles and the behaviours they wear shift the value they have for themselves to these external things. They commodify not just others but end up commodifying themselves. The less stuff you have the more confident you are because you have nothing to attach your ego to but Your Authentic Self. When the ego is attached to your Authentic Self, you engage in right action and it makes no difference if you have nothing or you have everything.

Respect and Appreciation are not on the same tracks as Love and Satisfaction. You can have all the respect and appreciation in the world but have no love and satisfaction in your life. But the same doesn't hold true for processes which begin in love and end in satisfaction. Those who are successful and get appreciated while working within an organization be it private, government or NGO need not do much work. Those who are interested in respect and appreciation just need to pretend to work within the system, suck up to the "seniors" and kick down the rest. They will always be surrounded by a codependent group of yes men or women who don't really like them but don't want a kick. Those who are in it to work for works sake will have the satisfaction of the fruits of their labours and the informal supports and appreciations of the true friends who they make beyond lifetimes on their journey wearing faded pants in dented cars and clap for themselves while the glory hounds glow in the credits of their efforts. They probably don't mind this because they know there will always be a lot of appreciation and love for them from themselves and others whether they are acknowledged or not even long after they are gone.

Silver Jubilee: SOCHARA

Panel Discussion-1

Tamil Nadu Floods: Narratives of the hyper-acute and chronic dimensions of disaster

Tamil Nadu floods are not unique floods. We can learn a lot from the response from people and civil society and government. Due to unprecedented rains in Tamil Nadu; Chennai,Tuticorin, Thirunalveli and other parts were affected by the floods., The marginalized and poor people are more affected by disasters than people from the higher echelons of society.

Kausalya Devi:Reaching out to people living with HIV affected by floods:

HIV Medicines are lifelong medicines. This example can be used for any disease requiring lifelong treatment

Key Players:

Goonj supported them with materials, community, people on the ground and people working in Hospitals

Positive Women's Network (PWN) also helped.

Outreach:

They reached 1791 families. 75% were affected directly by the floods. Lack of jobs and the inability to work due to ill-health and economic crisis due to price hikes was a major problem they found during intervention.

They did surveys and detailed case studies of 388 families on treatment patterns and level of damage

ART Message Tracking was done by volunteers for checking compliance

Currently an analysis is underway to analyse the relationship between economic conditions and treatment behaviors.

Major impacts of the floods:

1) Loss of valuable documents
2) Loss of medicines
3) Loss of livelihood
4) No access to food, vegetables, water
5) Loss of hope
6) They faced Discrimination.
7) Safety Issues
8) Difficulties in accessing medical centres
9) Loss of treatment and infections due to stoppage of medication

Suggestions and Solutions:

1) Provisions of 2-3 months medicines during natural disasters
2) Provision of ART in the nearest centre during disasters
3) Provision of ART through NGO/CBO workers in the affected site.

Steps Forward:

1) Consultations with the State Health Secretary, SACS, NACO and with other organizations working in the field of health and natural disasters to converge various programs
2) Treatment education to users and providers

Cuddalore District, TN Floods 2015

The rains started in 9 Nov. In the 9th and 10th the whole monsoon rains poured down 43 persons died during the rains, 32 bodies had a post mortem done and nothing is known about the remaining bodies

The Government gave a warning for 15th 16 and 17 November for the second episode. 57 km of coastal length and 683 village panchayats were affected.13000 acres of crop were affected. The water was 6-7 feet in height in the fields

Impacts:

According to the Disaster Management Act 2005

District level management plan and committee

Panchayat Level Management Plan and Committee.

Cluster level Management Plan and Committee

These have to give guidelines and give preparations.

There was no emergency planning: Mock drills not done for industrial disaster or chemical disasters either since there is a huge chemical industry in Cuddalore.

Acute Problems:

1) Low participation from the people
2) Inter-Departmental integration and coordination was poor: each department was rolling on its own resulting in a slow response
3) In the rescue centres there was the toilets were locked and there was no separate place for children and old people and open defecation was prevalent.
4) Lack of coordination between Civil Society and Government, Lack of Coordination between Government and other sectors

Chronic Problems

1) Crop Patterns have changed
2) Canals and river bed areas are occupied
3) Riverbeds are damaged
4) Sand Dunes are damaged by peoples activities
5) Most of the deaths have happened near where the drains were blocked
6) There is no desilting of canals, rivers and lakes
7) There is a nexus between politician beurocrats and land mafia who have encroached lands around the rivers.

Sujata Modi: Women Unorganized Workers.

No disaster is unique there is a lot of common features in disasters which we can learn from. The uniqueness of disasters is due to the geography around the disaster.

Justice for Disasters can be delayed. In the Kumbakonnam Disaster 5 women died and compensation of 5 lakhs was given after 12 years.

Impact on Women Workers:

1) Their Residents are in rural areas they go to work in buses, many were on their way to work or at work and there was no way to go back home.
2) They had to face wage cuts for the consequent days
3) All the stocked up rice and commodities were lost
4) Loss of household assets
5) The schools became unsafe because there was no hygiene and sanitation
6) The government direct transfer to the banks reached more of the unaffected than the afftected
7) Government can use disasters for slum evictions

Water:

Government organized Bottled Water and Tankers from Borewells, In unreached places people would drink rainwater directly or after boiling.

Panel Discussion-2

Rural Challenges of agriculture and sanitation:

Mr.Jayakumar

We live in a very unique time because if you look at the macro-picture of our country everyone loves rural areas unfortunately for the resources and land and not for the people. So people end up getting pushed out of rural areas into urban slums. Major sectors of expertise in the rural areas are Handloom and Agriculture, they also have a huge knowledge pool in this area but funding is being reduced.

Have technologies helped advance rural communities? One classical case is pesticides. Village extension officers were going to the farmers with the sprayer to spray pesticides. 110 chemicals in pesticides in peer reviewed journals affects health. Out of these 110, 56 chemicals are proven carcinogens, More deaths happen with Non-Communicable diseases as a result of this.

Fragmentation of collective community knowledge is a huge problem. Some of the rural indicators challenging our thoughts is surrogate mothers. There is a huge increase in surrogate mothers in India because they are less expensive in India, Is the market driving us in the right direction? Also in areas of food and climate is the market driving us in the right direction?.

The Agro – ecological report addressed hunger and the problems of distribution and access of food.

1600 Million people are obese in India. On a rural connect on endosulphan in Kasargod. When the people there started getting the impacts of pesticides they started believing it was because Shiva was angry. A Local Physician Dr.Mohan Kumar said it was because of water and aerial spraying. Dr Leelakumari said it was due to endosuphan. The biggest challenge in this is subsistence farming is the key in Kasargod. There are no crows, fewer ants and tribals cannot eat traditional foods.

Dr.Leelakumari could rally all the people in her village in Kanjangad, Kasargod so why cant we. High court banned endosulphan in Kerala. V.Sachitananda also set up a district level remediation and rehabilitation cell in Kerala and Achyutananda put in a lot of money into this cell.

Between 2006-2011 a very unprecedented thing happened with the State Government also jumpinig in to be a part of the protest. The Chief Minister of Kerala declared hunger strike demanding a global ban on endosulphan. This is a very inspiring story on how inspirations can flow across the border and create long standing impacts and change.

Food Security and Traditional Seeds: Usha S, Thanal

I will focus on one crop Rice due to limitations of time.

High yielding varieties, hybrids are spoken by the government but I am going to talk about traditional cultures.

Seeds are the most important input in agriculture. Most of the farmers who committed suicide are cotton farmers over the last 30-40 seeds

Every seed is a package of information understood by farmers; where it could be grown, how it could be grown. High yielding variety and traditional seeds are varieties. Seed is also food.

Food Security:

Food Security exists when all people have physical and economic access to sufficient, safe and nutritious food to meet the dietary needs and food preference for a healthy life.

Rice, wheat, maize and potatoes are produced more. There are 30,000 edible varieties of food available. The Indo-Burma region is the Centre of origin of rice. This region has maximum diversity. There were 1 lakh varieties in India. Dr.Richcharia collected 19.000 varieties of Paddy in Chattisgarh and found out 8-10% are high yielding and 8-10 % can withstand drought. Now there is an attrition to a collection of 30,000 varieties across 3000 communities.

Rice Grows in Diverse Environments:

In termsof topography and climate it is grow widely from North China to South Australia. We are reviving traditional varieties in Sundarbans which is a poor region, rich in the resilience of the people.

Policy Changes:

Green Revolutions in the 1960s came with a high yielding package variety of seeds and pushing pesticides and fertilizers to increase production so the approach was to increase production not to increase farmers income and farmers livelihoods. It was not based on our indigenous seeds and the massive knowledge system in our country, we have lost the collective wisdom of communities. We now depend on HYVs, mechanization and intensification of processes.

Policy Changes in HYV:

Short statured/ more yield gaining but needs more water and fertilizer and are prone to pests and diseases. They cannot tolerate floods droughts and salt. Their character is not stable and we cannot save the seeds leading to a loss of diversity. The quality of the seeds does not stay.

The narrowing down has only helped corporates and not farmers.

In the village, farmers mix fertilizer with pesticide which is completely unscientific, as a result farmers are suffering and consumers are suffering.

Rice and Pesticides:

Rice consumes maximum quantities of pesticide after cotton so contamination is common. Studies reveal 14 pesticides in the market in which 2 cause cancer.

Pesticides have resulted in the destruction of biodiversity of food from the field to fish (poor man's protein), frogs, earthworms and predators.

Intensification of Paddy Cultivation

What are the problems Paddy Farmers face

They produce a lot because the cost of production is going up but it's not enough to meet the need of people. 200 million tonnes are produced but of poor quality. How do we engage on HYV?

Accessibility:320 million people don't have access to food.

Cancer Train in Punjab

The train runs From Bhatinda to Bikaner. The proliferation of cancer among farming communities is immense.

Save our Rice campaign since 2004:

Conservation of traditional seeds has contributed to water security, knowledge of food and health in Kerala. There needs to be a connect between consumer and farmer. Biodiversity based on ecological paddy cultivation. They engage in the protection and promotion of traditional knowledge and community wisdom to ensure food security. They also play a role in protection of Paddy ecosystems.

Along with food security we need to ensure nutritional security to the people.

They didn't just work with farmers they worked with networks of students, rice millers and Women's groups. In the initial years we just did discussions and engaged on all these issues.

Revival of rice diversity in Karnataka and Tamil Nadu during festivals

They associate with Sahaja Samastha to propagate and support a larger system of environment and sustainability. Building of seed banks in villages is very important and bringing back children to agriculture and for the revival of traditional seeds.

They have revived 1,200 varieties in the last 6 years in 5 states and developed seed banks at the village level. Many varieties were more nutritious and had medicinal properties.

Genetic Erosion is a huge threat to food security. FAO says we have lost 80% of agro-biodiversity. Major policy support is needed to revive the diversity at farmer's level. *Beej Swaraj Manch* is a national alliance of seed savers and they have set up to address these issues.

Punjab has the highest level of arsenic water contamination because arsenic is present in Bran and the Bran Oil program was underway in Punjab

Translation in Tamil by Ameer

Is our Food Secure?Is our Food Safe? Is our Food Sovereign?: Sridhar Radhakrishnan (Thanal) Save our Rice Campaign (Session was translated into Tamil)

He presents the problems after Mrs.Usha Presents the solutions

Everyone knows we are living in agrarian crisis. 3 Lakh farmers have committed suicide and Millions of consumers are living with pesticides in the body- many causing cancer. From 1966 with the Green Revolution what have we achieved? We have increased food produced by the country with yet 30% going hungry and 30% being eaten by rats.

50%+ of farm households in India. We have 90 Million households in farming in India (30-40% of India s population). 30% are in debt. In areas where green revolution didn't come into play the biodiversity and agricultural debt is much less. Their agri-systems in the villages are thriving. The Centre for Disease Control found 287 Chemicals sitting in human blood with neurotoxins and carcinogens.

Huge contamination of food, food systems: soil, water, seeds

Let us talk about cotton. In 2002 in the peak of the agrarian crises when farmers were in debt leasing their land and transporting water paying through their noses and then the crop doesn't get the price because the local money lenders intervene and someone sitting in America decides the price. At the same time fertilizer industry is thriving, tractor industry is thriving, food industry is thriving. Only the central person- the farmer is left out of the loop. Even the current budget doesn't solve the problem because the problem starts at a global level and is propagated to the local levels.

The choices of food are also problematic and not just killing us but killing the agrarian system. When we choose to consume packaged food imported we kill the farmer.

Diversity, nutrition, safety, rural livelihood everything is linked to health in rural areas.

India never had a Food Security Crisis:

The whole issue stems down to one question. Why did we begin the Green Revolution? We brought it with a hoax that India was food insecure when the Bengal Famine happened while India was producing enough then and today except we haven't made it equitably accessible. At some time it happened that land is controlled by some people, water is controlled by some people, seeds were appropriated by companies. 90% of the cotton is controlled by Monsato. Though we have 4,000 varieties of cotton, the question is not just about food and crop security but also sovereignty.

Is our Food Secure?

1.2 billion people live in India and the total grain production is 244.8 million metric tonnes

Of whatever India is producing today you only need 40% to feed everyone in India. Even in Edible oil and pulses we are more than food secure.

Solutions:

We need to revamp agriculture and eating.

He proposes a four point formula to do this:

1) Organic Farming/Agro-ecological agriculture
2) Food Safety: There has to be a Food Safety Act to make all food safe
3) Right to a farmers land, water, food
4) Farmers have to have an income guarantee

Watershed Development in a Climate change Context: Marcella D'Souza

As you know parts of Karnataka, Andhra Pradesh and Maharashtra are under drought. We need Land and Water resources to meet the need. Very briefly, he shared an experience across many states. This is the scenario we are facing in many parts of the country: Lands degraded without tree cover and market forces pulling the people apart. What started a few years ago has become quite a movement in the country.

Watershed Development is the treating of land and water resources so people can continue to live in their ecosystems and not move to the cities. The local people have to rub shoulders together to revive national resources. This needs to be done by active involvement of all people in the community.

Impacts:

1) Ground water level improves
2) Farmers get a lot of benefit

What we have been observing is that extreme weather events which are not predictable like heavy rainfall over a few days affect livelihood

Socio-economic Drivers

1) Pressure to progress and modernize
2) Farmers are more self-driven to get more income driving them to an agriculture less risky, more productivity
3) In the current situation of crisis we are looking for quick reaction.

Is Drought only Climatic:

When we have the number of wells increasing what happens to the water level? This is the picture of one village where good watershed treatment is done, we are tracking the levels of ground water and the levels of the well have gone below the level of the river. We did a small study on farm ponds being built at a higher level to ground water on wells and who accesses the water.

Besides agriculture, it is the Construction industry which puts a huge demand on water because HYV are very water intensive destroying the soil and water and adding to bio degradation

Seeking Appropriate Responses:

Whenever any work is done we need to have a constant feedback. Watershed was not getting the response we should get so we realized we need to do a vulnerability assessment.

Why is it that the government is not getting the response it should get?

The reason is that there are standardized programs pushed across every part of the country. Unless we do research to a critical mass and push the customized methodology across, the government cannot understand what is going on, on the ground to make the necessary changes.

Vulnerability Assessment:

We need to have the perspective in a very systemic manner. We cannot work isolated for agriculture or isolated in health they are all integrated. Since agriculture was shifting towards HYV, farmers feel they need more tractors and less livestock so now we have less livestock waste for our soil, flattening of the lands to allow tractors and soil loss due to deforestation. So we decided to do a systemic study and present it to the government.

We are doing a pilot study in 3 states.

1) We need up scaling and out-scaling
2) We need strategies and feedback that are customized and we need to have constant feedback.

In one area in Ahmednagar District on a drought hit year farmers bio-diversified and shifted to a traditional variety of crops. In another area where HYV were used the farmers were not able to do this and stay stable or afloat during the drought. There is a need for partnerships and collaborative action with agriculture universities to address these issues.

Adaptive Sustainable Agriculture:

A more systemic way of crop intensification, using more organic methods like using leaves for fertilizers and micro-irrigation, with men and women farmers working together.

Understanding Challenges in Rural Sanitation: Prahlad I M

Having a toilet can be a challenge. Who is going to maintain the toilet and who is going to keep it clean?

Challenges are divided into:

1) Social Challenges
2) Economic Challenges
3) Political Challenges
4) Physical Challenges
5) Cultural Challenges

Case Study:

Out of 24 people employing open defecation, few have thought of suicide because of being embarrassed by flashlights, videos and pictures. Also, there is no one to accompany women at night.

Case Study: Pregnant Women: When we have a discussion on sanitation in the community one lady told me she was pregnant 8 months and she came to her father's house where there were no toilets, she had a stomach ache and she went 1 km away to defecate and went into labour. She delivered and went unconscious and the child died. Following the delivery there was an infection to the uterus, the uterus was removed and she was forbidding from visiting her father-in-laws home because of this.

Case Study-: Persons with Disabilities

A disabled person used to get abused because he had to be carried for open defecation. His relatives who used to carry him out to the fields used to ask him why he is alive.

Economic Challenges:

1) Local Masons Demand exorbitant rates which demotivate daily wage earners and agriculture workers
2) Poverty and Inadequate financing
3) Changing Funding Patterns affects the community
4) Toilet Models: People assumed it was a luxury and never thought of it as an appropriate technology
5) Sustainability

Political Challenges:

1) Corruption: Bribes to PDO, PRI
2) Absence of a concept of Equity- no concept of child friendly toilets and disabled friendly toilets in Swachch Bharath Mission

Contract Work

There is no use of having these types of projects if there is no communitization.

Programmes on Rural Sanitation

Examples were shown of

1) Unused Toilets

2) Dry Latrines

These are built by the Gram Panchayat

Physical Challenges:

1) Drinking Water
2) Disposal
3) Technical problems with the toilet
4) Lack of cleanliness and hygiene

Cultural Challenges:

Values:

In UP in some villages they do anal cleansing with stones and leaves what will their response be to building toilets?

Manual Scavenging

Ecological Challenges:

1) Water logging in areas with high ground waters
2) What is the use of building toilets in areas of water scarcity

The one difference between MDG and SDG is that the government is withdrawing. The MDGs failed to meet its guidelines by 2015 so they made SDGs to postpone them to 2030 with withdrawal from the government.

Climate Change:

Children of a Lesser God:

Sundarbans Video:

The archipelago is a unique ecosystem home to the royal Bengal tiger, its spreads from Bangladesh to the eastern part of west Bengal. 4 million people inhabit its 110 isles. They struggle on rain-fed monocrop agriculture. Forest Products from reefs and estuaries. More than half of the farming community is suffering from poor physical infrastructure with 399 km of railway line and poorly tarred roads, people have to depend on mechanized boats. They regularly face monsoon, storms floods and cyclones. The tropical cyclone hit the Sundarbans with a base speed of 130 mph and about 300 people lost their lives in the Sundarbans. The isles had destroyed homes leaving behind homeless children and destroyed livelihoods. 1000s of isles ceased to exist. The transport infrastructure collapsed; jetties and boats were shattered.

When high tide becomes low tide they starve.

The video gave us a snapshot of the people living in the Sundarbans. They have been working in Sundarbans for 5 years. The work is set on the premise of evidence that climate change is translating to difficulties to the people. Some of the technicalities in the area of climate change and how we can communicate that evidence to people to affect change.

20,000 hectares has shrunk to 3,000 hectares in some of the islands. Climate change translates to a very harsh reality to these people because it translates to loss of income. The health system is ill-prepared to cater to their needs.

Sundarbans has 19 administrative blocks which are vulnerable to climate change and its impacts.

How has Climate change manifested here:

1) Rise in Sea Levels
2) Increase in Sea Surface Temperature
3) Shift in Monsoon Patterns
4) Increased Risks of Disaster

Challenges in Health and Healthcare:

1) Geographical Inaccessibility: Boat surface only twice a day
2) Climate Uncertainty: Erratic weather pattern
3) Health System Challenges
4) Changing demographic composition: there is mass out-migration: there are families and villages with no men because they have migrated out for better opportunities
5) Saline water intrusion in the agriculture field

The Model:

Knowledge intervention model based on the premise that we need scientific evidence to say and show the linkage of how climate change affects the community to engage with policy makers.

Central Concepts in Research in Climate Change:

What is the difference between climate change and climatic variability

Essential Concepts and Terms:

Vulnerability: The degree to which a system is susceptibility to, or unable to cope with, adverse effects of climatic change, including climatic variability and extremes.

How much can I do and how sensitive I am to an external shock

Exposure: to climate variation is primarily a function of geography

Sensitivity: is the degree to which the community is affected by climatic stresses

Adaptive Capacity: is the ability of a system to adjust to climate change(including climatic variability and extremes) to moderate potential damages

Resilience: the ability to resist and recover from climate shock

Conceptual Pathway:

Diagrammatic guidelines on what affects what.

How Climate affects Health,

Research Designs:

1) Cross Sectional Studies
2) Longitudinal Design

Broad Research Questions :

How does climatic adversity affect communities in terms of its impact on livelihood?

How vulnerable are communities to climatic adversities?

What is the scale and distribution of climatic events in the region? (GIS studies, spatial intercollation)

What is the scale?

Quantitative Techniques:
Mixed method research studies

They use Standard instruments to gauge livelihood

Qualitative Techniques

1) Participatory Rural Appraisal techniques
2) Hazard Ranking
3) Perception Mapping
4) Transect Walks
5) Seasonal Calendars
6) Timelines
7) In-Depth Interviews and semi-structured interviews
8) Focus Group Discussions

Transect Walks:

Take the villagers on a walk with you to understand the social context in which they live

Vulnerability can be done through Participatory research techniques and quantitative methods.

Developing a vulnerability index

Adaptive Capacity:

1) Socio-Demographic indicators

2) Livelihood Strategies

3) Indicators for social support and networks

Sensitivity:

Health Conditions/Morbidity Prevalence

Food and water shortage

Perceived impacts of climatic Shocks

Research Policy:

1) Evidence informed Policy
2) Policy for Research

Key Audiences:

Academicians/Research Community

Policy Makers and Advisors

RMP Associations

NGO/CBO think tanks

Community Opinion leaders

Media

Key Opinion Leaders and Opinion Makers

How do you guage the policy environments?

Media Strategy

They drew up a comprehensive media strategy including establishment of connect with Sunderbans Local Media

The villagers learnt to take photos and started taking pictures and meetings. They had state meetings in press clubs where they gave the stories translated from Bengali to English.

Photo Voice:

Three Goals:

1) To enable people to record and reflect on community's strengths and concerns
2) To promote Critical dialogue and knowledge about important issues through large and small groups
3) Whose Voices:
   Crab and fish collectors

Places where cancer expresses itself:

1) Beedi workers

2) Farmers using large amounts of pesticides and insecticides

3) Prawn Catchers in the Sundarbans

Sochara Photo Journey:

Acknowledged all the founding members of CHC both formal and informal.

Dr.Mohan Isaac: President, SOCHARA

The objective of a good NGO is to make its objectives redundant through its actions.

Acknowledgement of those who have passed on:

C.M. Francis

Dr.Ravi Joseph, AIIMS

Prof.Benjamin, CMC Vellore.

Prof.S.V.Rama Rao

R.L.Kapoor

Dr.Uma Sreesharan,

Dr.Sreedharan

Dr.Pankaj Mehta

Dr.Paresh Kumar

Dr.Ajay Khare

They taught us the importance of spending time with young enthusiastic people, cycle to the villages

Dr.Shirdi Prasad:

You need to manage things with minimal resources.

Resources classified into short, medium and log resources – economical or knowledge resources, bring them together with the principles of community health and watch them become equal. No need to tie people or make them people, people are human and you can work with everyone.

Photo Journey: SOCHARA Team

Genesis and Early history:

1984: Moving beyond the medical college and teaching hospital into the community.

What made them walk out?

Supported by Fr.Claude and Fr.John, they had meetings sitting on the floor as ex-doctors and community health workers.

Some Key Points:

The Miraj medical college was supposed to become the first medical college with social research recognizing the shift from community medicine to community health

Health as a Social Movement

SOCHARA is a part of many movements at the global level and national level.

Continued engagements with the civil society networks: mfc, People's Health Assembly and People's Health Charter in India.

Jan Swasthya Sabha had over 2000 participants from 19 states across india.

In the first Global People's Health Assembly 1454 Activists got together at Kolkota for the PHA, People's Health tribunals in India (Jan Sunwai- Jan Samvad helped form the framework of the NRHM.)

From 2003-2006: hosted the People's Health Movement Global Secretariat

Social Movements:

RTI

RTE

Right to food (NREGA)

SOCHARA Policy Engagement:

1) 2 year rigorous process with Karnataka Task Force. Incorporated many key recommendations

2) Reports to Madhya Pradesh, Chattisgarh and Odisha
3) Reports of mission groups on public health
4) Karnataka Knowledge Commission.

CEU Tamil Nadu:

Objective 1: Create awareness of the principles and practices of community health across all sectors.

Objective 2: Promote and support community Health Action (Voluntary Sector and Gvernment)

Objective 3: Undertake research programs in community health policy issues and strategies

Objective 4: Evolve Innovative Educational strategies CHLP and training

Objective 5: Dialogue with the policy makers in health planning

Objective 6: Establish a library of materials

Objective 7: Contributions to media

Centre for Public health and Equity in Bhopal

Objective 1: Train 2 batches of 20 fellows starting 2009, fellows were from MP and most are working now in MP with the govt., with NGOs and Larger agencies

Objective 2: Nutrition Health Promotion in Anganwadis with NGOs and govt. of MP.

Objective 3: Vector Borne Diseases

Objective 4: Community Health Fellowship Program (CHFP)

Community Health Action Network of Madhya Pradesh

Community Health Learning Program:

Pedagogue:

Sharpen analytic skills and deepen understandings of social and societal paradigm

To develop a critical mass of knowledgable community health practitioners.

Sharings about SOCHARA:

S.K.Ghosh

Spoke about the problem of Zika Virus. There is an articles saying there is no Zika Virus in the country but the fact is there is Zika Virus and we have been given responsibilities with surveillance. We areorganizing a conference on Malaria and Epidemiology at Hebbal in Bangalore all the National and international experts will be joining us to tell us how we can eradicate Kala-Azar and Malaria.

Fr.Claude

Appreciates the relationship with SOCHARA and the wonderful work being done by the organization and reminds us of the inspiration and principle which guided Dr.Ravi and Dr.Thelma which comes from Alma Ata. Development is an invisible art, theres no ending it goes on by itself. Glad they didn't build and institution and a curriculum.

Dr.Regi

We are all fellow travelers on a difficult road, told us about how he was guided by Dr.Ravi and Dr.Thelma and we are happy to be associated with SOCHARA.

Dr.Rakhal

The 2 values which I hold close to my heart from SOCHARA: the completely non-hierarchical way of questioning and reasoning which has held him in good stead in his work and research. Secondly he talks about the multidisciplinary approach.

Dr.Arvind:

My association with community health started with CMC Vellore, the first job I took was with CHC. He was part of CHAI. I agree with Rakhal on how the was CHC functioned taught me a lot. My report was called COFFEE. Dr.Ravi and Dr.Thelma have inspired through their work many people and faculty and students.

Dr.Rajan:

I was one of the beneficiaries of this travel. Which reminds me of a *shahiri.* "I was blessed to be a part of this group which has left behind indelible memories. The style of leadership we were groomed in helped us evolve as youngsters and the confidence that came out of it has helped us everyday till today. Thanks for your mentorship."

Dr.Manikalliath:

I met Dr.Ravi as a medical student, I have journeyed with SOCHARA and discovered my roles in other locations. One thing that struck me in SOCHARA that coopted in a positive way: various inspiring people have helped imbibe in young people alternate values in an idealistic attempt with the hope of continuing it. My own involvement was in the health of the urban poor which was quite a strong area for me but more recently I have been involved in Mental Health where I find my heart and mind together. Yesterday Dr.Sridhar said a hoax was proposed on the nation on food issues and the negative

impact has continued in a negative light. Similarly a hoax has been projected in Mental health and mobilized people can be helped. Hearty congratualations on 25 years in SOCHARA.

Key events in CAH: Rakhal

Governmental initiated program.

Collectively evolved and designed with a 5 year expansion plan. Evaluated both qualitatively and quantitatively showing positive results. It has a continuing National Focus In 2003 it reached obstacle after obstacle there was a very qualitative difference in what was being demanded and there was no focus on proper training so in 2004 the program stopped.

Reflections on Participation:

From Buzz word to Fuzz word.

A fuzz word is a word which can take on different meaning in different contexts. Community participation means different things to different people. Dr.Thelma demonstrated the health secretary wants to show community participation.

Change in Context:

Participation for legitimation vs. emancipation. Today we are shy of adopting conflicts and prefer to sit on committees.

Reflections on Community:

The community is not homogenous. Different sections of the community are able to participate in communitization. Are we domesticating community actions by avoiding conflicts.

Reflections on the State:

The neutral arbiter vs the executive committee of the bourgeois

How does one see and do participation in this light?

Call in the 80s for more specificity

Karen Coelho – Participolis – Urban Participation

Aradhana Sharma

Communitization of the Health System: Ameer Khan

On behalf of CAH team

Historical Context:

Its not with government documents or people's health charter

Communitization of Child Rights:

It is a recent trend in Child Rights Sector.

Different dimensions and Different Ministries/Departments involved.

1) Nutrition
2) School Education
3) Health
4) Protection and
5) Participation

Flagship Programs:

1) Sarva Shiksha Abhiyan
2) ICDS

Communitization in Anganwadi:

VHN Day (Restructured ICDS – Mission Mode)

ECCE Day

Anganwadi Level Monitoring

Challenges:

1) There are too many committees at all levels
2) No recognition / incentives in participation
3) Vested interests in selection of members in committees
4) Except VHW&S committee there is no financial allocation
5) The importance of the committees is not understood by the people
6) Political and Caste issues are involved in Committees

National Policy for Children – 2013

Addressing the rights and needs of children requires programming across different sectors and integrating their impact on children in a synergistic way.

Community and Local governance play a significant role in a child's optimum development and integration.

Governance Indicators and Performance

On behalf of Public Affairs Center, Bangalore

By Dr.C.K.Mathew

He felt uncomfortable when bureaucratic apathy and words about the government were spoken at the Jubilee because he has worked in the government for 35 years.

When you think about our country what are the first words that come to your mind? Similarly when you think of a state what are some words which come to mind? He showed us a map of the popular perceptions of states of India but asserted that informed citizens should base perceptions on hard data.

Public Affairs Index is an Instrument to measure governance in the states of India.

The Political problem of mankind is to combine 3 things economic efficiency, social justice and individual liberty – *J.M.Keynes, Essays in Persuasion, 1931*

There is a difference between governance and government

He says the PM called for maximizing governance and minimizing government.

List I, II, III of the constitution and state responsibility

The dilemma is to find a comprehensive matrix to define governance is addressed by a three tier Matrix consisting of 10 themes , 25 Focus Subjects and 68 indicators that capture governance

1) Infrastructure
2) Human Development
3) Social Protection
4) Women and children
5) Transparency and Accountability
6) Delivery of Justice
7) Economic Freedom
8) Law and Order
9) Environment
10) Fiscal Management

Arising from the 10 themes are 25 Focus Subjects:

1) Power
2) Water
3) Roads and Communication
4) Housing
5) Education
6) Health
7) Women
8) Children
9) Violent Crimes
10) Policing

11) Atrocities
12) Pendency of Cases
13) Vacancies in Judiciary
14) PDS
15) Pensions
16) Minority Welfare
17) Fiscal Management
18) Development Expenditure
19) Pollution
20) Environmental violations
21) Forest Cover
22) Renewable energy
23) Transparency
24) Accountability
25) Economic Freedom

Arising from 25 Subjects are 68 Indicators which cover the Gamut of Government activities

Some examples of the 68 indicators are:

Covering the 10 themes:

1) Per Capita Consumption of Power
2) Households electrified as a percentage of the total percentage of households with water
3) Total Irrigated Area vs. Agricultural area
4) T&D Losses
5) Water Regulatory Commission:
6) Ground Water Regulation Act
7) Surface Roads as a percentage of roads
8) Road Density as a percentage of total Roads
9) Road Density per 1000 sq.km.
10) Percentage of household with cellphones
11) Number of *Pakka* homes as a percentage of total slums as a percentage of total population
12) Percentage of Households with a toilet inside the premises

Covering 25 Focus Subjects:

1) Allocation and offtake of grain under Food Security Act
2) Percentage of Pension beneficiaries of the total above 60 population
3) Percentage of households with no land
4) Incidence of crimes against SC/ST
5) Number of Minority Children given a pre-metric scholarship
6) Unemployment Rates
7) Percentage of Manual Casual Labour

8) Crimes against Children
9) Percentage of Child Labour
10) Percentage of Beneficiaries under ICDS
11) Child Sex Ratio
12) Percentage of Malnourished Children
13) Women Working Population Ratio
14) Utilization of Janani Suraksha Yojana Funds
15) Male-Female Literacy Gap

Comprehensive List of Variables:

1) Adherence to Section 4 RTI
2) RTPS Act Legislated or not?
3) Number of Services Provided under the e-governance plan
4) Lok Ayukta: Constituted?/Bill Passed?, Existence of individual sites and Chairperson appointed
5) Number of ACB cases disposed as a percentage of total
6) Social Audit under NREGA: Percentage of Gram Panchayats covered
7) Panchayat Devolution Index Score
8) Fiscal Surplus (Percentage of GSPD)
9) Debt Burden (Percentage of GSPD)
10) Per Capita Development Expenditure
11) States own tax revenue growth
12) Number of Industrial Entrepreneurs
13) Memorandums Filed

PAI data is available to all citizens.

Methodology Used:

Secondary Data mainly from Government Domain which Focusses on Processes and Institutions

Utilized Three years Data to indicate movement in each state

Weightages assigned to indicators on perceived importance

Why is PAI Different:

It is a mix of development outcomes and governance processes, processes are merged with outcomes.

Measures processes, evaluates institutions

New Variables discovered

Sentiment analysis

To supplement our study we have done one chapter in our book to see if they match and arrived at definition of states through sentiments.

Reflects current status and movement over three years.

Governance is a journey not a destination

The findings of PAI index scores for each state were shared.

PAI is the most comprehensive index created by the government.

Website: www.pai.india.org

Discussion:

1) What about looking at utilization rather than how much budget a policy is picking up
2) Is government data reliable? Every state is in competition and wants to show best performance but if we put all states data they undergo review and scrutiny from competing states.
3) Why are all the indices so close to each other why is there no diversity in states?
4) What is the validity of government data when there are huge disparities on the ground? And what is the alternative? The problems of our country are of such a magnitude that we cannot even assess the magnitude of the problems because of so many uncovered areas of governance.

Grace: Grass-Root Action on Community Empowerment

We were greeted and oriented by Fr.Bosco, Secretary of Grace who has 26 years of experience in Social Work with the urban poor.

How GRACE functions in and around Bangalore

GRACE is registered under the Karnataka Trust Registration Act, it is an NGO. They work on issues related to the urban poor. Specifically: Children, Women and Rag-pickers.

Mission:

Grace acts as a coordinator between urban poor, urban citizen and the government

Activities:

1) Work with Street workers
2) Slum Development
3) Child Rights
4) Sanitation
5) Advocacy
6) Self Help Groups
7) Networking
8) Women Empowerment
9) Income generating activities
10) Vocation Training
11) Urban Homeless
12) Consultations
13) Health Awareness
14) Tuitions for school children
15) Working with Adolescent Girls
16) Job Placements
17) Community Development Activities to develop and empower the urban poor

Key Primary Centers:

They have 13 centres around Bangalore.

Nagavara Centre: Educates children of coolie workers in basic Kannada and English so the children don't go back to waste picking and coolie work. The children are given a loan for up to 6 years and helps them get into govt school. Also helps them with singing dancing and games, mid-day meals.

Tution Centres: School going children are aided in claring their doubts and encouraged to study and they train them in life skills, personality development and singing.

Women's Empowerment:

In many slums in and around Bangalore city they have started SHGs to solve problems among themselves like water, sanitation, health, hygiene, education. GRACE offers training in different activities so that the women may make their livelihood. They give them awareness of their basic rights as citizens.

Community Development Activity:

4 blocks of 22 Flats have been constructed by the government in association with an NGO CIVIC. These are 1BHK with an attached bath, water and electricity. They helped in advocacy to get the flats and all the benefits they are entitled to.

Vocational training:

Training School Dropouts from the slums to make a living in society, subsidized training, bus pass, food and jobs

Courses:

Sales

Assistant

Office Admin

Beautician

Hotel Management in coordination with Unnati for training and referral services for jobs.

Training in: Basic computers, life skills, driving

Waste Picker Development Activities:

They work in the east zone of Bangalore City. They have got Id cards for 1200 waste pickers to ensure they have the facilities required to live in dignity in society The waste pickers pick waste from various apartment complexes and segregate them before sending them to the landfill hence helping the BBMP by preventing mixed waste from entering the landfills.

Dry Waste Collection centres:

All the dry waste collected is gathered. The waste pickers segregate the plastics: tetrapacks, Bottles.etc for recycling.

The waste is segregated to wet waste and dry waste. Corporation takes care of wet waste, they take care ofdry waste, they work in association with waste pickers sanghas and enabled them withid cards signed by the commissioner. Dry waste collection Centre was given by BBMP. In each ward they take care of all the dry waste comes to their centre. They appoint waste pickers to pick the waste and segregate the waste for recycling. The most important thing for GRACE is that the workers have to get a decent job.

Recycling Centres:

Most of them are on Mysore Road.

How do you ensure you don't get any wet waste:

The BBMP Vehicle will only bring dry waste to their centre

Dry Waste Consists of:

Paper

Plastic

Bottles

Pet Bottles

Iron Items

Glasses

Plastic Glassses

Iron

Foot wear

Tetra Packs

What is the benefit to the rag pickers from the sangha and the NGO:

Grace is a small NGO, so like Grace there are many NGOs who work together to form a Waste Pickers Movement Asurudalla under this Association there are more than 5000 Waste Pickers for whom they have provided i.d cards signed by the commissioner which gives them access to ration card, aadhar card and voter i.d, other benefits are they will get decent jobs. They are given uniforms and caps.

They give letters to the children of the rag-pickers so that they can join school, Certificates are given to people attending training programs.

Training Programs Collaborations:

Vocational Training Courses with Unnati is for 50 days, They also send to BOSCO and REDS.

Source of income and and Logistics

Resident Association of Apartments has to be on your side. They fix the timing once or twice a week depending on the interest of the apartment association. The waste is kept ready in one place. The waste is from apartments they aim to get 350 rupees a day per waste picker. They get small donations from people in apartments and waste from apartments which they sell after segregating.

Govt. builds and gives grace a center for which they had to deposit 25,000 per annum and appoint one dealer, the dealer has to know all the processes and rates for different waste. After Segregating the waste and packing they will get some money which they give to the segregators. 350 per head per da is given, the remaining money is kept by the dealer. The money kept by the dealer is also used to buy new waste for collection.20-30% waste is collected by the informal waste pickers. Segregated waste is sold once a week after 5-6 tonnes is accumulated. A truck is hired and sent to Jalimahal in Market where the recycling people come and take the waste.

How to select a dealer:

Since they are working for many years they know who is a good dealer and employ appropriately. The dealers are themselves waste pickers.

Once in the month there is a meeting, sharing and report. They monitor the work of the dealer.

Staffing

24 apartments in one ward 3 pickers are required. Inslums they have to educate the people to segregate the waste.

Problems they are facing:

Police problem: Police come and ask for money

BBMP problems: BBMP collects wet waste and sends it to the landfill or composts it. Sometimes they bring plastics with wet waste, dump it near the center and incinerate it near the centre.

Solution: Raise the issue with the engineering department

Problems while getting i.d card they don't sign the labour cards

How do you manage problems in the Sangha: Asarudalla (Green Warriors)

In Bangalore there are 8 zones, GRACE works in East Zone. Through Asarudalla they get appointments and jobs. Asarudalla has assigned staff to conduct meetings and camps.

Rag-pickers

Most of the ragpickers are migrants from Andhra, Tamil Nadu who stay in the slums.

Experience Sharing: General Discussion on Housing

They tried for 16 years to get clearance from the Slum Clearance Board

In a project 3 blocks have 32 houses and there are a total of 112 houses that GRACE is involved with, The work always starts with children. They give preference to blind and handicapped children and make sure that they get ground floor houses. The School Activities give them access to children and their parents. Most of the issues come out in the meetings when they form sanghas of parents and elders.

1.8 lakh rupees is the cost of the house. For each house they have to pay 21,000 rupees in 4 or five installments to the governments for the*akku-patra* (ownership right). All houses have electricity and water.

Rather than build religious buildings they encourage the community to build schools and structures useful to the community. They gave them a space outside the community to build temple.

The people in the slums collect money from political parties more so during election time. They are mainly migrants from Andhra Pradesh and Tamil Nadu.

Important Takeaway:

It is important to have meetings with the informal heads- male and female, the authorities in the BBMP for the block the project is in, and the elected representatives of the ward and constituency, to involve them and acknowledge them publicly before starting any new project involving the community.

Learnings from CLIC and CHLP Sessions

Strategies for Social Relevance and Community Orientation: A Medical Education Project Report:

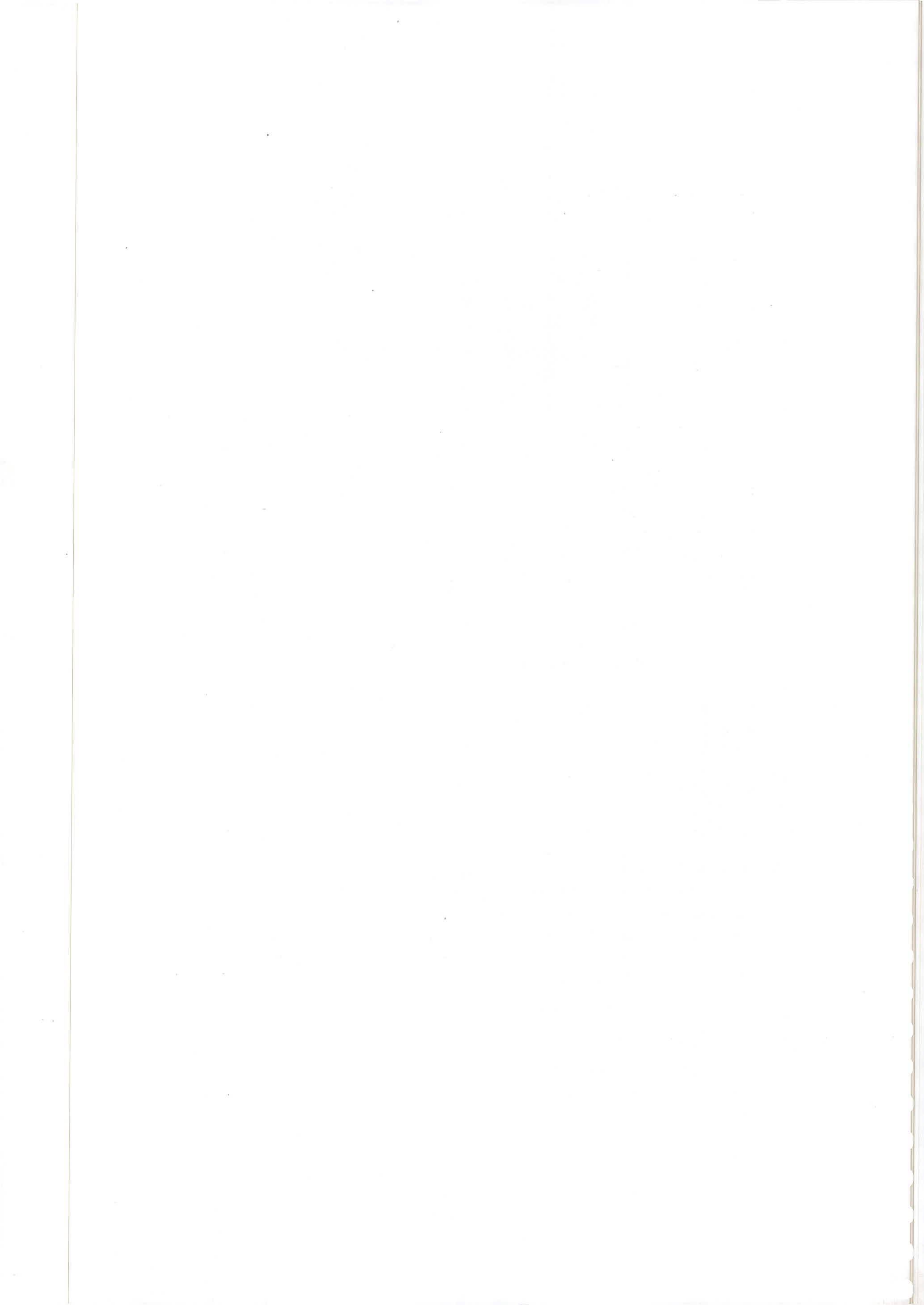
Medical Education is a subject I hold very close to my heart as I believe Education and Health go hand in hand and if education of health professionals is adequate not just in terms of the biomedical model but also in terms of sensitization to the wider picture of health and community it would be possible to start breaking down the impasse that exists with the participation of trained professionals towards a community driven model to the benefit of all stakeholders and people.

Problems Identified by the Srivatsava Report in 1974

The problems that need to be addressed in medical education are the stranglehold of the inherited system of medical education, the exclusive orientation towards the teaching hospital, the irrelevance of training towards the health needs of the community, the lack of incentives and adequate recognition for work in the rural communities and a lack of countervailing powers to the export of medical manpower. These are some of the issues identified by the Srivatsava report in 1974 that need to be addressed in order to have a healthier health system in place. There needs to be a system of education deeply rooted in scientific method, yet profoundly influenced by local health problems and by the social, economic and cultural settings in which they arise.

Proactive Measures Taken at the National Level to Counter these Problems:

1) Reorientation of Medical Education Scheme, 1975
2) ICCSR/ICMR Study Group Report on Health for All: An Alternative Strategy, 1981



3) The National Health Policy, 1982
4) The Recommendations on Undergraduate Medical Education of the Medical Council of India, 1982
5) National Education Policy, 1986
6) The development of the Health University Concept
7) The draft National Education Policy for Health Sciences, 1989

Gaps in the process of Medical Education:

1) A lack of interaction and dialogue between the government health programs and services, medical colleges, voluntary agencies, NGOs and other groups interested in alternate medical education due to divisions and inadequate networking.
2) Inadequate publication of the strengths and weaknesses of these various initiatives, the groups are unaware of each others efforts. There is a growing mass of grey literature, reports, handouts and circulated papers which are not easily accessible to the serious medical educators who are not aware of the wealth of knowledge within the country itself.
3) Lack of objective evaluations and peer group assessments within and without the system. In some instances where these have been attempted the results are not easily available
4) Tendency by medical educators to be carried away by expert advice and ideas that have originated in other countries and may not be socially, culturally or economically relevant and viable. Recommendations need to be grounded in local realities and experience.
5) Inadequate attention is given to traditional systems of medicine and healing as well as prevalent health culture and folk health practices.

Trends in Medical Education:

A number of trends have emerged with deep rooted consequences to the society and community orientation of medical education and health

1) The growth of capitation fee colleges
2) Glorification of high tech diagnostics
3) Corruption and erosion of ethics
4) Pre-Occupation with illness care in tertiary care centers and disregard to preventive, promotive and social health
5) Commodification of healthcare with interests in the abundance of ill-health

Expertise in Innovation:

The book gave me an idea of what constitutes orthodox expertise and what constitutes alternative expertise to innovate strategies and solutions to the problems in the health sector. Medical Colleges and Expert Committees who offer solutions and recommendations to the government are the Orthodox

Sector, The voluntary training sector and the graduates with PHC training with experience in rural and peripheral setups have a wealth of appropriate responses to the inadequacies of training and the inadequacies of the health sector and they constitute the alternate sector. There needs to be sufficient documentation, publication and dialogue between the sectors for the systems to flourish in every sector, to breed a critical mass of not clinical scientists and human biologists but social biologists who will use their knowledge to spread awareness and stimulate community building programs.

This book taught me that the process of such an activity is dynamic and evolves as the process unfolds. The project proposal was drafted and circulated to the advisory committee, peer groups and a group of selected resource persons in the country. Their comments, reactions, suggestions were received and considered by the researchers. At the meetings of the Advisory committee all the suggestions were considered and discussed to evolve a modified set of objectives keeping in mind the limitations and the constraints of time. The processes and agendas evolved with each meeting for more practical outcomes.

CEHAT: Ethical Guidelines For Social Science Research in Health

Ethics is concerned with the conduct of human beings. All scientific activities, including those by social scientists, are conducted with the participation of human beings and have an impact on human beings, wider society and environment.

Evolution of a code of Ethics:

The Nuremberg Code (1947) and The Declaration of Helsinki (1964)- these were the first documents codifying ethics, which was amended subsequently (WMA 1989).The Council for International Organizations of Medical Sciences (CIOMS) and World Health Organization also proposed guidelines in 1983 and adopted them in 1992. The Medical Research Council of Canada, The Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada appointed the **Tri-Council Working Group** which was an effort to combine evolving common ethical guidelines by medical, social sciences and natural science disciplines to respect and protect human rights of participants of research in 1997.

National Ethical Initiatives:

These international developments inspired several initiatives at the national level in India too: In 1980 ICMR formulated "policy statement on ethical considerations involved in research on human subjects" and in 1997 it brought out the draft of Consultative Document on Ethical Guidelines on Biomedical Research involving Human Subjects.A Multi-Disciplinary National Committee was constituted in 1999 that brought together decades of experience in social science, health research and activism that provided an ethical framework based on four moral or normative principles and ten principles relevant to ethics in research in India.

Key Features

The guidelines formulated rights and responsibilities of major actors in research endevour:

1)Researchers

2)Institutions

3)Sponsors and Funders

4)Gatekeepers

5)Editors and publishers

6) Peer Reviewers and referees

They kept the development of organizational mechanism for ethics in social science research in health as an open process to be evolved by the community of researchers and institutions.

Why we need ethical guidelines:

1) The lack of ethical guidelines can adversely affect the credibility and autonomy of the research and the researchers

2) Ethical guidelines systematize the research and the environment in which research is conducted and increase the quality and legitimacy of research.

3) To protect and promote the human rights of participants

4) Ethical guidelines Sensitize Researchers and Participants to their human rights and values and enable organizations to develop appropriate values for ethical self-regulation which can be refined through periodic reviews.

5) The ethical principles and guidelines give a benchmark to the ethical dilemmas that face researchers and allows researchers to balance the demands made by moral principles of research in relation to context and circumstances.

4 Principles of all ethics:

(i) The Principle of Non-maleficence

(ii) The Principle of Beneficence

(iii) The Principle of Autonomy

(iv) The Principle of Justice

10 Ethical Principles

i) Essentiality: Adequate consideration to existing literature/knowledge and its relevance, and alternatives available on the subject/issue under the study.

(ii) Maximisation of public interest and of social justice: Research is a social activity, carried out with the motive of maximised benefit of society. It should be undertaken with the motive of maximisation of

public interest and social justice.

(iii) Knowledge, ability and commitment to do research: Sincere commitment to research in general and to the relevant subject in particular, and readiness to acquire adequate knowledge, andpossessing essential prerequisite skills and abilities for good and ethical research.

(iv) Respect and protection of autonomy, rights and dignity of participants: Protect the autonomy, the rights and the dignity of participants. Participation must be voluntary and based on informed consent.

(v) Privacy, anonymity and confidentiality: Maintaining Confidentiality. For revealing or sharing any information that may identify participants, permission of the participants is essential.

(vi) Precaution and risk minimisation: All research carries some risk to the participants and to society. Taking adequate precautions and minimising and mitigating risks is, therefore, essential.

(vii) Non-exploitation: Research must not unnecessarily consume the time of participants or make them incur undue loss of resources and income. The relationship within the research team, should be based on the principle of non-exploitation. Contributions of each member of the research team should be properly acknowledged and recognised.

(viii) Public domain: All persons and organisations connected to research should make adequate efforts to make public in appropriate manner and form, and at appropriate time, information on the research undertaken, and the relevant results and implications of completed research.

(ix) Accountability and transparency: The conduct of research must be fair, honest and transparent. It is desirable that institutions and researchers are amenable to social and financial review of their research by an appropriate and responsible social body. They should also make appropriate arrangements for the preservation of research records for a reasonable period of time.

(x) Totality of responsibility: The responsibility for due observance of all principles of ethics and guidelines devolves on all those directly or indirectly connected with the research. They include institutions where the research is conducted, researchers, sponsors/funders and those who publish material generated from the research

Simulation of Parliament

We had a role play and simulated a parliament session. The group was divided into Politicians, Speaker, MNCs, IAS officers, Public, NGOs. Doing the play made us understand better, the distances that exist between the people and the people in Parliament and the disorganizations in the system. The dysfunction and disorganization is a function of the challenges in communications and dialogues to subvert threats to the diverse vested interests that exist in a democratic body. Imbalances between people, relatives, doctors and hospitals were discussed. Unethical practices were discussed.

Indian population distribution in 1995

65 Million Elite

180 million consumers

275 million climbers over the poverty line

150 million poor aspiring

200 milliondestitute(*reference:* MARG poll April 1995)

Definition of poverty line is false and poverty is rising. People don't have the purchasing power for every member of the family to have the requisite calories for the work the day.

50-60% of population is below poverty line

Levels of hunger:

Obesity is prevalent in urban population because of unhealthy food.

Who decides nutrition policy? (National institute of Nutrition most people are from a bramhinical background), ICMR. Some policies are keeping children undernourished. Childs brain develops most in intrauterine life and first three years of life. Dietary policy is extremely important for health

Definition of national health policy

NHP is an expression of goals for improving health situation, the priorities of the goals and the main directions for attaining them.

Health in all policies is an approach that is used and advocated so as to address the determinants of health, including the health system.

Example: UK has a Clean Air Act established in 1965, pushed for by public health professionals.

Definition of Health System:

Comprises all organizations institutions and resources devoted to producing actions whose primary intent is to improve health.

Most National health systems include public, private, traditional and informal sectors. The four essential functions of a health system have been defined as service provision, resource generation, financing and stewardship.

Key components of health care:

Financing: Public, private, as of now most of the healthcare spending is out of pocket

Organization of health care systems

Governance and accountability mechanisms

Implementation issues

Quality of Care

Outcomes and impacts including equity

Social Determinants of Health:

Social Determinants of Health are conditions in which people are born, grow, live, work and age, including the health system. So if a child is born in a slum that's part of their social determinant. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. Every year we add an Australia to our population. The social determinants of health are mostly responsible for health inequities.

Health for All through the Public Health Systems: An Overview:

India has 6,20,000 villages and 9,00,000 ASHAs. Based on the populations of villages ASHAs are allocated. The public health system works towards health for all to achieve universal access to health care, society and state needs to develop and invest in public health systems with:

1) Adequate infrastructure and equipment
2) Services at various levels of care with referral links
3) Competent, caring staff with supportive backup

Challenges and barriers

1) Social inclusion exclusion
2) Political Choice, negotiations, contestations
3) Peoples participations perceptions beliefs and experiences
4) War, violence, conflict, natural disasters

Important policy influences/ drivers

1) Power and strategic positioning of each group and interactions between them
2) Political parties, manifestos, willingness and ability to act
3) Corporate interests
4) Pharmaceuticals and industrial lobbies
5) Professional bodies and lobbies
6) Ministries and Directorates of Health, Staff lobbies
7) Patient Groups and Consumer Groups
8) PHM/JSA, JAAK/MNI, Networks, Movements, Civil Society, Media

Issues with ASHAs:

ASHA workers are paid on an incentivized case by case basis and are incentivized poorly. The Government is planning to do away with ANMs and planning to man PHCs with nurses instead of ASHAs. Nurses aren't trained in community health they are trained for bedside care this will contribute to the professionalization, decommunitization and desocialization of the Public Health Systems.

Civil Society:

The Civil Society in Bangalore is very strong. Where civil society is stronger there are more checks and balances and life is more balanced. Professional bodies can play either positive or negative roles in civil society.

Placebo Policies:

Placebo Policies are Policies with no intention of being implemented tabled with the purpose of keeping people happy and hopeful but masks the situation and allows for capture of policy space by elite. Occurs with a passive disempowered population.

NRHM

The framework for implementation was setup by the Center cabinet; Budget earmarked, state and district health societies, District health plan, state PIP, reviews concurrent CRM

History of Public Policy: Important documents

The Sokhey Committee in 1939: tried to democratize the Congress, they setup a planning committee anticipating independence. Advocated the need for one health worker in every village. Soon after independence started working on TB. The Sohkey Committee introduced the concept of BCG vaccinators soon after independence.

Bhore Committee in 1946: The Bhore Committee report spans three volumes.

Key points:

No permanent improvement of public health can be achieved without the active participation of people in the local health program. It considered that the development of local effort and promotion of a spirit of self-help in the community are as important to the success of the health programme as the specific services, which the health officials will be able to place at the disposal of the people.

Principles:

1)No individual should fail to secure adequate care because of inability to pay

2) Health services should have special emphasis on preventive work and environmental hygiene

3) Work as close to people as possible with maximum benefits to communities

4) Active cooperation of people through village health committees

6) Doctor as social physicians (remedial and preventive measures)

Mudaliar Committee in 1963:

States the Prerequisites for Health for all: "Unless the conscience of the citizens as a whole is stimulated to demand and accept better standards of health, Unless the principles of sound hygiene are inculcated into the mases through health education and other efforts and Unless Government feels strengthened to take positive measure"

Kartar Singh: There used to be a health worker for each disease who used to visit each house independently they combined them into one multipurpose health worker.

The Srivastava Report in 1975:

The Srivatsava introduced the community health volunteer scheme. They had a very good manual on different forms of healing including local remedies. However, they didn't have a democratic way of electing their workers so they weren't service oriented and it wasn't fully evaluated. This report wanted a health referral system which has not been implemented to date.Medical and health education commission. The Srivatsava Report was the first document to ADMIT that they had failed in Primary Health Care. They set up more para-professional and semi-professional health workers, CHWs, MPWs and took measures to integrate modern and indigenous systems of medicine in the National System of Medicine.

Inspirations towards social justice in health:

1946 to 1988

Health For all by 1971 A.D

The Srivatsa Report – 1975

The Alma Ata rehabilitated the Bhore Committee Report

Post Alma Ata there was a prescription of ICMR and ICSSR in 1981 for a mass movement towards health for all.

Also to:

1) Reduce Poverty, inequality and to spread education
2) Organize poor and underprivileged to fight for their basic rights
3) Move away from the Western model of health care and replace it by an alternative based in community
4) Provide Community Health volunteers with special skills, readily available, who see health as a social function.
5) New Orientation to health development

There is often the lag between sociocultural aspirations of the people and their articulation by the political forces.

CHW (1978)

Health for all (1981) Sees health as a social function

Bajaj Report – National educational policy in medical education

National Population policy in 2000

Composition of the Karnataka Task Force on Health and Family Welfare – 2001

Consists of:

1) Twelve members from different sectors and disciplines (mostly non-governmental)
2) Fifty participatory sessions
3) Nine commissioned research studies

Policy Gaps:

There is a need for strong enough countervailing powers to articulate demand and ensure policy practice with social justice.

Policy Process:

The policy's purpose is to give direction, with a focus on sustaining and building

Important Links:

www.phm-india.org

www.globalhealthwatch.org

http://mohfw.nic.in/NHM.html

www.phmovement.org

www.ghwatch.org

Data Analysis:Rahul

When you ask yes and no questions you can calculate percentages. To comment in Percentages you need a denominator.

The different ways in which you can represent the percentages are:

1) Graphs
2) Pie Charts

3) Bar Graphs
4) Maps
5) Line Diagrams

How to interpret a table to convert information to knowledge:

Textual Data:

The Data is first classified into Themes and Subthemes:

Proforma for studies involving Textual Data:

Introduction

The Introduction must include. What you want to do and summarily how you are going to do it, where you did it. For Example:

You did ______________ study in ______________ area for ______________ purpose with ______________ study participants :Social Demography profile (AGE GENDER CASTE OCCUPATION RELIGION INCOME).

Methodology:

How you are going to do the study must be elucidated to the reader

Result:

The Result must also include a note on how you arrived at the result.

Table Title

What information will you give in a title?

Table number.Socio-demographic profile. What, who, where, when

Eg.Age distribution of respondents.

Sub headings:

Makes reading easier and allow you to skip directly to the relevant section.

Thematic Analysis:

Identify themes and sub themes. Explain how you identified themes and subthemes in the methodology section. Depending on your topic your data can flow into themes. Eg. Before migration, why people migrate, where they migrated, what their life was after migration.

Start reading articles and journals so you get an idea about how to write. You can give the table first and data later or vice versa but maintain throughout.

Alma Ata Declaration:

The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care, Almaty (formerly Alma-Ata), Kazakhstan which was formerly the Kazakh Soviet Socialist Republic, in 6-12 September 1978.

It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health For All" but only in developing countries at first. This applied to all other countries five years later.

The conference called for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urged governments, the WHO, UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The conference called on the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of the declaration. The declaration has 10 points and is In the year 1988 at Riga, the WHO convened a meeting and realized there were improvements following the Alma Ata Agreement and though there were improvements the improvements were not sufficient. They renewed and strengthened the strategies for primary health, Developing and mobilizing leadership for health for all by strengthening primary care at the district level and by training individuals for health for all and the development of appropriate technologies.

Structural adjustment programmes:

Due to Structural Adjustment Programmes introduced by development banks the markets opened up and the private sector was at an advantage. In the early 90s it was realized that countries were not going to meet the requirements of Alma Ata by 2000 due to the structural adjustment changes. The Peoples Health Assembly decided to fight for comprehensive health care as an approach. Lot of grass-root level organizations were represented at the Peoples Health Assembly. They decided they would confront the neglect of Primary Health Care or if the government continued to neglect the people and advocated the people would take primary health care into their own hands. Multiple workshops happened simultaneously where people discussed these issues and how people can be mobilized to address these issues, what are innovative ways to do so, what was going wrong and how to correct it? This led to the creation and endorsement of the People's Health Charter.

WHO conducts World Health Assembly once a year

PHM Functions as a bridge between local and global governance structures

Reflections on TheAlma Ata Declaration:

The Alma Ata is an important set of guiding values and approaches to development and health services as it calls for a reallocation of focus to the fundamental determinants of health and priority health

needs. The Policy has the potential to change our world by equalizing the wide socio-economic inequities in the lives of all the human beings though the various instruments of governance that provide health and well-being for all on Earth. It is as inspiring as it is outrageous and idealistic. The visionaries of Alma Ata had envisioned a Utopian world. A world we are so far away from 38 years later because, like every Holy Book or Document that passed through time the meanings of the words were corrupted by the gatekeepers of the systems that propagated them.

Alma Ata is the compass out of the quagmire we have created for ourselves. Local Ownership promotes creativity and persistence in those who practice it as a discipline in their lives, and these individuals kindle the lights of others who cross their paths and affect changes at a macro-level. It is a wonder that the medical establishment and the formal systems misunderstood the Alma Ata and sabotaged it systemically when in fact The Alma Ata would have helped organize the health sector with all the other sectors so much better for the spiritual and material benefit of all- The Providers and the Provided until the lines ceased to exist. If the world managed to provide health for all through education, livelihood and the various elements that make the lives of every person more empowered we would be living in a world of multi-sectoral organized abundance. Not a world which is dysfunctional, disorganized, fragmented and individualized.

Unfortunately people do not realize that the more we take the more we lose and the more we give the more we gain not just as individuals but as a collective coexisting entity. Fulfilling the Alma Ata with the collective actions of Civil Society is going to be more important now, with the Governance Structures folding their hands and looking away. Particularly in that: The Millennium Development Goals have passed the buck to the Sustainable Development Goals without the ownership and accountability for the outcomes and the government disowning responsibility for the health of its people. Saying that, I must also say the Millennium Development Goals have played a crucial role in our world, it has breathed new life into battling the social inequities of health across the globe. When Government ownership is not involved the enlistment and unification of Civil Society and the diversified small private primary health sector including the unrecognized sectors and NGOs becomes increasing important since they are a majority service provider of primary health care. Caregivers need to be sensitized to shift the empowerment to the people and suggested alternate strategies with a wider net and reach as catalysts in the process since they are an educated critical mass. They are also the providers of choice to many, since there is a stigma that the private sector provides better services than the government sector since they charge more for their services. So it is important that the people providing Primary Health Care are enlisted and sensitized to a community based approach through a model that is of appeal to the current generation of providers.

Effect of Shutting Down the Planning Commission:

With the shutting down of the Planning Commission there was a shutdown of Accountability and Monitoring Systems and a policy paralysis with a lack of role clarity.

Some Observations:

1) More Supply than Demand of Tertiary care in city

2) More demand than supply of primary care in rural and poorer socioeconomic classes

3) Good Tertiary Care in Cities

4) In progr.ms like NRHM VHND ICDS all facilities are affordable and available where they are available

5) Healthcare is low cost compared to global averages but is still expensive for the poor.

6) Low cost innovations and appropriate technologies are of the need of the hour due to lack of human and material resources especially in rural areas.

Negative Impacts:

1) Most of spending is out of pocket for health care
2) Government spending on healthcare is low compared to the global averages
3) Lesser number of hospital beds compared to global average for population
4) Lack of equitable distribution in health programs
5) Lack of Human resources and equitable distribution of human resources
6) People are not feeling accountable enough to carry out their duties responsibly
7) Unneccessary investigations, surgeries, extended stay at hospitals
8) Lack of sufficient regulation and review in the training and practice of medicine
9) Monopolization of private players in pharmaceuticals and health care delivery and lobbies

Solutions:

1) Increase Awareness

2) Health Insurance

3) Fill the government posts

4) Ensure Availability of modern equipment in Government Setup

5) Increase payment and ensure delivery of timely payments to govt. doctors

6) Increase medical seats or add a training program of a shorter duration which is recognized by the MCI

7) Add ethics to medical education program

8) Ensure quality of training and regulation in training

9) Regulation and Empowered Investigators and Ombudsmen to ensure ethical practices in training and practice

10) Development of a referral system

11) Setting up of Telemedicine facilities to bridge the gap in inequities of delivery of services

12) Standardizing and Integration of All bodies of health service delivery (AYUSH and allopathy) with proper quality monitoring and regulation.

With Inputs from:

Balentina Lamare, Fathima Begum, Asha Begum, Uma Chaitanya and Chandrashekar.M.N

lamarebalen@gmail.com

mswfatima@gmail.com

ashamdnagar@gmail.com

Chaitanya.tpg@gmail.com

Chandra.shekarmn553@gmail.com

Governance:

Governance refers to all processes of governing, whether undertaken by a government, the market or network, whether over a family, tribe, formal or informal, organization or territory and whether through laws, norms, power or language. It relates to the processes of interaction and decision-making among the actors involved in a collective problem that lead to the creation, reinforcement, or reproduction of social norms and institutions.

Whatever form the entity of governance takes, its governanceis the way the rules, norms and actions are produced, sustained, regulated and held accountable. The degree of formality depends on the internal rules of a given organization. As such, governance may take many forms, driven by many different motivations and with many different results. In addition, a variety of external actors without decision-making power can influence the process of governing. These include lobbies,political parties, and the media.

Role of Governance Systems:

1) Regulating the behavior of health providers or in the health team.
2) Curtailing the autonomy of individuals.
3) Monitoring has to be linked to action.

Accountability:

Public Affairs Centers, Public Affairs Foundation, COPASAH.Citizen report cards. NARIGA started social audit long back. They too develop a report card.

Community Action and Communitization in NRHM:

Community action and communitization is an arm of NRHM. Community planning and monitoring of health services and common review mission (CRM) are accountability complexes in NRHM. A national pool of people are chosen across levels from Anganwadi to District Hospital to do an appraisal pool. This is part of community led action for health.

Objectives of NRHM

1) To provide regular and systematic information and community needs to guide the planning process
2) To provide feedback according to the local developments
3) Community Action is a three way partnership between health system, community, CBO (Community Based Organizations), NGOs and Panchayat Raj.

Role of Civil Society Organizations:

They serve as members of monitoring committees, resource groups for capacity building and facilitation and as agencies helping to carry out independent collection of information. The goal is in giving real power to the people (planning, management and evaluation)

A quote to randomize the report: *Investing in health expenditure is not an expenditure its an investment. – Ravi Narayan*

Spatial Differences , Sanitation Practices, Built Environments and Perceptions: Rebecca

Is there a relationship between built environments and sanitation practices? How do physical environments impact migrant communities?

Affecting Factors of Influence in Bangalore:

From 2001-2011 Bangalore's population has grown by 47%

Migration Patterns: In actuality its quite sporadic and not necessarily from rural to urban rather its circulatory.

NUSP and SBM

Framework:
Sanitation processes are affected by social, economical and political, beliefs, cultures and attitudes.

Objectives:

1) To map social, economic and demographic information of migrants in Bangalore
2) To determine access to public sanitation facilities in spaces for migrants in Bangalore
3) Identify sanitation practices
4) To identify push and pull factors.

Methodology:

It was an Observational Study

The Study Area was New Byapanahalli

Selection Criteria:

The person has to be 18-64 years of age

They need to have worked as migrant informal workers <5 years or >5 years with their primary residence in selected field site and they have to be individuals who use private toilets.

Data Collection Techniques:

Semi-Structured and Open-ended interview questions

Field Notes

Verbally administered

Sample size tool: Data Saturation per field size location.

Data Analysis:

Semi structured responses, open ended responses and field notes which will be categorized into themes

Ethical Issues:
The consent process was verbal.

Risks:
Economic, Social Cultural Risk, Psychological Risk , Physical risk

Benefits:
There were no Direct Benefits to the study but there were many Indirect- social benefits

Ottawa Charter for Health Promotion (November 1986)

The Charter creates Supportive Environments with a socio-ecological approach to health, it strengthens community actions health promotion works through concrete and effective community action in setting priorities, making decisions for which there is a need to develop personal skills and reorient Health Services increasingly in a health promotion direction. This will be a priority in the future. The right to health is an affirmation for a standard of living adequate for the health and well- being of a person for the well-being of himself/ herself and his/her families.

Discrimination in the Health System:

Health is burdened by the problem of inadvertent discrimination. Eg. Transgenders and street children are never seen in hospitals, Outreach activities assume all communities are reached by a single language or dialect. Due to the inadvertent discrimination all public health policies and programs should be

considered discriminatory until proven otherwise placing the burden on public health to affirm and ensure its respect for human rights.

UN Commissioner on the Right to Health:

The right to health does not mean the right to be healthy, nor does it mean that poor governments must put in place expensive health services for which they have no resources.

STEPs to realize universal health

1) Addressing the underlying societal determinants of health
2) Strengthen the public health system
3) Community capacity building
4) Working with and strengthening civil society
5) Inter connected Rights

Right to health involves a broader perspective with the Involvement of ethics, responsibility, obligations, accountability frameworks, duty bearers. It requires a Co-ownership of process, democratic spaces and an actualization of equity delivered within reasonable time frames. Law and Health play an important role in the ownership and response towards health systems. A Transparency in health care units need to be maintained coupled with the strengthening public health related systems.

Poverty deprivation and quality of employment:Trends:

1) Informalization
2) Casualisation of work
3) High prevalence of informalization of the workforce (93% is in unorganized sector)
4) 60% of our population depends on agriculture
5) Disparities are hampering progress systematically reflecting hierarchies of advantage and disadvantage

Social Exclusion:

The inability of our society to keep all individuals in access of all resources,

What is ethics?

The study of standards of conduct and moral judgement. When referring to a profession, ethics is a groups principles or code of appropriate behavior.

Approaches to study Ethics

1) Descriptive Approach ("what" studies) scientific studies,
2) Analytical or Conceptual Ethics
3) Prescriptive or Normative Ethics: Defending the moral norms of a group uncovering, developing and justifying the basic moral principles.
4) Standards of wise conduct defined by reason rather than custom

Ethics was first described by Greeks

What makes actions good or bad right or wrong? Is morality objective? Do moral judgements have a true value? Can they be determined to be true or false?

Those that don't agree are called moral subjectivists.

The Is-Ought problem: David Hume

The is-ought problem states that many writers make claims about what *ought* to be on the basis of statements about what *is*. Hume found that there seems to be a significant difference betweenpositive statements (about what is) and prescriptive or normative statements (about what ought to be), and that it is not obvious how one can coherently move from descriptive statements to prescriptive ones. The is–ought problem is also known as **Hume's law**, or **Hume's guillotine**.

A similar view is defended by G. E. Moore's open-question argument, intended to refute any identification of moral properties with naturalproperties. This so-called naturalistic fallacy stands in contrast to the views of ethical naturalists.

Video with Joga Rao onCode of Medical Ethics 2002- Parliamentary enacted legislation for medical practice.

Learning: Do not ever make the community feel taken for granted

Conflict

Kumar brainstormed the various types of conflicts and started a session on conflict resolution.

A serious disagreement or argument, an incompatibility between opinions and principles results in conflict. In general the word conflict is negative. But if it is kept within limits and managed effectively it will have advantages too such as being an agent of change. Conflict may be necessary for change but not be necessary for development, The word conflict means different things to different people.

Conflict may not always be necessary for change, change can also be brought about by inspiration and peaceful example even to people with vested interests. Conflict is an inevitable part of change and one cannot have any change or any sort of development without conflict. The change can also be negative.

It can be opinion, contradiction, confrontation, shouting, struggle, dilemma, uncertainty, misunderstanding, competition,war and so on.

Before managing conflicts externally we need to reflect if we as individuals have any internal tensions and resolve our internal conflicts.

Managing conflicts:

Objective is to keep it within limits where it maybe useful, and prevent it from growing out of control. In other words it can be managed and has to be managed.

Warning signs of conflict:

It is most useful to recognize early signs of conflict as a manager or team leader and be able to act before it goes out of bounds.

Early signs:

Withdrawing, difficulties over decisions, arguments over minor issues, gossip, grumbling, individual absent, short tempers, abuse and so on.

5 ways of conflict resolution

1) **Avoiding Style:** attempts to get rid of the conflict by denying conflict exists or by postponing any attempt to deal with it. (Withdrawal). This task gives little importance with task. Associated with low levels of responsibility and commitments. Ignores his or her own needs and needs of the other party. Gives temporary relief, Used in: sometimes if it is not an urgent issue you can avoid it, or to cool down, need to collect more information, or you feel other people are capable of resolving the conflict., If the issue is a symptom of a wider problem, when people can be hurt by the other styles.
2) **Smoothing over**, You lose, Others gain. Yield to others. Emphasizes agreements and lets others win. Tends to be cooperative, not assertive. More importance to the task or relationship and not to the task or real issues. Conflicts dealt with this way will not be solved.
3) **Compromising Style:** Both Gain and Both lose. This style attempts to reach or negotiate a midway position. Search for a solution that brings both parties satisfaction. Acceptance on compromise agreement on both sides. Bargaining may make both sides take an inflated position. In search of compromise both sides may have to compromise values. Agreement may be reached but commitment may be weak. This style may not be ideal but is often practicable. It is important for everyone and every organization to be able to negotiate, to make concession. If time period is short this is the style of choice. If the goals of both parties are not very important or if both parties is equally strong and their commitment is equally strong
4) **Dominating Style** (You gain others lose) One party imposes its gains over the other. High level assertion, but low levels of cooperation. Winning is more important than preserving the relationship. Use of authority or power to overcome the other party. It leads to winners and losers and loser doesn't agree. Loser can be surprised, hurt and damaged. Used in competitive societies and cultures. Persistent use of this style may be seen as aggressive and may cut off by other people from interaction and information. Sometimes used when there is a majority vote. Used: Only when you have to make quick decision or when an unpopular decision is necessary, also when there is a question of war or life is threatened.
5) **Joint problem solving**This emphasizes energy given to analyzing and jointly solving the problem. The aim is to meet the needs of both the parties, identify each other's needs and together identify an alternative solution. Both parties expect to modify their views in order to reach their agreement. This style represents a high level of assertion and analysis. It is a creative strategy which helps in both individual and organizational growth but is a slow process. It requires trust

on both sides. Is appropriate when both parties agree that conflict is important and is worth and both sides are committed to a joint solution.

Agriculture:

Around 1770s the Farmers Movement came up to protest against urbanization and industrialization working against farmers.

Farmer suicides started increasing from early 90s due to:

1) Competition
2) GM Crops
3) Increased prices
4) Debts
5) Crop Failure
6) Climate Change

MSP: The central government fixes a price for a govt.

270940 farmer suicides in 2012?

Peoples health resource book

2 Red books for class by Dr.Ravi on Globalization.

Organ transplantation Is monetized in Singapore.

Exclusion vs. Inclusion

The concept of possession

Definition of Society

Group of people who share a common culture, occupy a particular territorial area and feel themselves to constitute a unified and distinct identity

Social Exclusion:

Social Exclusion first originated in Europe policy focus on those living in deprived areas poor political voicing poor housing, inadequate social services and a lack of decent work all combined to make an experience of social marginalization

Social Exclusion is the outcome of multiple deprivations that prevent individuals or groups from participating fully in the economic, social and political life of the society in which they live.

Causes of social exclusion:

1) Caste
2) Creed
3) Sex
4) Disability
5) Poverty
6) Illiteracy
7) Ignorance
8) Unemployment despite external achievement
9) Prevalence of male dominated society
10) Urge for inclusive growth

Social Inclusion

Social Inclusion is an affirmative action of change, to eliminate the circumstances and habits that lead to social exclusion

Reservations Vs. Merit debate For:

Reservation is needed provided it is regulated in an equitable fashion and the aim of reservation shouldn't just be quantitative. Underprivileged classes must not just be given a seat in a college but must also be equipped to thrive in the course.

Is it ever possible to remove the caste system from our country?

Attributes of Inclusiveness:

1) **Opportunity** should be created to earn a living and increase their income over time.
2) **Capability:** is the economy providing the means for the people to create or enhance their capability in order to exploit available opportunities.
3) **Equity:** It is also known as equitable allocation of resources in order to benefit every section of the society.

How to Redress

1) Change of mindset
2) Through the constitutional mandate

Globalization:

Dr.Ravi asked the batch what globalization meant to them. The following points came up.

1) Homogenization of culture

2) Free Trade
3) Increased Competition
4) Corporatization
5) Global village
6) Technological advancements
7) World without distance and boundaries
8) Standardization of Ideas

Negative impacts of Globalization: Farmers Suicides and Urban Suicides due to the materialization of culture and trap economics: Cream of Indian agriculture: over 100,000 farmers have died in the last 10 years after taking risks with cash crops and loans

Malnutrition and Childhood Malnutrition: Due to shooting prices of food decided by global drivers and shift of focus from food crops to cash crops so farmers have to buy food instead of eating from their fields. More and more women are being driven to revenue generation activities instead of ensuring nutrition for their children. Also the shift of focus from food crops to cash crops in primarily agricultural economies to keep up with the pace of prices and the global market would reduce global supply of food crops and further increase prices and feed into the problem of malnutrition. If poor people are dying of starvation its only a matter of time before the negative distributive economics catches up to the other classes and could this lead to an international food crisis down the road??.

Climate Change

Obesity and Non Communicable Disease: All of us are increasingly depending on outside food, fried food and salty foods increasing the burden of NCDs and Obesity.

Violence against Women: In a patriarchal society where women are becoming empowered and outside

Like the new international economic Order after the formation of the UN for the unification of the world we are trying to make a unified health order for the world through the Alma Ata Declaration to ensure health for all. There were lot of ideas about how developed countries would give aid to Developing countries. So Even if The developed countries gave 1% of their excesses to the poorer countries to develop them.

In the 80s there was an economic crisis and the idea of passing aid to developing countries started getting doubts. The idea of a need based sharing for a just society started disappearing and an economy for the sake of greed started. In the 90s a new economics came called neo-liberal economics and only until the last 5 years because of people like Amartya sen this economic model is crumbling.

The new idea for globalization that the world can be made into one big market with complete dysregulation and fewer controls from the government especially for welfare activities , start exporting more, open up to foreign direct investments. Because WHO UNICEF did not agree WTO, WB and IMF became involved in health economics and they don't give aid they give loans on a percentage. So Aid slowly became trade.

People's Charter's Vision:

1) Equity
2) Ecologically Sustainable Development and
3) Peaceful development are at the heart of a better world. Healthy life is a plausible reality for all. A world which respects appreciates and celebrates all forms of life and diversity , a world that enables the flowering of peoples talents and abilities to enrich themselves and others, A world in which peoples voices guides the visions to achieve a people led globalization.

.Secularism: Kumar.K.J

In a state the religion should not be a part of the state.

Secularism is not Religious, sacred or spiritual

The term comes from the Latin word *Secularos*. Secular means agnostic or Anti-God

Secularism stands of the belief that the state morals and education should be independent of religion

The term secular was described as "Promoting a social order separate from religion without dismissing religious beliefs. The Indian constitution was amended in 1975 to include the term secularism in the official description of state. Equality of opportunity is guaranteed in public employment as well except in circumstances described by the article which provides that officials serving in connection with the affairs of religious institutions or organizations shall be individuals who practice that religion.

It abolishes the practice of untouchability and makes such practice punishable by law.

Section 15.1 Freedom of conscience and religion is secured to all citizens

Section 15.2 No citizen of India shall be debarred from entering shops hotels and places of public entertainment on grounds of religion, caste, age, sex and place of birth

Section 16.1 Cant deny office under the state on the basis of above things

Section 25. It guarantees freedom of all religion to all persons and does not assign a special position to any particular religion

Section 26. Every religion has the right to establish and maintain institutions of religious and charitable purposes

Section 27. No person ican be compelled to pay tax which would be spent for the promotion or maintainance of any particular religion

No citizen can be denied entry to education institutions

Minority communities are guaranteed the right to maintain their own language, choice and culture and to establish educational institutions of their own

Indian citizens are guaranteed the right toequality before law. Not to discriminate against any citizen on grounds of any religion. Race, sex, caste , sex or place of birth. The state has to recognize and accept all religions and respect pluralism,. Goa is the only state which has a uniform civil code.

India is the birthplace of 4 religions Hinduism Buddhism Sikhism Jainism

Positive aspects:

1) Deep respect for all groups
2) Equality of all people
3) Breaking down of barriers

Indians Citizens are free to profess, practice and propagate their religious beliefs and irrespective of these beliefs, are equal before the law of the land and have equal access to government employment

Some Questions:

Can India have a uniform civil code? Can India claim to be a secular country? What secularism means for each of us? Who created the idea of untouchable. Are we free from this even after 68 years of independence?

Whats the difference between religion and spirituality?

Religion is a discipline and a way of life

Spirituality is something more.

Writing a research paper: Some Key Points

Purpose: We publish to translate and disseminate knowledge. To learn about ourselves and to share the knowledge with others.

Title: Its very important to give thought about your title, so that it captures the broad idea of the study (add geographic specificity, scientific, specific)

Authors Names: List the authors in terms of the intellectual efforts given by the authors. What if all authors gave equal or almost equal intellectual effort?

Acknowledgements: Everyone who contributed directly or indirectly to your work deserves to be acknowledged

Introduction: Table of Contents: Abstract (under 200 words with methodology and key findings, think about your words): Chapterization: Write down your chapterization, the broad table of contents can be top down or bottom up. You can even start with your reference list or bibliography) .

In order to be a good writer you have to be a good reader as well.

Introduction/ Background:

Background about the issue basd on the review of literature and based around where ou are doing the study. You can put a context of the place where you are doing the study.

The review of literature has to be done analytically.

Have atleast 10 references: Softwares for referencing: reference manager and NNOTE. More references are always better.

University Grants Commission and some universities put their publications and masters thesis online

Are there online resources where we can find all thesis in one place?

Answer: SHODGANGA all indian university thesis

Pubmed, Google Scholar (better search results) only key words

Goals/Aims and Objectives:

You may have general objectives and specific objectives

SEARCH in Chandapur district in Maharashtra the researchers went to study sickle cell anemia and ended up developing the *daru mukti morcha.* If you study the budget of any district the total budget spent by the government is less the the money spent on alcohol.

ICMR Ethical guidelines on biomedical research.

Recommendations and conclusions of study: It must be evidence based

Write your value frame write in the beginning

Positionality:

Where you are coming in from and what your value frame is must be put right in front.

Decentralization of Health and Panchayati Raj: Dr.A.S.Mohammed

Health is a function of Ministry of Health and Family Welfare

Panchayati Raj is a function of Ministry of Rural Development

Health at Village level

TBA (Traditional Birth Attendant) ANMs, ASHAs

Monitoring done by village health and sanitations Committees (VHSCs and VHNCs) created by the panchayati raj system

Sub Centres caters to 3000 population in hilly and tribal areas to 5000 population in the plain areas ANM ASHAs Multi-purpose worker who is now called a junior health assistant. Since many male worker positions are lying vacant they have started hiring female workers to these positions but female workers salaries come from the center under the family welfare program. At the Govt. of India level there used to be 2 secretaries. Since the tenure of Keshav Desiraju it has been merged into one. The male workers salary comes from the state department and the state government in order to cut down expenditure is not filling up the posts. Health is the state governments responsibility. Some sub centres have been given two ANMs

RCH is funded by the World Bank and they are dictating the policy for RCH. Bilateral Agencies such as USAID DIFID, and international agencies such as IMF, JAICA and World Bank are involved in most developmental and health programs in the country. United Nations funds UNICEF, UNDP and other multilateral agencies and United Nations is kept alive by funding from the various countries.

The funding agencies have a good hold on the policies they are funding.

Panchayat:

There is a Gram Panchayat and Block Panchayat.

Gram Panchayat is the governance arm. Bloc is the developmental arm.

Hobli (called Paragana in the North) is the administrative unit for a cluster of villages.

Taluk Tahsil

Development block: 1 lakh to 2 lakh population. Head of Development Block is Block Development Officer (BDO) He administers 29 Services. Offlate BDO under the Panchayati Raj System has been put as the Executive Officer who is the Member Secretary to the Panchayat Samhiti. Counterpart of Development Block is CHC (Comprehensive Health Care) in which 90% activities are preventive and promotive. 5 to 6 subcentres make one PHC. At the District level there is a Zilla Panchayat counterpart.

District:

Health is a part of Development so Primary Health Centres have to be put in Development blocks.

The chairperson of the Zilla Parishad is equivalent to a State Minister and they are in charge of various committees each committee has a chairperson. There is a health committee as well. The elected body is supported by the selected bodies. The elected bodies are in charge of framing the policies. Implementation has to be done by the selected bodies. In the Health Department the Counterpart is The DHO or The District Health Officer. He is responsible for the Health Programs and how they are

functioning in the district. Program Officers in charge of each of the 19 programs that run in the district report to the DHO.

Dr Ravi: Health for All

Primary Health Care

Universal Health Coverage

He differentiated between Health Coverage and Health Care Coverage

The Bhore Committee pre-alma ata dreamt of health for all in 1972 in 1947 and anybody within 8 to 10 km would be able to reach a PHC or sub-centers

There is a need to provide basic health care for people who can't afford to pay.

Central List State List Concurrent List: Health Falls under both

The Lancet, January 2011 has writings from all key people trying to promote health for all.

Themes Covered:

1) Infectious Disease
2) RCH Nutrition
3) Chronic Diseases and injuries
4) Equity and Health Care
5) HR
6) Financing Health care

Challenges:

1) Health Rights
2) Gender Equity
3) Markets/Access
4) Good Governance
5) Corruption
6) Addressing Social Determinants of Health

PPP/Economics

Big Challenges are:

Equity- The Most Equitous Service: if your services cater to all to the extent that they can reach a Dalit, woman with mental health issues you have achieved equity.

Access-Villagers have to walk 15-20 km to get basic health care, if people can access your services in under 15 minutes you have achieved access.

Corruption- Not just material Corruption but Spiritual Corruption as well. As an attitudelf everyone in a system does for others without expecting anything in return the question of corruption does not arise.

Hunger Index in India

Madhya Pradesh has the highest ISHI of 30.9% which is worse than Sub-Saharan Africa , there is no data from 8 states J&K, Himachal, Uttarakhand and some North Eastern States.

India's Health Indicators 2005

IMR All India: 58, MMR: 301, Total Fertility Rate 2.9

Shift From BIMARU to EAG States

BIMARU states are now Called Empowered Action Group States Empowered by activists and Government to catch up with the rest of India towards its goals for Health For all. Most of the creative work to provide health for all are evolving in the EAG group of states.

Examples of Empowered Action in EAG:

1) Rajasthan is the first state to provide generic medicine for all
2) Chattisgarh is the first state to provide ASHA workers for all
3) Jharkhand started a movement called Sahiyas

Challenges:

1) Diversity in Health Systems

Diversity in Surveillance Mechanisms Bihar has reported less AIDS than states in South India because Surveillance is better in South India.

2) Diversity in Health Human Resource Development
3) Impact of the current global crisis-2000
4) Neo-Liberal Economic Reforms
5) Negative Macro Policies

Amartya Sen:
The subject of justice is not merely trying to achieve – or dreaming about achieving- Some perfectly just society or social arrangements, but about preventing manifestly severe injustice.

Challenges of Decentralisation

1) Weak Public Health Systems
2) Poor Political will
3) Poor private sector regulation/ weak regulatory scenario

4) Challenge of Decentralisation: Functions, Finances ad functionaries
5) Health Rights and Entitlements
6) Enhancing Communitization

The New Epidemiology:

The Primary determinants of disease are mainly economic and social and therefore its remedies must be economic and social

Medicine and politics cannot and should not be kept apart – Prof. Geoffrey Rose

Researching levels of analysis and solutions

Reference: Report of the Independent Commission of Health in India 1998 by bringing people together to move the movement forward.

Universal Health Coverage

Definition of UHC

Ensuring equitable access of all Indian citizens through accountabile, appropriate, health services of assured quality (promotive, preventive, curative, palliative and rehabilitative of sufficient quality to be effective, while also ensuring that these services does not expose the user to financial hardship.

Public Health Services addressing the wider determinants of health

Government is being the guarantor and enabler, although not necessarily the only provider of health services.

What we need for UHC:

1) Need more jobs
2) Financial Protection
2) Greater Equity
3) Guaranteed Access to an essential health package including cashless ipd and opd provided free of cost

These are required at the levels of:

1) Primary Care

2) Secondary Care and

3) Tertiary Care

Choice of Facilities: People can be free to choose between Public sector and contracted in Private Providers

Challenges to UHC:

1) Health Financing
2) Access to medicines
3) HR for Health
4) Health Services norms
5) Management and Institutional Reforms
6) Community Participation and Citizen Engagement
7) Social Determinants of health
8) Gender and Health
9) Process of Consultation

Solutions

1) Health and sanitation committees
2) Health assemblies
3) Community Health Workers
4) Approachable body in the organizations

Introduction to Urban Health in Slums: Chander

Urban Poor and Marginalized:

Not all Slum dwellers are poor. It is not easy to identify the urban poor within the slums.

Chander listed the occupations of slum dwellers and showed us a video "Bangalored in Bangalore that showcased the two sides of Bangalore. The video showed us that the whole city is geared towards the rich and not the poor. While the rich are able to fly in from various countries and have their hearts fixed, their knees replaced by the best of the best healthcare professionals in the best of the best facilities paralleling the developed nations, the poor don't even have access to even basic primary health care. Bangalore has lost its caring capacity. It isn't able to support the people who built the city with their blood, sweat and toil, they have forgotten the people who have built their comforts selflessly while they are busy proudly showcasing to people from elsewhere the infrastructure with ambitions of paralleling cities like Singapore ignorant of the parallel universe that exists for those who blessed them with these blessings who are quietly falling victim to the growing divide. This video was showed just a day prior to leaving to Chennai to work with children from the slums as part of the flood response in Chennai.

We also saw a video on schizophrenia about a person called Reshma who was schizophrenic.

Womens Health, Womens Movements, The Indian Womens Health Charter.

Our Roles and Responsibilities as Community Health Practitioners : Dr.Thelma Narayan

Gender Power Relations Varies by culture, region and time

In West Bengal, Meghalaya ,Kerala Nair Community women are empowered.

Patriarchy is the unusual share of power unusual share of power unusual share of resources favouring men more than women.

How did change happen so far

1) Through struggle across the world and in India
2) By women's groups across the country
3) Through a growing women's movement

Women and Health WAH, 1990 Shodini

1) Mahila Samakhya GOI (Ministry of Human R D), function more or less like NGOs, Form women self-help groups
2) Womens Health Empowerment Programme 1998-2002 (Intersectoral collaboration across four ministries) The funding came through govt but they worked with NGOs to facilitate and help self help groups. Community level manuals
3) District Level Manuals
4) State Level trainers manual

5) Six Womens groups/networks as part of the Jan Swasthya Abhyan since 2000

-All India Democratic Women's Association

-Joint health network

First Jan Swasthya Abhiyan Peoples Health Assembly in 2002: The Peoples Health Movement adopted Womens health charter 8th March 2007 was held in Bhopal – grassroots movements, small groups got involved with the NRHM

Questions which cropped up in my mind:

What is the difference in the work done by these various groups?

How do we prepare men for women's empowerment?

How do we prepare women for women's empowerment?

The Womens Health Charter

The Charter Talks about Women's Rights in the context of the Social Determinants of Health.

It deals with Women's Right to health and healthcare, State obligations to promote women's health, Medical Ethics and Rights of women

Why is Women's health an important separate agenda

Across the world:

Women Do $2/3^{rd}$ of its work at $1/10^{th}$ of the income and own $1/100^{th}$ of the property.

Issues they deal with:

-Overwork

-Frequent pregnancies

-Malnutrition –Anemic poor compliance with iron and folic acid

-Lack of Quality Healthcare

- Unsafe Deliveries: Not all institutional deliveries are safe deliveries for every woman who dies at childbirth there are 20 others who die due to complications of pregnancy. Gender ratios at birth shows that the number of women are progressively declining.

Women: Bio Ethics

1) Increase in unnecessary Hysterectomies. Womb free districts
2) Tubectomies at young age
3) Surrogacy
4) Access to Healthcare

Teams: By Chander:

Learnings:

Team succeeds when its members have:

1) Commitments with common objectives
2) Good Personal Relationships
3) Team Morale
4) Clear communications
5) Effective decision making

Stages in team building

1)Forming

The team defines the problem, Agrees on goals and formulates strategies for tackling

Determines the challenges and identifies information needed, Individuals take on certain roles and develop Trust and Communication

2)Storming

Realise that the task is more difficult than they imagine, there is a fluctuation in attitude about the chances of success and there maybe resistance to changes. These may result in poor morale and collaboration.

Storming Diagnosis:

Do we have common goals and objectives?

Do we agree on roles and responsibilities?

Do we have adequate interpersonal skills?

3)Norming

Members accept the team.

Team roles and procedures are finalized.

The individuality of fellow members is accepted.

Team members realize they are not going to crash and burn and help each other.

4)Performing

Team members gain insight into personal and team processes and a better understanding of each others strengths and weaknesses.

Develop close bonding.

Team player qualities:

Attitudes:

1) Tolerance towards others
2) Positive mindset
3) Optimism
4) Sensitive
5) Giving and receiving constructive feedback
6) Affability
7) Loyalty to stand by your team
8) Trust between team members

9) Respect of healthy boundaries
10) Transparent communications

Knowledge:

1) Knowledge of place
2) Knowledge of culture
3) Knowledge of purpose, goals and objectives
4) Knowledge about team
5) Knowledge of limitations
6) Knowledge about self

Skills

1) Planning
2) Interpersonal Relationships
3) Organizational skills
4) Managerial Skills
5) Motivational Skills
6) Anticipation

United we stand divided we fall: A house divided into itself cannot stand

A Team Leader Requires

Knowledge:

1) About Team
2) About Self
3) About the Task
4) About Resources
5) Limitations
6) Scope
7) Existing Norms and Boundaries
8) Ethics

Attitudes

1) Stewardship
2) Trust
3) Fairness
4) Transparency
5) Ownership
6) Supportive Supervision
7) Loyalty
8) Humility

Skills

1) Problem Solving
2) Motivation skills
3) Communication skills
4) Coordination
5) Planning
6) Negotiation
7) Delegating
8) Good Listener
9) Good Observer
10) Shrewdness
11) Analytical Skills

Social Vaccine:

Social Vaccine aims to address underlying social causes of diseases through social monitoring and action.

Its implications are:

1) Social
2) Cultural
3) Economic
4) Political

**Inspired from mfc- a nationwide platform of secular, pluralist, pro-people, pro poor health practitioners, scientists and social activists- critically analyzing, and developing a system of healthcare which is humane and meets the needs of the vast majority of people.*

National Program for NCDs Prevention and Control

Diseases Covered:

1) NBCPs and Cataract
2) Oral health
3) Iodine deficiency
4) Anemia
5) Cancer
6) Diabetes
7) Cardiovascular diseases and stroke
8) Elderly people

Objective

1) Prevent and control common NCDs through behavior and lifestyle changes
2) Provide Early diagnosis and management of common NCDs

3) Build Capacity at various levels of healthcare for prevention, diagnosis and treatment of commonNCDs
4) Train Human Resources within the public health setups with doctors paramedicsand auxillary staff and nursing staff to cope with the increased disease burden of NCDs
5) Establish and Develop Capacities for palliative and rehabilitative care

Strategy

1) Early Diagnosis and Treatment
2) Group Formation
3) Health Education
4) Recreational Activities

Screening:

1) Define the condition
2) Identify the population
3) Screen by risk factors
4) Decide the vulnerable group
5) Decide Tests and Screening apparatus

Opportunistic Screening- People who come in contact to the clinic are screened. It has inbuilt components of awareness creation, self-screening and trained health providers. Such screening involves simple clinical examinations and simple methods which are financially appropriate

Implementation:

Requires Material, Money, Well trained Human Resources, Monitoring & Evaluation

At every level there will be a committee to monitor and evaluate

Healthcare In Mumbai: Sadanand

Health is a function of the Municipal Corporation of Greater Mumbai, The Annual Budget of which exceeds many states like Jharkhand and Chattisgarh.

Primary Health Care is through 174 dispensaries, 168 outreach health posts, 15 RCH health posts and 30 maternity homes

Secondary Health Services is via 18 peripheral hospitals and 5 speciality hospitals, 1 ophthalmology center, 2 ENT Hospitals and 1 TB Hospital.

Tertiary care hospitals are growing very rapidly in the private sector, due to high expectations of people from modern technology and its affordability among increasing percentage of mumbaiites, 30% of healthcare is covered by insurance or reimbursements by their employees

The total number of beds available are:

Municipal 28%

Government 22%

Private 50%

There is no authentic data for allopathic doctors in Mumbai: MMVC is stuck with a figure of 80000 doctors since 2002. There are more tban 22000 doctors in Mumbai there is 1 doctor per 600 people almost equal to 1 in 500 in UK but health indices do not match.

Life expectancy in Mumbai is only 57 years

TB accounts for nearly 100% death rate.

HIV/AIDS was under control but due to withdrawal of Gates Fund there is a lurking fear that AIDS may reappear.

NCDs

Cardiac Diseases-10%

Trauma is the biggest killer 4-5k cases in Sion hospital alone

Suggested 3 pronged approach:
PHC for every 20000 population served by 4 doctor and helped by a physiotherapist and psychological counsellor

Only simple medicines and cheap investigations

MBBS doctors must receive additional training to give primary care

Substance Abuse:Chander

7.5 crore Indians are drug addicts

6.2 crore alcoholics

90 lakhs are cannabis dependent

Surrogate Advertising:

Because tobacco advertising is banned Tobacco and alcohol is advertised indirectly through other ads. Tobacco advertising contributes to 300-400 crore in a 8000 crore advertising industry

CODPA: Cigarette and other Tobacco Act

FCTC: Framework convention of Tobacco Control

Supply reduction strategies

Shift from Tobacco to other crops in a phased manner

Alternative Livelihood for tobacco workers

Incentives for growing other food crops

Sustainable Development Goals: Anusha

Formulated at the Addis Ababa High level forum on Sustainable Development

She told us about each of the targets under each of the goals

Common Themes

1) Cooperation between the developed countries and developing countries
2) Equity
3) Policy
4) Social Inclusion
5) Technology is highly focused
6) Technology transfer between developed nations and developing nations

Dr.Thelma Narayan:

Health is a function of Development and development is a function of health

Macro Policy is driven by politico- economic determinants, backed by unprecedented wealth and concentration of power, these enhance socially embedded hierarchies and inequalities due to:

1) Gender
2) Race
3) Ethnicity
4) Caste
5) Language
6) Belief Systems
7) Disabilities
8) Mental Illness

Eg. WCD budget is slashed by 50%

Disparities hampering progress are systematic, reflecting hierarchies of advantage and disadvantage and public policy choice.

Global Inequities

High income countries represent 15% of the Worlds Population, 40% of the world's population i.e 2.5 billion people living on less than $2 a day but account for 5% of the global income. 2/3 of the poor are small farmers and agricultural laborers. Unfair Trade undermines their livelihood

Led by EU and USA developed country agricultural subsidies are over $350 billion a year i.e. almost $1 a day, supporting large farmers and corporate agri-business.

For a fraction of that cost, universal education, health and water can all be achieved.

Sustainability, Development and Health

What is Sustainable Development

Humanity has the ability to make development sustainable – to ensure that it meets the needs of the present without compromising the ability of future generations to meet these own needs. (Brundtland Commission report, 1987)

All sectors of society can project their interests to this malleable definition

Developmental Approaches

Human needs are basic and essential, economic growth and equity is required to sustain them, equity is encouraged by effective citizen participation.

Important Developments and Events

1) World Commission on Environment and Development initiated by UNGA 1982: It took 5 years to submit its report in 1987
2) 1980: World Conservation Strategy of the International Union for the Conservation of Nature.
3) 1992: Earth Summit in Rio de Janeiro, Un Conference on Environment and Development with a Declaration of principles
4) International agreement on Climate Change and Biodiversity
5) 2002: World Summit on Sustainable Development, Johannesberg, South Africa.

Johannesberg Declaration:

3 Pillars of Sustainable Development:

Economic, Social, Environmental at local, national, regional and global level, with **Intergenerational Equity.**

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School of Public Health, Equity and Action (SOPHEA)
SOCHARA
 # 359, 1st Main,
1st Block, Koramangala,
Bengaluru – 560034
Tel: 080-25531518; www .sochara.org