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DIMENTIONS

A SOCHARA – SOPHEA NEWSLETTER

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Editorial

Several milestones have been crossed in the three decade long journey travelled by team SOCHARA. The year 2014 marks a decade of work by the Community Health Cell (CHC) Extension Unit (CEU) in Tamilnadu (TN). Ten years have sped by and the team has built on work done earlier. The CHC team had a long association with voluntary and non-governmental sector health initiatives in the state of TN since the 1980s. This was a time when the community health movement was developing. Closer links evolved in 2000 and beyond as part of the build up to the first *Jan Swasthya Sabha* (People's Health Assembly) in Kolkata. The launch of the *Jan Swasthya Abhiyan* (JSA), which is the People's Health Movement in India, marked a strategic shift in approach through a proactive process of engagement with the state and the public health system on the one hand, with efforts to strengthen civil society role and capacity on the other hand. The purpose was to strengthen the public health system and accelerate equitable improvements in health in order to realise health rights of all citizens. The TN state unit of JSA popularly known as the *Makkal Nalavazhyu Iyyakam* (MNI) in Tamil initiated a series of campaigns; addressed important issues; and undertook studies. The MNI sustained itself as a movement through a networking approach through which it has built up a social sector alliance. The CEU was initiated in 2004 in response to the tsunami. A community approach to a disaster response through a network of institutions and CBOs (community based organisations) was facilitated. A situation analysis identified Pazhaverkadu (around the Pulicat Lake area) in Tiruvallur district as an area where work was needed, in addition to work in resettlement colonies in Chennai for persons who were displaced by the tsunami. A small team was based in Chennai, located in rented premises in Balamandir. Since then the work of the team has grown from strength to strength based on ongoing reflection, reviews and analysis. The team have developed a community of support around them. Community Action for Health (CAH) was an extensive initiative undertaken across 14 blocks in six districts of TN in partnership with the State Health Society and the Directorate of Public Health as part of the *'communitization'* component of the National Rural Health Mission (NRHM). CAH is closely linked to the Advisory Group for Community Action (AGCA) a Standing Committee of the NRHM established by the Ministry of Health and Family Welfare, Government of India. Working specifically in the Tamilnadu context there have been a number of lessons learned in this process of multiple engagements.

Another significant milestone in SOCHARA has been the decade long experience of running the community health fellowship and learning programmes. 2002 is referred to as the pre-fellowship year during which several young persons were taken on for varying periods of facilitated learning. This led to the First Batch of six in the Community Health Fellowship Scheme in Bangalore in 2003. This was later renamed and the Community Health Learning Programme is now in its third phase. In 2009 the first batch of twenty joined a Madhya Pradesh Community Health Fellowship Programme, a two year Hindi programme in Bhopal. During the decade, over 200 young professionals have been through the community health learning programmes in Bangalore and Bhopal. Young enthusiastic pioneers who emerged from this have played leadership roles in CEU as well as in CHC Bangalore and the Centre for Public Health and Equity (CPHE) in Bhopal. Over 95 % of alumni continue to work in community health and development. This is against the reported 40-60% dropouts from postgraduate programmes in Community Medicine and Community Health. Fellowship programmes have been evolved by other organisations, though not all have continued.

There are interconnections between the learning programmes and the work of the SOCHARA teams in Bangalore, Chennai and Bhopal. Both are committed to social justice in health and to addressing the underlying determinants of health building on a community health approach. The Community Action for Health in Tamilnadu has become a site of learning for community health fellows as well as for research. The Community Health Learning

Programme has also evolved. The establishment of the SOCHARA School of Public Health, Equity and Action (SOPHEA) in 2010-11 brought together the learning processes within the organisation. SOPHEA is further strengthening the learning and research component, without losing the flexibility and experiential component of learning and unlearning through its being grounded in community and changing social realities.

This issue of DIMENTIONS provides ***'first person accounts'*** of some of the learning by community health fellows of Batch 9 and 10. Ganesh explores the impact of a lack of access to toilets on the mental health of women and persons with disability. This feeds into efforts by Prahlad, his team mentor, who has been working in 8 districts of Karnataka with partner NGOs promoting sanitation and environmental health. Prahlad has been recognised as a ***'Sanitation Driver'*** by UNESCO recently. Kanishka a flexi-intern who joined after being trained as a dentist, writes reflectively about the Mobile Medical Units in Tamilnadu. She has gone on to a post-graduate programme in public health. Madhavi who has completed school in the USA spent a year as a flexi-intern. She shares glimpses of her field work with the Association of Persons with Disability (APD) in Bengaluru. She also plans to study public health. Sharanya also a flexi intern during her MPH programme looks at women's health among vulnerable communities using a gender lens. She now works in a research project of the Governance Hub of the Public Health Foundation of India, studying community processes for health. Samantha writes about her two month field work with Swasthya Swaraj in Kalahandi district, Orissa and how this experience has moved her. She has subsequently opted to go back to Swasthya Swaraj after completion of the CHLP to work for 3 months. She is a young dentist, trained in Bangalore with an MPH from Australia before joining the CHLP. Kumar a team mentor who visited Orissa as a teaching learning facilitator also shares his thoughts and dreams. Dr. Sr. Aquinas a SOCHARA member and our former Vice President is the spirit and energy behind Swasthya Swaraj. She was a faculty member in the Department of Medicine at St. John's Medical College who has been moved in a powerful way into community health. She together with other Sisters established the Holy Cross Comprehensive Rural Health Programme in Hannur, Kollegal taluk, Chamrajnagar district, Karnataka. Later as Provincial of her Congregation she was a paradigm shifter. Now in Kalahandi she continues her tireless work. Job Joseph a postgraduate in Social Work spent an entire six months of CHLP field work in three phases with the District Mental Health Programme (DMHP) in Thiruvananthapuram, Kerala. He was inspired and energised by the team spirit and team work that he experienced there. He was given several responsibilities by the DMHP team due to his commitment and competence. His account provides insight into the tremendous effort being made in the DMHP. After completion of the one year CHLP Job too spent a month in Kalahandi with Swasthya Swaraj and is now working in Chhattisgarh. Dr. Abraham Thomas who works with the Dr. T.M. Samuel Memorial Medical and Dental Centre, in Kadapa District, Andhra Pradesh shares vividly his experience about access to sanitation in government schools. He was a first batch CHLP Fellow and besides working as a full time dentist he is engaged in interesting work with the public in his town and in surrounding villages. We hope to have a CH fellow from his area in future who can be mentored by him.

All of us in SOCHARA are deeply appreciative of the work and presence of the young CH fellows and alumni. They keep the flame of the community health movement alive! Many are also at the meeting point or *Sangam* where the People's Health Movement, the emerging public health movement and social movements engage, interact and intersect with each other, raising critical questions, participating in action and continuing the life-long learning and transformative process.

We hope you enjoy reading this issue! Your feedback is welcome!

Editorial Team

'Poor access to sanitation facilities' - A determinant of mental health

Ganesh C K, CHLP Fellow, SOCHARA, Bangalore (Batch - 10)

As part of the community health learning programme of SOCHARA, I carried out a study on the 'mental health impact of poor access to sanitation facilities (toilets)'among women and persons with disability in 7 villages and 2 slums located in Hospet Taluka in Bellary District, Karnataka state. The study was carried out with the support of 'SAKHI', a voluntary organization that addresses the sanitation and other needs of the community in Hospet Taluka. The study design adopted qualitative methods using 25 in-depth interviews and 2 focus group discussions. Through this process of enquiry I found sociological and psychological problems faced by women and people with disabilities as a result of poor access to sanitation.

Photo of Ganesh discussing about sanitation with a group of women in Hospet Taluk, Bellary

Problems faced by women

No issue touches the lives of women, particularly poor rural women as intimately as that of access to sanitation. In low income settlements where there are no individual toilets, women queue for long periods to use public toilets; as a result some have to bear the indignity of having to defecate in open fields which exposes them to the possibility of sexual harassment or assault.

Men also suffer from the burden of poor sanitation particularly those who are disabled. In many villages and towns, men urinate and defecate in open spaces. Whereas women, whose anatomy, modesty and susceptibility does not allow them to discreetly relieve themselves in public, have no choice but to wait until it becomes dark. Usually they go early in the morning when there is less risk of being accosted. '*Going to the toilet'* for these women often means squatting in a private spot or waking up before dawn to queue at public toilets. Usually in villages in the morning and evening it is observed that young men stand at the outskirts of the village, while women go for defecation. It was reported at times that these men follow the women and misbehave with them. Women are also often teased and called by nick names. This attitude by these young men creates psychological problems for women. Additionally most respondents said that they have health related problems as a result of not taking sufficient food and water in order to avoid or reduce the need for using a toilet. Some respondents complained of gastric and body pain, but the family members did not think that this was related to poor eating habits cultivated in order to avoid or reduce toilet usage. Other complaints by women are constipation and reproductive tract infections.

For want of privacy the women walked long distances, which took much time. It was reported by many respondents that they were being misunderstood by their family members for misconduct. They spoke of the unnecessary doubts and questions asked by the family members that many a time led to them feeling stressed.

Problems faced by people with disabilities

Most of the respondents who are persons with disability informed that they suffered greatly due to poor access to toilets. The disabled persons were also very much depressed by lack of toilets. Most of these disabled persons are very poor and could not afford even to meet the minimum daily living standards. Many of them were dependent on others for support in meeting the basic daily needs. People who are severely disabled are dependent on others to take them to toilets. Many families who support such persons considered it a burden. At times these people used a place near their habitation for toileting needs as they are unable to walk long distances. As result they are labelled by the community as *'*nuisance creators*'*.

Mental health impact

Women face more problems in this regard. While going for open defecation they face harassment, fear, suspicion and, domestic violence. As a result many reported that they were under stress and depression.

1. They feel ashamed

Regarding the toilet issue, for women who are disabled and who depend on others this is a sensitive issue. They said they feel ashamed while being accompanied by the family members, and are not comfortable to relieve themselves in front of them.

2. Stress and Depression

Women burdened by their biological condition especially adolescents during their monthly period said they get stomach pain therefore they need to spend 10 to15 minutes in an open place lacking privacy to get relief from pain. They said this leads to stress. Most of the respondents said they get psychological stress because of open defecation which lack privacy. The other problem that precipitates their stress is fear about men and animals.

3. Suicidal thoughts

The adolescent girls and the young women reported that they face stress and depression as result of teasing done by young men while visiting the place of open defecation. Besides this they are also being misunderstood by their family members for their conduct. Many of them reported as a result of these they contemplate suicidal thoughts.

CONCLUSION

Through this study I came to know that access to toilets is a practical issue that is linked to health and affects mainly the women in terms of mental health. Many of them expressed that it is a serious issue of concern. It is of great concern that factors such as sexual harassment, patriarchal system, absence of privacy, poverty, cultural traditions, suspicion at home and humiliation in public are causing major impact on women's mental health.

The problems are so deep and personal that the women are unable share about them; as a result they are silently suffering from psychological stress. This in turn leads to fear, reduced sleep, reduced intake of food, lower self confidence, distress, confused state of mind and constant worry about the future. The feeling of being worthless and suicidal tendencies was also pointed out. All these are characteristics that can lead to mental illness.

We can conclude that absence of access to toilets is a key determinant contributing to poor mental health of women.

The role of Mobile Medial Units (MMU) in the National Rural Health Mission (NRHM) in Tamilnadu

Kanishka Koshal, (Flexi Intern), CHLP, SOCHARA, Bangalore

Introduction

We stepped on to the deserted platform at 10 pm; a few others got off the train and rushed out to their waiting friends and relatives. I was struggling with my 2 bags, and the third I had so gallantly offered to carry. We walked out of the train station and peered into the empty street outside. For the first time since I left Bangalore this faint thought crept into my mind that *"I might have taken up a challenge I was not ready for."* I turned to my companion who looked as cool as a cucumber as she dialled on her phone she said. *"Don't worry I will call someone to pick us up"*, this was Dr. Chandra who told me as she sensed the dread on my face. Later on, our way home she gave one of her disarming smiles and assured me, *"By the end of two months you will become as bold as me."* I soon felt the panic and doubts fading.

Photo of a Mobile Medical Unit

The next few weeks were nothing short of an adventure involving travel through the picturesque countryside, experiences of a new culture, and lots of hand signalling and tons of affection liberally showered on me. I think my field placement was indeed a life-changing experience where I met some remarkable people from whom I learnt more than I had expected, and in the end as I expected, I did indeed emerge a different person, definitely bolder and more humane.

For my field placement I went to rural Tamil Nadu where I spent time from October-December 2013 in Kandili and Alangayam Blocks of Vellore District, Tamilnadu studying the Mobile Medical Units (MMUs). The MMUs are an outreach service operated by the Government since 2009 to cater to the needs of rural population living in remote regions or areas where access was difficult. It was reported that in Tamil Nadu all 385 blocks (an administrative region at a sub-district level) have MMUs in operation currently.

Aim of my study

My aim was to understand and study the MMU not only from the perspective of the health system, but also from that of the intended beneficiaries of this service. My quest took me from the perfectly laid out bright green paddy fields of Kandili to the glowing silver sugarcane fields swaying along the hillside in Alangayam. While Kandili is an area in the plains well connected through roads and public transportation, Alangayam is spread out across and between the dense reserve forests of Jawadu Hills. I covered a total of 21 villages (chosen for their remote location) during the course of my study, and met local government health service providers as well as people in the villages and their leaders.

First Impressions

One of the first documents I came across during my initial inquiries about the MMU was the Government guidelines pertaining to the operation of the MMU. Although this booklet is available with every Mobile Medical Officer (MMO) who is specifically recruited for running the MMU, the guidelines seemed rather cryptic. It is evident from the guidelines that the MMU were conceptualized as a broad-based public health initiative and not just a mobile clinic. I came to know

Photo of Kanishka interacting with community members

through my interaction that no orientation training had been conducted for the Medical Officers nor was any further guidance given to them on how to achieve the listed 8 objectives. I understood as result of this the MMUs were essentially functioning as a mobile clinic where check-ups were done and medicines dispensed. There was no focus on the promotive and preventive aspects of primary healthcare.

Community Perceptions

Through my conversations with various users and non-users of MMU and community leaders, I learnt that the village population was not involved in any way in the functioning of the MMU nor were they consulted regarding their specific needs. As was echoed by the teachers of the government school in Mambakkam (a tribal village situated in the foothills located about 15 kms from the closest Health Sub-Centre); they had been asking the MMU staff to conduct blood group type tests for the school students for the past 6 months but had not received any response.

Even though the State Health Society website states that the MMUs are being operated under the 'control of the PHC's Patient Welfare Societies (PWS)', and the *Panchayat* President is a member of the PWS, in almost all areas I covered they had never been informed of the existence of such a body in the PHC.

Practice of Caste System

Another issue that came to light during these interactions was the strong belief of the local people in the caste system. It was prevalent in all non-tribal areas; the tribal people do not have a caste system. Most villages had a well demarcated Schedule Caste (SC) Colony. This living area would usually be at

Entrance of SC colonies marked by a statue of
Dr. B R Ambedkar, Puliyur Village, Alangayam

the outskirts of the main village with its own water supply and there were minimal interaction between the residents of the two colonies. It was observed that *Anganwaadi's* were also segregated based on caste in these parts.

The designated point where the MMU stops is usually an area which is chosen for its ease of accessibility and central location in the village e.g. the *Anganwadi*, government school or the village temple. On questioning, the MMU staff informed me that no announcements were made about the arrival of the MMU or the services that could be availed through it. For this reason, in many villages that I visited the residents did not know about the existence of the MMU or its visits. This disparity of course affects the residents of the 'Scheduled Caste Colony' more. As Thangavel (name changed), 65 years from the SC Colony Thelangamatrapalli told us – *"I walk about 5 kms through the fields to the main road, then take a bus or shared auto to go to the Gajalnaikenpatti Primary Health Centre to get my blood pressure medicines"*

After getting the feedback from the community members I decided to spend a few days travelling with the MMU staff to know more about who the actual beneficiaries of this service were. From my observations most of the MMU users were pregnant women (who were informed beforehand by the Village Health Nurse of the date of visit of the MMU) or elderly people who came with complaints of bodily aches or for their monthly supply of drugs for chronic ailments. They found the MMU to be a more convenient option.

This led me to the question of whether the MMU has brought about an improvement in the healthcare seeking behaviour of pregnant women in these areas. The answer was affirmative and heartening. Women who had in their previous pregnancies (before the MMU service was introduced) gone for only 2-3 check-ups were now getting regular monthly/bi-monthly check-ups done. In some cases complications had been detected at an early stage too and were duly referred, as well as informed of necessary arrangements to be made for the delivery.

The lack of announcements, even though the MMU is fitted with a loudspeaker system and an LCD Television also affects the community perception at large of the services provided by the MMU. This was further reiterated when we spoke to non-users of the MMU. If we used the Tamil term for MMU *Nadmadum Maruthuva Manai* (mobile hospital) very often they could not identify it. If we showed them a picture of the MMU they would identify it but use terms like *Garbhini* (pregnant woman)and *Tadupoosi* (immunization) as the purpose of the vehicle visiting the village.

Photos of user of MMU

In Thatharamanoor Village (Kandili) which is visited by the MMU once a month, even though there has been a case of Chikungunya which was reported to the PHC, there has been no follow-up or discussion with the community members on the cause of spread of the disease or prevention of breeding of mosquitoes. These definitely are lost opportunities. An intervention at this stage could help prevent future cases.

Issues related to the health system

On the other hand, it was noticed that there is a gross shortage of MMU staff. The physically demanding nature of this job which involves a lot of travel to remote areas every day means there are few takers for a post with the MMU. Both the MMUs in Kandili and Alangayam were understaffed. There was no laboratory technician in either MMU. In Kandili, medicines were being dispensed by a boy who had passed the 12th standard, who had been hired to distribute tokens to patients at the PHC, as there was no pharmacist present with the MMU.

At Alangayam, the MMU vehicle was non-operational for the entire duration that I was there. I was told by the Block Medical Officer (BMO) that the staff usually hires an auto-rickshaw or an Omni van to make the trip to the remote villages. Most villagers in the areas which are supposed to be serviced by the MMU could not identify the MMU even from a picture. On the state health website, the most recent performance figures for the MMU at Alangayam showed that 14 camps were conducted during the month of September 2013 instead of the proposed 40. It appears that the visits by auto and Omni van were reported as MMU camps.

Another point that stood out for me was the criteria for measuring the performance of the MMUs. The only two parameters being used by the Department of Public Health were 1.Number of camps conducted, 2. Number of patients seen. Each MMU is expected to conduct 40 camps in a month and see at least 100 patients in a day. In my opinion this approach seems to reduce healthcare to just a few target numbers that need to be met every month and does not build any accountability at all on part of the MMU staff.

This was evident by the fact that although the MMU in Kandili was operating fairly regularly and the villagers were aware of it, there was no Information Education Communication (IEC) material for health education and health promotion given by the MMU. Even though there was an LCD Television and a DVD player system fitted in the MMU it appeared to me not being used at any time.

A few instances of misuse of the MMU were also witnessed during my stay there; such as for transporting medicines and other PHC Supplies from one place to the other and also as an emergency transport vehicle in case of complications occurring while performing surgery during the Family Planning Camp at the Block PHC. The MMU does not have equipment to stabilize a patient in a critical condition.

Another observation made was on frequent diversion of the MMU staff to the PHCs to compensate for staff on leave makes the regular operation of MMU to its full capability difficult and also may be a hindrance in building credibility among the community it caters to.

CONCLUSION

Mobile Medical Units (MMUs) have great potential as an outreach medical service and can help check outbreaks of many preventable diseases which plague remote rural areas. They can be used for prevention of communicable and non-communicable diseases through awareness created by video films and health promotion. They can be the starting point for many community based interventions such as eye camps, dental health camps as well as mental health outreach and care. Currently, the MMU does provide respite to certain sections living in remote rural areas. Some innovative thinking and genuine commitment on behalf of the health system and improved community participation in planning and implementation of services through MMUs could go a long way in making these a real asset and complement to the government healthcare system.

My experience with the tribal people in Orissa

Kumar KJ – Faculty Member, SOPHEA, Bangalore

During the month of December in 2013 I had the privilege of visiting Mr.Venkatesh (a community health fellow of SOCHARA) who was my mentee and was placed for field learning in one of the poorest tribal belts in Orissa, India. I had travelled many times to the northern parts of the tribal belt, and always it was well planned and I usually had my train reservations done well in advance. On this visit however, though I had made my reservation, it was on the waiting list and I did not want to postpone my visit since arrangements with the concerned people were already made.

Though I was on the waiting list on the day of my departure, I took courage and went to an un-reserved compartment of the train where I found a seat. It was quite interesting being there. The first experience was the foray by transgenders, their arrogance in demanding money from the poor travellers and the abuse meted out by them if their demands were not heeded to. The second one was that of the toilet facilities which were invariably stinking and the inability to use one due to overcrowding. The people were of various cultures, eating different kinds of food, speaking different languages but were quite happy, friendly with each other and ready to help when a need arose. I managed to fill my stomach when the trains halted at stations since vendors usually do not come to the unreserved bogie which is a sort of discrimination against the poor.

The trip was long and tiring - 20 hours of sitting at one seat and not being able to move because of the fear of losing that seat. Once I reached my destination I started panicking because Venkatesh was not there at the station to pick me up as planned. I did not know what to do as people do not speak English and my Hindi is quite poor. A rapid exchange of phone calls ensued which finally resulted in a beautiful car arriving to pick me up and I was very proud to travel in an air conditioned car to reach my destination which was 50 kms away. Venkatesh was smiling and happy to welcome me at the destination which followed a small round of introductions with all the team members of MITRA. Later I met Dr. Johnny Oomen, who has been an inspiration for this organization. MITRA is part of the Christian Hospital, Bissamcuttack which has worked for a very long time.

Bissumcuttack has the most beautiful landscape which I have ever seen. The atmosphere is very serene, there is enormous richness of vegetation and minerals, green mountains and people moving around. Over there I was struck by a beautiful old building which was the hospital which caters to about 100 patients on an average every day.

I was immediately taken care of by the team and a beautiful room was given to me (such luxury I could not even imagine in that context). I started my day with a tribal breakfast following which I was taken to see the hospital and its surroundings. I was introduced as the mentor of Venkatesh, who was already well known there. He had become popular and they spoke about him being very handsome., Thus I too became very popular.

Since my days there were limited and I wanted to get as much as information as I could, I also explored the possibility of visits to some of the tribal villages where MITRA is working. The local people are very much deprived of their rights to the basic needs such as education, health and employment. MITRA is creating awareness among them on these issues.

I was struck by the sincerity, hospitality and availability of these tribal people and how cultured they are when compared to the people of the city. Thespeople are more civilized than us and they teach us many things like values, morality, hospitality, truthfulness and so on. The language they speak is *Kubi* which is unfamiliar, yet somehow I was able to communicate with them through actions. I started loving this part of the country and fell in love with people of this area. My love for nature has increased due to the beautiful landscape, the serenity and the absence of pollution.

Thanks to MITRA for the opportunity to see their work both in the field and at their office. I was fascinated by the idea of AQTE (Adding Quality To Education) where one young person who has done some studies at school is identified who substitutes the teachers in their absence and supplements the education of the poor tribal children. The village completely takes care of these youngsters by giving shelter and a minimum salary. MITRA also runs has a residential school for tribal kids up to 7th standard with people's participation where the quality of education seems to be good.

I also had the opportunity to pay a visit to Kalahandi where Sr Dr Aquinas has started Swasthya Swaraj organization with a small team of 5 persons. Though time was limited I was able to get an idea of that area- the walks were long; the roads were stony, bushy and dusty but there was serenity all over. I was struck by the unhygienic situation of the tribal people due to which communicable diseases were predominant. Many suffer from tuberculosis, leprosy, scabies and under- nutrition. There is a lot that needs to be done and the team has to be very much appreciated for their commitment and professionalism. There is a need for more people like them to bring a change in this place for equity and social justice.

My learning from this visit is that it gave me a feeling of solidarity with the tribal people and their struggle for life and enduring everything in an atmosphere of tranquillity. They are very loving, affectionate and face challenges as it comes and never think back. Their life is a challenge to me personally, and I dream of one day being able to live there.

My "Tribal" Journey in Kalahandi, Odisha

Samantha C Lobbo, CHLP Fellow, SOCHARA, Bangalore (Batch - 10)

Samantha in Kalahandi

My two-month field placement in Thuamalrampur block, Kalahandi district, Odisha under the Swasthya Swaraj Comprehensive Community Health Programme was a one of a kind experience. Like most urban settled individuals, I was apprehensive about shifting out of my comfort zone to a complete unknown rural setting, that too in a different state. More importantly, I was entering a health field that I had never considered before, 'tribal health'. For me, tribal communities meant those who lived high up in the mountains amidst forests who hunted for their living. On arriving in Bhawanipatna, I was pleasantly surprised by the silent and peaceful environment that contrasted the bustling city life that I was used

Mother with malnourished child

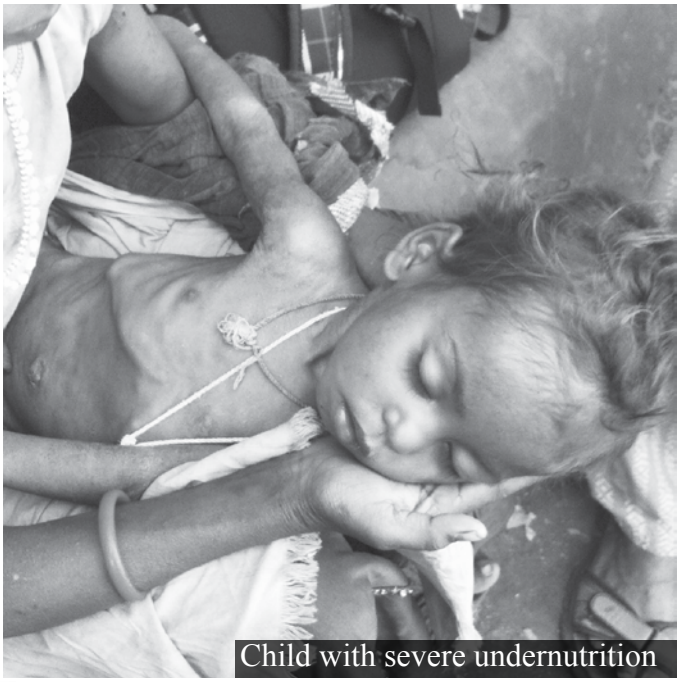
to. I expected or rather was mentally prepared for beautiful scenic views; many mountains and streams; health issues similar to those previously seen in a semi rural setting and of course, no communication networks or electricity. However, what I experienced was something altogether different.

Yes, I did see beautiful sceneries, a lot of mountains, but the health issues that I encountered were far worse than what I had imagined or expected: anaemic women with pale skin and children hanging from their waists, constantly suckling away from their bosoms; malnourished babies and children with big bellies, brown coloured hair and scaly skin; tired men looking older than their actual age and troubled by constant body aches. This was a common sight in every village I visited. The highest educated individual in any village would be either a fifth pass or a tenth pass. No one had studied further due to lack of knowledge about what they could do next, and also because of financial issues. Naive children who eagerly wait to attend schools face disappointment due to absent school teachers. Young boys and girls who managed to complete their twelfth grade, keen to study science or commerce subjects, were left with no choice but to continue studies in an arts college due to lack of other educational facilities.

Men work as daily wage labourers or are involved in any other sort of menial labour. They are paid very low wages for their hard work, usually as low as ten rupees per day! For years together mothers have continued to give birth alone in a dark room by themselves and are prepared to give birth to a live or a dead child. What is more haunting is the common emotionless narration by these very mothers about being pregnant five times and only three of their babies surviving. Death is considered and accepted as a norm of their everyday life.

Health facilities are almost non-functional. Even though there is a Community Health Centre (CHC), absence of either doctors or other staff makes its presence pointless. The district hospital is almost 75kms or more from the villages. Those who make it to the hospital have to be there within a certain time limit or else have to bear extra expense as the doctors from the district hospital shift to their private practices by afternoon. Transport is another major issue for the tribal communities with only two to three buses travelling from the main town to the villages. They have to walk, passing through two to three mountains to reach the bus stop from where they can catch a bus. The buses leave only at a certain time and if one misses the bus, the only option is to walk all the way back to their village from the town. Due to lack of health personnel at health facilities and loss of daily wages, the people tend to ignore any health issue they face and are obligated to visit the local healers or quacks in their villages. Anytime we visited a village, we were always requested to visit one house or the other to check on someone who was seriously ill. During clinic sessions that happen on every Saturday, most of the tribal folk would come with complaints of itchiness and wounds on their hands and in the private areas of the body that would be diagnosed as scabies. This scabies 'effect' was not restricted to any age group, being present even in recently born infants. With these wounds they continue to do their laborious work and walk long distances. Malaria too was another major health issue seen amongst this community with Tuberculosis not too far behind.

In the Swasthya Swaraj Comprehensive Community Health Programme, the team is trying to focus on the various aspects of health issues faced by the tribal folk and try to help the respective communities have their own primary healthcare providers. It primarily addresses the social determinants such



Child with severe undernutrition

as education, health awareness, nutrition and employment for the youth etc that are affecting the tribal communities.

I was a part of the recently started training programme of the community nominated *Swasthya Saathi's* (tribal *women primary healthcare providers*). It was delightful to see the women transform from shy, silent tight lipped ladies on day one to open, outspoken and creative ladies by the end of the programme. This programme was recently kick-started with one doctor managing everything with a few team members to support. The challenges faced by the team are many, one mainly being the need for more human resources especially, doctors and nurses. Travel too is a very big challenge as most villages are placed in remote interior regions of forests and hills.

I was also lucky to learn a little about the culture of the tribal community with respect to the marriage customs, body art, piercings, communication and other traditions. Marriage customs are similar to those seen in romantic stories, where the boy woos the girl and then ends up kidnapping her from her native village to prove himself worthy and brave. Body tattoo art and piercings are a big favourite among the women who enjoy decorating themselves. The love and trust among the tribal communities is something I think we all can learn in this day and age where it is seen to be diminishing.

My learning from this journey has been rich both in number and value. I closely witnessed equality, community support and the simplicity of tribal communities. There are huge gaps in the delivery of primary healthcare services that immediately need to be addressed along with health promotion and education. I now have a better understanding about how social determinants play a critical role in health. Health is not restricted just to treatment of diseases or conducting programmes with a top down approach but it has many components that need to be understood and addressed. The social exclusion of tribal communities is something that needs prime consideration before these communities disappear due to so called development or urbanization.

My Experience at the Association of People with Disability (APD), Bengaluru

Madhavi Venugopal, (Flexi Intern), CHLP, SOCHARA, Bangalore

This past November and December 2013 I worked at the Association of People with Disability, also known as the APD. The APD consists of a school, nursery, physiotherapy and speech therapy units, an early intervention unit, prosthetic manufacturing sites, and a horticulture department. It is a Bangalore- based organization that started in 1959 for children and adults with various types of disabilities-primarily physical disabilities like cerebral palsy, spinal cord injury, developmental delay, and speech and multiple disabilities. The coverage extends to Tumkur, Kolar, Koppal, and Haveri districts of Karnataka State.

Madhavi at APD with children

I spent my time working in the communications department, particularly the Early Intervention (EI) unit, physiotherapy and speech therapy units. My tasks were to examine and fill out a survey for the 0-6 year old child, assist in the speech and physiotherapy activities if needed, and interact with the children and parents at the school. I would frequently travel to PHCs in DJ Halli and Devanahalli and also went on house/slum visits with the community-based

physiotherapist. I also assisted in the many camps conducted in the two month span, particularly a nutrition camp at the Lingarajapuram campus and an overnight camp for women and children near Devanahalli.

One of my favourite things about the APD is the lack of stigma for children with mental and physical disabilities. Most of the staff are supportive and caring and the students have friends around. Initially after orientation, I spent time assisting and observing speech therapist's work; visiting and interacting with workers; interacting with visitors and staff at horticulture branches in Jeevan Bhima Nagar and Kylasanahalli. I attended the Primary Health Centre (PHC) community baby screening for any spinal or physical deformities and observed the speech therapy sessions of children with cerebral palsy, autism, aphasia, and mental retardation. There is a wide array of disabilities at APD, ranging from autism to cerebral palsy. We focused on motor skills, recognizing objects and colours, and producing vowel sounds.

One of the challenges that I faced was my difficulty in communicating with children in the local language. I learnt the basics in local language and continued to interact non- verbally with the students who have cerebral palsy that use the AAC chart. They were all eager to learn and spend time with us. Many other school children came to speech therapy as well. As soon as students have to notion they are in speech therapy, they hesitate and do not fully participate. Playing with them to ease their nervousness helped the students calm down and trust us. Many students from the Community Learning Centre (CLC) came with their parents so they would cooperate and the parents would know what activities to be carried out at home. The staff member in the communications department barely has the time to sit because there are students coming for speech therapy and walk-ins as well. The early intervention is set up to provide knowledge on nutrition and offer some advice and therapy to 0-6 year olds and their families. There are a lot of families that come from far distances for advice and hearing their background was moving. The determination of a middle-aged gentleman with aphasia and apraxia who attends speech therapy in the afternoon was inspiring.

I had the responsibility of communicating with the CLC and making sure the children knew what time they had therapy. We continued to focus on working the lip and tongue muscles. These exercises included tongue exercises such as moving it from side to side and up and down slowly. The children enjoyed the bubbles and blowing candle activities as I learned how to coax children into enjoying the session by starting with bubbles and then slowly incorporating other exercise movements. Staff members briefed me on the various circumstances and condition some children and parents face and the lack of continuation of the lesson at home. I realized that my sign language skills have greatly improved and I am conscious of how I shape the vowels and consonants. It is very nice to hear them scream '*akka'* (big sister) from a long distance away!

I am sad that the APD placement is coming to an end as the next week will be my last. The commitment of the APD staff and parents to work with some of the severely disabled children is inspiring. The students have a break for Christmas and it will be interesting as to what activities I can do without the students all over the place. I am fully appreciative of the experience and feel I have grown as a person in the past two months. I made connections with many students and teachers and became more exposed to the types of disabilities in the community, as well as the stigma surrounding those disabilities. I plan on visiting the campus soon and hope to be a part of the organization in the future.

'Signs of Hope in the Midst of Gloom' An experience with the District Mental Health Programme, Thiruvanthapuram, Kerala

Job Joseph, CHLP Fellow, SOCHARA, Bangalore (Batch-10)

Mental health is one of the crucial milestones on the road to individual health. It is the driving force in the development of a community or society. Unfortunately it is an area that is ignored, associated with taboos and is alienated. Therefore it is important that focused attention must be given at the grassroot or community level to bring about a change.

The Government of India initiated the National Mental Health Programme (NMHP) in1982 with the objective of improving mental health services at all levels of health care (primary, secondary, and tertiary) for early recognition, adequate treatment and rehabilitation of patients with mental health problems within the community and in hospitals. The Government also implemented the District Mental Health Programme (DMHP), under the National Mental Health Programme 1996–97, which was developed by the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore at Bellary district of Karnataka. Later this became a model for implementation by the states. These were the historical mile stones in evolution of the promotive, preventive, curative and rehabilitative aspects of mental health in India.

The objectives of this programme are:

a. To provide sustainable basic mental health services to the community and to integrate these services with other health services;
b. Early detection and treatment of patients within the community itself;
c. To ensure that patients and their relatives do not have to travel long distances to go to hospitals or nursing home in cities;
d. To take the pressure off from mental hospitals;
e. To reduce the stigma attached towards mental illness through change of attitude and public education; and
f. To treat and rehabilitate mental patients discharged from the mental hospital within the community.

On my journey to Thiruvanthapuram, the capital city of Kerala, as soon as I walked out of railway station I saw a man walking through the street- suddenly I stopped and looked at him and murmured to myself. I later jotted down my thoughts on a notepad. Here are the lines of this reflection:

Oh! I see the wandering mind at the street...
Wearing torn cloths, unshaved, unclean,
wanderers of a dreamy world…
Some of them are lonely... and depressed....
Who made them lonely... Who made them mad...
Don't they have a beautiful childhood where they dreamed reality...
Didn't their mothers dream a beautiful future for them...
But we just ignore... Seal them as mad....
Just to see them as human, just to accept them as they are...
Unless we do that, we are mad...
Just because we do not accept reality!

Meeting the team

It was my privilege to meet the team led by Dr.Kiran the nodal officer and psychiatrist of DMHP, who was professionally assisted by Ms. Amrutha-clinical psychologist, Mr. Vinod- psychiatric social worker, Mr. Santhosh-psychiatric nurse, Ms. Megha-clerk and Mr. Pathmarajan- attender. As they move across the district they depict visually that '*team work is dream work'*. Integrity and quality in service, equity in reaching the rural poor and tribal community, empathetic understanding and action are the core values that I could observe from the team. I observed them enjoying their journey and work. I must not ignore or forget the school mental health team, together trainees and other volunteers who join with them in this journey for a short period of excellent training and capacity building to meaningfully contribute to DMHP services. This collective action spreads throughout the district offering different forms of psychiatric services.

Care for patients

One of the major services offered is conducting outpatient clinics in collaboration with staff from the Primary Health Centers (PHC), Community Health Centers (CHC) and Taluk hospitals in the district. Key activities of the clinics include: treatment, counselling, psycho-social education to patients and care givers, maintaining case records, functional services, and referrals to the mental health center.

Patients receive the treatment regardless of caste, gender, age and economic status. The goal of primary health care and mental health care for all is realized through case detection with the help of student trainees under the guidance of ASHA workers; mental health camps including three review camps; maintenance of case records; and initiatives by the medical officers of concerned centers for rehabilitation of patients to ensure comprehensive and complete treatment.

Information, Education and Communication (IEC)

Stigma existing at the community level prevents those with mental illness to receive treatment, therefore the DMHP is engaged with providing information, educating and communicating to the general population and also to grass root level community workers such as ASHAs, ICDS workers, *Kudumbasree* members, self-help groups etc. These awareness programmes are conducted through street plays, puppet shows, art and essay competitions, exhibitions, and presentation of mental health awareness charts in all health care centers. These activities seem to have increased health seeking behaviour to a large extent. These activities of the DMHP programme aims to bring to an end, ignorance about government mental health services, and also to remove the stigma attached to mental illness. It also helps in building support systems for people living with mental illness and carers.

Targeted interventions and more - School mental health (*Thalir*)

A unique programme developed by DMHP Thiruvanathapuram, *Thalir*, helps in addressing the mental health needs of children in the district. It provides psycho-education to children parents and teachers by trained professionals. It includes awareness creation at school level through puppet shows, documentary screening, and lecture cum discussion classes, general information on adolescent growth and development, healthy living, life skill education, teachers and parents training, school counselling camps by child psychologist, and case detection and referral to the DMHP clinic. This covers preventive, reconstructive and rehabilitative aspects. So far this programme has reached more than 46 schools across the district and continues to extend services to the rest of the district. The major issues at school are scholastic backwardness, low I.Q, attention deficit hyper activity, anti-social behaviour, issues concerning to relationships, family disharmony, financial problems, alcoholism, single parenting, internet and porn addiction, poor inter personal skills etc. This programme provides the children a space to resolve their issues with the help of counsellors and teachers. School mental health could be considered as mental health promotion as it helps in developing personal skills of students and also provides a creative and supportive environment by providing education to teachers and parents. This programme also helps in reorienting the health services enabling and encouraging children and parents to access curative services when necessary.

Geriatric mental health (*Thanal*)

Ageing has become another daunting challenge in Kerala. Though increased life expectancy is a good sign of health, there is another side to it as well. Lack of attention given to the aged and elderly has led to a poor quality of life for this group. Apart from the destitute elderly, the large scale migration of youth from Kerala all over the world has led to elderly parents being left alone at home. This loneliness is termed the Empty Nest Syndrome (ENS). Mental health of the aged must be promoted, and the elderly should be cared for. Problems like memory loss, dementia, deteriorating physical health and related stress are common among the elderly. The DMHP team visits various old age homes run by government and conducts health check up, dementia screening, counselling and recreational activities.

Occupational Rehabilitation

I was privileged to visit one of the rehabilitation centers run by the DMHP in association with the

mental health authority and local self-government at Mangalpuram Panchayat. *Mangalapuram* rehabilitation center was established on 1st September 1998 with an aim to rehabilitate people with mental illness especially those who get back home after treatment from the mental health centers. The former state mental health authority secretaries Dr.Surajmani and Dr. Najeeb (former Medical Officer of Mangalapuram PHC) have set up a community board for the implementation of rehabilitation center. The DMHP has been implementing occupational based rehabilitation at the center for the past few years. The main activities undertaken are paper cover making and gardening. This model is currently being tried in other parts of the district.

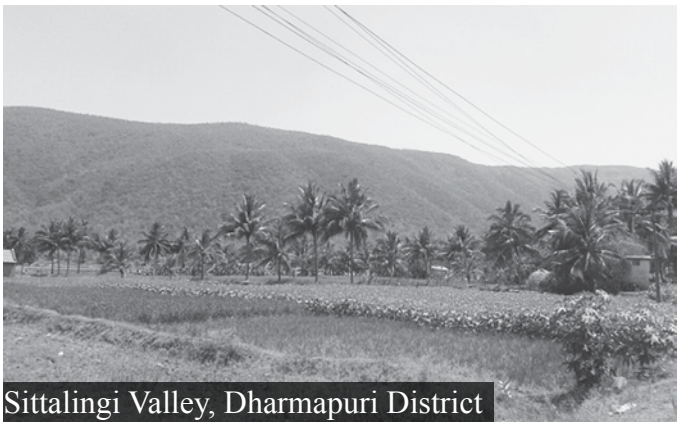
There are other various programmes for promoting health of the adult population for instance at the work place such as the *Bodhana* stress management programme; and the *Jeeva Raksha*- suicide prevention programme; and so on. It really seems to me to be a misconception that India has a shortage of psychiatrists and paramedical professionals – at least in Kerala. I believe that if we implement the DMHP in a proper manner like the DMHP of Thiruvananthapuram, we have hope for the current and future generations of India in promoting mental health and wellbeing. This is an unmistakable sign of hope in the midst of gloom.

A Social Justice perspective concerning women's health in a Malayali tribal community in Dharmapuri District, Tamilnadu, India.

Sharanya Thanapathy, Flexi Intern, SOCHARA – CEU, Chennai

It is often thought that tribal women belong to a more egalitarian community historically. They were socially respected with greater decision making power compared to women in other communities. In policy circles though they are considered as one of the most vulnerable groups of our country due to geographical inaccessibility, discrimination and denial of health rights and gender inequality. Women's health is a major concern in any community including tribal communities. Due to poverty and social exculsion, equality and the right to health are most often denied. Being a female and belonging to a socially marginalised community makes them more vulnerable in attaining good health and empowernment which influences their well being. A socially just society should be concerned with equal justice to all in every aspect of life, and not just in courts alone. This concept demands that people have equal rights and opportunities irrespective of their socio-economic background.

A just society would be the one that understands and values the human rights and dignity of all human beings. This study focused on social justice from a gender and caste perspective, lenses to understand women's health and discrimination. This study also addressed the role of VHWSNC (Village Health, Water, Sanitation and Nutrition Committee)



Sittalingi Valley, Dharmapuri District

Interview with Post - Natal Mother

members, together with support of health system staff and the community to attain greater well being of women among a tribal population. This was an exploratory study conducted among *Malayali* Tribal community, in the *Sittilingi* Valley, and in non-tribal *Bayernayakenpatti Panchayat* (local bodies), both located in Dharmapuri district of Tamilnadu State, South India, to analyse the social justice dimensions. The public service provider for the study area was *Kottapatti* Primary Health Centre (PHC). The study respondents were women aged between 18 – 25 years (married/unmarried); VHWSNC members; PRI (*Panchayati Raj* Institutions) representatives of both the *panchayats;* the Village Health Nurse (VHN); and the Medical Officer from *Kottapati* PHC. The study utilised methods such as observation, case study analysis and key informant interviews. The objective was to explore and understand women's health through a social justice perspective in Malayali tribal panchayat at Dharmapuri district.

Findings

Better transport facilities and education services, together with the services and work of the Tribal Health Inititaive (THI) were reported as some of the some of the main factors that have led to improvement in the health and lives of people in this area. People's awareness has improved and their fear of accessing health care services has reduced. The Medical Officer felt that the tribal region had experienced more improvement as compared to other regions, though people are still ignorant regarding health issues. Women sought treatment for STIs (sexually transmitted diseases), white discharge, UTI (urinary tract infections), contraceptive advice ANC and PNC (antenatal and postnatal care). Though physical injuries and mental effects were noted due to domestic violence, women preferred not to report it for obvious reasons. Vague symptoms and hesitant talk were the cues by which the health providers identify women who experienced domestic violence.

It was observed that the tribal women had ownership rights for household money and were able to utilize these resources without informing their husbands, though men kept an eye on expenses. In contrast the non tribal women had to inform men about expenses incurred by them. In both communities men used most of the money for drinking alcohol and as a result the remaining money was not enough to run the family. In addition,women were paid lower wages for the same work that men did, hence they reported frustration towards such discrimination. Tribal women were allowed to work, but non tribal woman were not allowed to work even in their own agricultural fields , and men suspected them if they worked anywhere else. Men exploited women physically and verbally after consuming alcohol which was an untreated trauma for women. While the tribal women raised their voice saying that men should not beat women to show their physical strength, the non tribal women were more passive in accepting that men 'behave like that' and women should 'adjust'. A rural women respondent narrated:

"It is the biggest mistake. There are no families where men don't drink. Now-a-days government itself started wines shop. Because of that those who were non drinkers also started drinking. Health gets affected. Even school boys have started drinking. Most of the earnings are spent for drinking. With the remaining money it is very difficult to run the family. They should stop drinking. Ladies also have many problems, but we don't drink. We find it difficult to manage the family with the money they give. We don't get proper wages or job. These men won't even allow us to go alone for job, hence we don't have any other go other than living with them and they take it as advantage and beat us.

When there was no development people were afraid of family members, now all became brave to drink and shout at elders. If women drink the whole village will talk badly about her. It is just because they are men they can drink and beat women. They say women should take care of family, if she drinks the whole family will be affected. In that case men also have same responsibilities. It is all because men always dominate women. Whatever we do - cry, scream or shout men won't leave their drinking habit and beating us. Women can't even go out freely, if we go out, society will talk wrongly, but men can do anything as they like. Government says that there is an equal right for men and women, but in village it is not there. Still women didn't get equal rights in front of fellow human beings."

In some cases though women were allowed to participate and make suggestions, men were the final decision makers, since they were the main earning member in the family and thought that women might take wrong decisions due to lack of awareness. Even if a woman earns, the social situation would the remain same till men understand equal rights of women. While the men were prepared to do household work if a woman suffers with an acute illness, in case of chronic illness most of them were allowed to remarry with support from society.

The key respondents felt that men did not share household work and women were being over worked in the field and at home. Even for treatment of reproductive health conditions men would not allow women to go to a health facility so easily, since others would think that his wife got such kind of diseases due to men's behaviour of having multiple sex partners.

There was no Village Health Nurse posted in the tribal panchayat, nor was the VHN visiting Health Sub-Center located in the tribal area. People felt that if the VHN was posted it would help them during emergencies. It would also solve accessibility issues and reduce indirect expenses. It was reported that the ASHA's passed on the information about immunization only. The non tribal area had a Village Health Nurse posted who stayed in village which solved most of the issues of this rural population. One of the respondents from the tribal area said;

"She will come to village very rarely and does not even stay for half an hour. They will not even inform all of us before they come. If we go late after hearing the news, they will talk to us harshly. It will embarrass us a lot. They come only to give immunization. They don't go to school and conduct adolescent health programmes no care for old people, all old people go to Tribal Health Initiative(THI) only". T*hough she belongs to this same panchayat she stays only in town and does not show courtesy to her own community*."

The tribal women felt the PHC Medical Officer did not listen to their complaints and did not provide proper counselling and explanation to patients. He did not attend deliveries or emergencies at nights. The non tribal women said the Medical Officer was responsible and provided advice, and briefed them about their treatment, listening to patient's complaints with calm.

The communities were not aware about the functions of the Village Health, Water, Sanitation and Nutrition Committees (VHWSNCs). The Medical Officer of the PHC said that though most of the committee members are women, they were not interested to discuss about women issues. Mostoften they would talk about money issues such as the Muthu Lakshmi Reddy (MLR) scheme of the Govt. of Tamilnadu which is a cash transfer to pregnant women, or any other public issues. The women said they have not benefited by the MLR scheme since it did not reach them on time, and they had to spend money to pay the Village Health Nurse (VHN) to get the application registered and processed. Regarding privacy issues the tribal women were against having a scan done in front of other women and they wanted privacy to be improved in the Primary Health Centres (PHC), whereas non-tribal women thought that due to lack of human resources and infrastructure availability it would be difficult for health system staff to provide privacy for large numbers of patients. Efforts need to be made to address issues of privacy in public health facilities.

CONCLUSION:

The roots of gender and caste discrimination and their effects on women, which also affects their health, are embedded within the community. The attitude of health system staff plays a very vital role, since it leads to poor health service delivery among women. Patient health awareness, education and social support influences demand and availability and accessibility of health services. Both communities felt that lack of privacy at the health center was an important issue that needs to be addressed. Though the community did not define the concept of social justice, the tribal community was able to recognize rights and equality denied from various angles. They fought for their justice in a silent, quiet way without opposing society and men. The rural community however adapted themselves to the existing situation in the belief that they would not be able to change it.

Toilets! Yes. Power and Running water? Big question mark????

Dr. Abraham Thomas, CHLP Alumnus, Dr. T.M. Samuel Memorial Medical and Dental Centre, Kadapa District, Andhra Pradesh (Batch - 1)

As you know in the summer of 2013, after a year in a Govt primary school at Bayanapalle, Koduru, my older son was finding it impossible to continue in the school due to lack of basic facilities like toilets, water, and electricity. His younger brother was to join that academic year. Perhaps, I did not want to dilute my commitment to the school and neither did I want my children to lose the opportunity of having free education under qualified teachers.

I realised that government schools get very meagre financial grants that are inadequate to complete the tasks they are meant for. That year they were given five thousand rupees to repair the toilets in response to the Supreme Court's directive. This could not even suffice to buy enough brick and sand for the repairs, let alone make them functional.

Having a first-hand, daily involvement with the school, my wife who was volunteering at the school, teaching English, observed that over 36 children were sharing one bucket of water to wash their plates after the mid-day meal. Further, when a child wanted to defecate, he/she walked back home in a hurry and never returned that day. Those children, who wanted to use the loo, had to fetch water first before they planned to defecate. This was very painful to see. Urination meant going across the village road and finding a safe spot.

This had to change if I wanted my children to continue there. Finally, we raised money from our finances, and with the help of contributions from a dozen friends, we began the work on the school toilets.

We chalked out a plan and the budget outlay for the project included a solar power unit, 2500 litre water tank(s) (considering the usage of water by 50 to 100 children together with water for plants and three teachers. The urinals separated the messy boys from the girls. Western toilets improved the chances of cleaning the toilets by the children themselves and gave respite to the girls. The three levels of urinals made sure boys of all age groups found it easy. Piped running water guaranteed cleanliness. A separate toilet for teachers was provided as a bonus.

Power supply from a solar system had to cover fans, lights, motor pump for water, and audio-visual equipment use during school hours. The toilets needed a roof, good quality toilet fittings, tiles for easy maintenance, a tiled plate/hand wash basin with multiple self closing water taps. The school needed additional facilities like a compound wall and a gate. The school also needed a good paint job. Thus we provided these facilities at a total cost of roughly 3 lakh rupees.

The gist of the project was hygiene, which every little child in the school needed. Since then the school strength has increased and the number of kids from neighbouring villages increased dramatically.

Now, we are saving money to provide ground level desks to the children. Our aim is to keep the floor seating while providing ergonomic writing tables with a small storage to each child. We won't stop with that! I discovered recently that the high school neighbouring the primary school in Bayanapalli with 325 children between 11 and 17 age group, don't have a single functional toilet. We've gotten assurances from friends and I'm rearing to go. We won't stop with this either. The children are planning to employ a cleaning person by themselves and provide cleaning materials and uniforms to wear with the help of a rupee a day contribution to a school fund.

Every day the children in the school are themselves keeping the school premises clean, sweeping and mopping the floor, each taking turns. We see that there is hope in the next generation that they would take part in moulding the future of this nation of ours. When one listens to their sincere national

View of Solar Powered Government School

Child friendly Washbasin

anthem, ones' heart will melt with tears that cannot be hidden. The sweet Telugu poetry that they recite, will give anyone the renewed hope that sense will prevail on the law makers, the bureaucracy, and the entire country that peace, love, kindness, joy, knowledge, hope, diversity, and common sense will prevail

We also have the hope that our children's school should lay the foundation for replicable, applicable, and sustainable plans to the Government Educational Department while planning toilets, walls, gates, books, audio visuals, and electric power. These are basics to start a larger change in society. We thank our friends for their lovely involvement and enthusiasm that keeps them and us, spirited!

The government is planning some large scale changes in increasing access to and use of the toilets all across the country and we look forward for this change.

Renovation of old toilets and constructions of Sandpit

Newly done Toilets

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