PROGRESS REPORT

July – December 2014

Submitted By

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INTRODUCTION OF THE ORGANIZATION – JECUP

Joint Efforts for Community Uplift to Prevail - JECUP is a charitable, non-political, nonsectarian voluntary Social Welfare Organization, which has been working since 2013 and got registered under the Societies Registration Act (Reg. No. RP/573), in 2014 with the objective to promote and implement community services, activities, formal and non-formal education, vocational training, healthcare, rehabilitation and disaster (natural and man-made) relief.

Vision Statement

"Striving for Community Uplift"

Mission Statement

"To literate communities and assist them in Healthcare, vocational and technical education and rehabilitation of victims of disasters and poor ambiance."

Who we serve
JECUP was established to fulfill our responsibility towards humanity regardless of race, gender, ethnicity, class, location, religion, color, cultural diversity and social background, with a special focus in majority of the population living below the poverty line.

Where we serve
Disaster struck areas throughout Pakistan, Brick Kiln Factories, Brick Kiln Workers Community, Villages near and around Raiwind.

Advisory Committee
Our advisory committee is a collection of individuals who bring unique knowledge and skills which augment the knowledge and skills of the formal board of directors in order to more effectively guide the organization.

Foreword

JECUP has been making efforts to provide better opportunities to oppressed and deprived communities in the mostly remote and isolated areas of Central and Southern Punjab. During six months (July – December 2014) our team had been doing their best and with full enthusiasm to provide opportunity to the poverty stricken people especially “Bonded Labour” (Brick Kiln Workers).

While the need is of enormous magnitude the resource of JECUP is limited but still we strived hard and helped the needy and affected people. This was done through JECUP’s projects like: Disaster and Crisis Management, Mother and Child Healthcare Center (MCHC), Disabled Support Center (DSC) and Mobile Healthcare Unit (MHU) for Brick Kiln Workers. All these initiatives have responded to the needs of the beneficiaries.

We seek God’s blessing in this work and I am really indebted to our well-wishers for providing in-kinds and technical unflinching support for the implementation of projects, for vivid ideas and guidance. I want to thank JECUP’s team for their effective services to achieve our goals for this noble cause.

The report shows the activities, achievements and challenges that we have been come about during this period. Community’s participation in the development work encouraged us in making greater efforts to achieve our vision, mission and goals. I believe that changes can come about through sincere commitment and dedication.

Phaystle I. Zac Walters
Coordinator

TEAM with Volunteer Staff

DISASTER AND CRISIS MANAGEMENT

Our methodology is response and Recovery. We response as emergency relief by providing food rations, temporary shelter and medical aid. After the immediate threat to human life has subsided, The recovery phase begins. The immediate goal of the recovery phase is to bring the affected area back to normalcy as quickly as possible. Medical health care program stays intact till the disaster struck are fully recovered and sustained health care from the government is in working order again.

In this regard, JECUP organized the following projects in 2014.

1. **Medical Relief to the Internally Displaced Persons (IDPs) of Waziristan**
2. **Medical Relief Camp for Flood Affected Population of District Muzaffargarh**

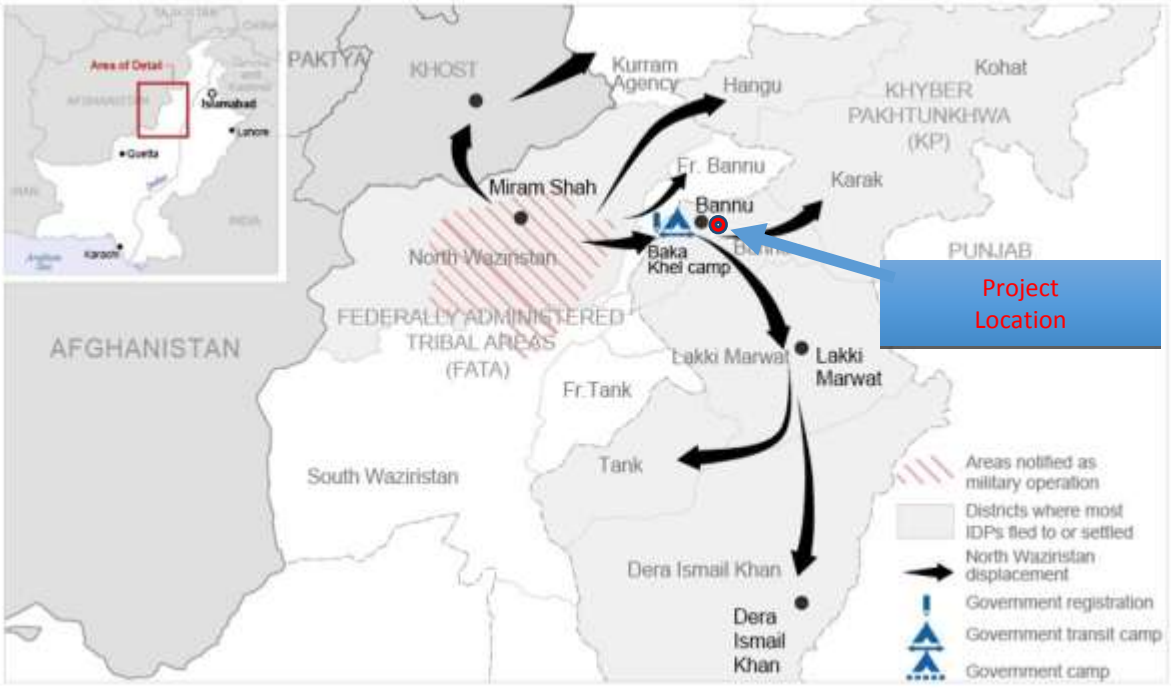
1. MEDICAL RELIEF TO THE INTERNALLY DISPLACED PERSONS (IDPS) OF WAZIRISTAN

WAZIRISTAN'S IDPS

On June 15, 2014, The Pakistan army launched a long-awaited operation against foreign and local militants in the area of North Waziristan, a tribal region near the Afghan border.

The population was heavily affected and were turned to Internally Displaced Persons. The majority of the displaced families took refuge in Bannu district, with others moving to Hangu, LakkiMarwat, Karak, Dera Ismail Khan, Charsadda, Tank and Kohat districts in Khyber Pakhtunkhwa province, as well as to other parts of the country.

As on July 18, the Federally Administrated Tribal Area(FATA) Disaster Management Authority (FDMA) registered 992,649 IDPs belonging to 90,750 families.



Overall Impact of war on terrorism

These displaced persons turned into refugees in their own homeland faced many risks. At camps, outbreaks of sickness were being reported and the people now displaced, struggle to survive. A new exodus, as the army started a new offensive in Waziristan, it was likely to make things even harder for all those fleeing homes, as more pressure was exerted on existing facilities and more pour into camps.

Problem Analysis

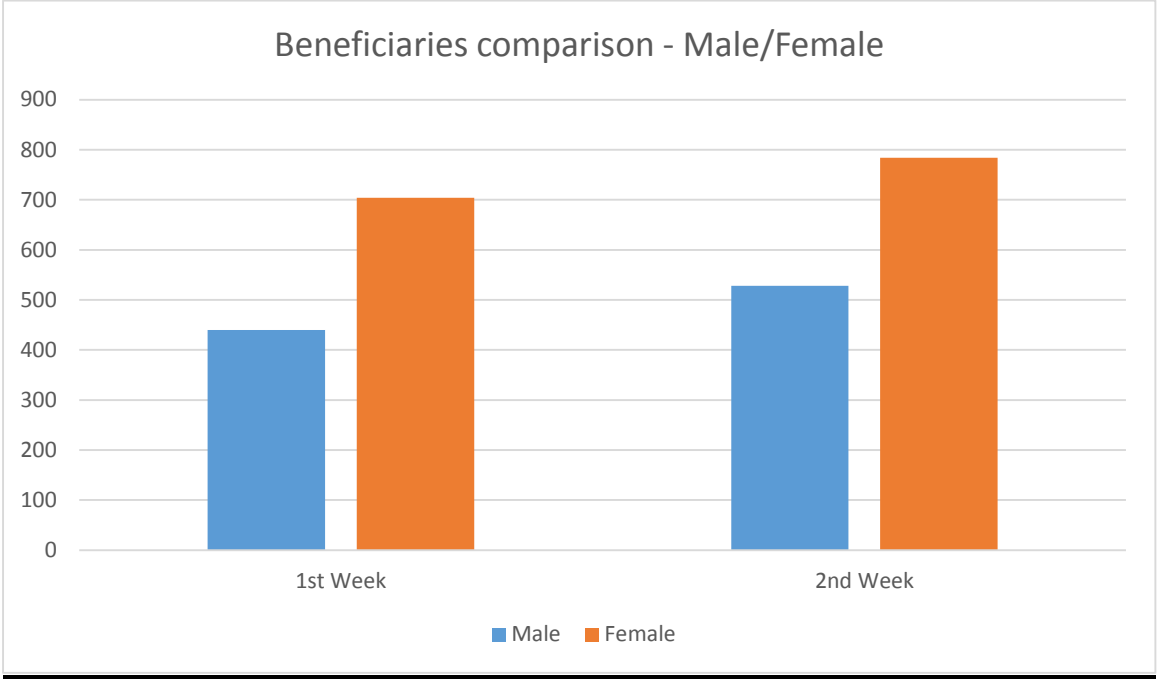
Every crisis, in one way or the other, exposes both the best and the worst of humankind. This is being seen too at the camps. Mostly women who migrated were in different periods of pregnancy. Health issues were immense. Women are dying during childbirth. As there were no proper arrangements for clean water, sanitation and sewage system, lot of IDPs were suffering from stomach ailments like dysentery, diarrhea, and gastro. During the migration, a large number was also injured due to crossfire.

JECUP's Contribution in Rehabilitation

In this situation, the committed team of JECUP accepted these challenges, teaming up with Mission Hospital – Bannu, set-up a medical camp at Pennal High School and Don Bosco High School, Bannu. The team started serving their brethren, with a 2 week medical camp (July 18 – August 02, 2014) within the host IDPs without taking note of the harsh hot weather conditions and other difficulties and challenges. The JECUP team not only provided medical relief but also provided psycho-social support to the victims. Their warmth, dedicated and affectionate behavior served as an emotional therapy. Health Education was also provided. During these 2 weeks, 2456 patients received medical treatment.

PATIENTS TREATED THROUGH MOBILE HEALTH UNIT DURING 2 Weeks (18 July – 02 August 2014)

Duration	0-5		06-18		19-45		46+		Total		Total
	M	F	M	F	M	F	M	F	M	F	ALL
1st Week	64	88	136	224	176	280	64	112	440	704	1144
2nd Week	72	96	192	216	168	312	96	160	528	784	1312
TOTAL	136	184	328	440	344	592	160	272	968	1488	2456



IMPACT

- **2,456 patients were treated** through the Medical Camp. The patients got quality medical services free of cost from Mobile Health Unit which was not accessible before due to their weak financial health.
- The community received education about the prevention and precautionary measures with regard to common diseases and personal health and hygiene.

2. Medical Relief Camp for Flood Affected Population of District Muzaffargarh

Flood in Pakistan 2014

Heavy monsoon rains started in north western Pakistan from September 2, 2014. Following continued with heavy rainfall, causing rivers to breach their banks. The river turned into floods which gradually moved from north to south along the Chenab River. By September 12, 2014, the flood was unstoppable and it wiped out a large area of District Muzaffargarh in a blink of an eye.

Problem Analysis

Health Care Facilities were severely damaged in flood. There was increased need for primary healthcare as communicable, non-communicable and vector borne diseases threatened the lives of people. Government lacked funds for the operations and maintenance of these medical facilities.

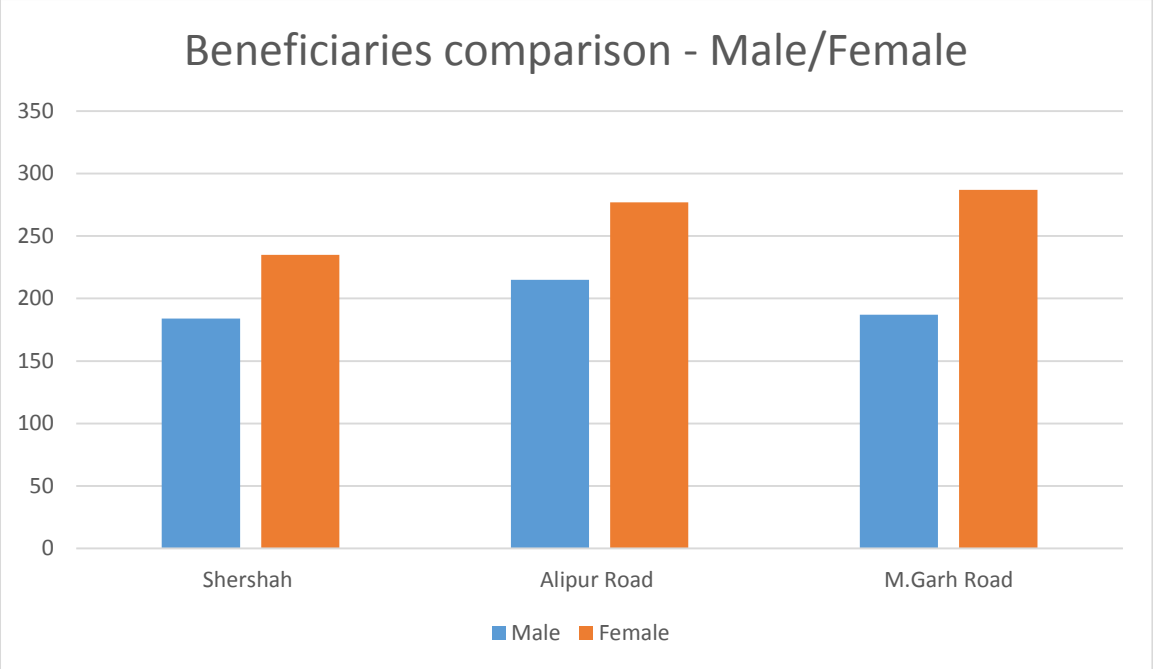
JECUP Response

Scrutinizing the current situation in the country, the management of JECUP focused on the disaster struck area providing healthcare services in District Muzaffargarh, which was in tent based camps through a Mobile Health Unit. Our team started providing Healthcare through treating patients and giving Health Education to the affected families.

A 9 day medical camp (September 20 – 28, 2014) was initiated in the areas of Shershah, Alipur and on the banks of Muzaffargarh Road. The team toiled hard without taking note of the harsh hot weather conditions and other difficulties and challenges. They also provided psycho-social support to the victims. During these 9 days , 1385 patients received medical treatment.

Patients Treated through Mobile Health Unit (MHU)
September 20 - 28, 2014

Location	Duration	0-5		06-18.		19-45		46+		Total		Total
		M	F	M	F	M	F	M	F	M	F	ALL
Shershah Tent Village	20 - 22 Sep.	43	54	49	64	53	69	39	48	184	235	419
Alipur Road Tent Village	23 - 25 Sep.	53	69	57	73	59	76	46	59	215	277	492
M. Garh Road Tent Village	26 - 28 Sep.	33	51	53	77	47	72	54	87	187	287	474
TOTAL		129	174	159	214	159	217	139	194	586	799	1385



IMPACT

- **1,385 patients were treated**. The patients got quality medical services free of cost from Mobile Health Unit which was not accessible before due to their weak financial health.
- The community received education about the prevention and precautionary measures with regard to common diseases and personal health and hygiene.

ONGOING PROGRAMS

- **Mother and Child Healthcare Center (MCHC)**
- **Disabled Support Program**
- **Mobile Healthcare Unit (MHU) for Brick Kiln Workers**

PROFILE OF THE PROJECT AREA

The village of Bhai Kot is situated 35 kilometers South South-West of Lahore, which is the capital of Punjab province. The total population of Bhai Kot and its surrounding 7 villages (i.e1) Manik 2) Pajiyan 3) Naela 4) HavailiBagrdhu 5) BadokiShani 6) Mall 7) Warasaduwala) is estimated to be around 30,000.

The mother tongue of majority is Punjabi but almost everyone knows Urdu as well. Most of the area is covered by fields/farms. The major crops are rice, wheat, sugar cane, pulses and vegetables. The irrigation of the land is through canal systems and tube wells. Only 30—35% households are owners of fields/farms, most of the inhabitants are very poor, they are either unemployed or work on irregular daily wages. The average monthly income per house/family is approx. PKR 3,000 – 3,500. Some work in the farms or as laborers, in factories or are street vendors, shopkeepers, drivers, public transport drivers or they work in brick kilns.

The villages have no proper sanitation. Dirty water runs into small drains or lanes. The solid waste and the Rubbish /animal dung are thrown into own heap of rubbish, which is always shifted into fields as fertilizer. There is no Governmental or non-Governmental Development Organization in the area. In addition, there is no provision of gas supply for cooking. People use kerosene, animal dung cakes and firewood for cooking purposes.

Housing construction is done largely with local materials of poor quality. Households are of one or two rooms of wood and mud construction, with corrugated metal roofing. Kitchens are most commonly located in courtyards adjacent to dwellings. Most are single-family households.

Climate: The area has extreme climate. The summer begins in April and ends in September. June is the hottest month in which the temperature rises to as high as 46°C. The winter season begins from November and remains cold till March, January to be the coldest month, in which the minimum temperature falls to 2° C at night. The monsoon rains start by the end of June and extend up to early September.

Transport and Communication: A Railway Station is just in the centre of Raiwind, which is 5 km from Bhai Kot. It is a mainline connecting Lahore with Karachi. The town of Raiwind is connected to the National Highway some 25 Kilometers by an all weather road. Another main road connects Raiwind at the east side to Dist. Kasur. One main road also connects the town to Tehsil Chunia.

In Bhai Kot Village, there are a few vehicles other than tongas and chingchi rickshaw, people mostly travel by foot or have donkey cart or bull cart. The local public transport connecting to the town does not run after 11:00 pm at night and people have to face hardships for their emergencies.

Healthcare System: At present Health care facilities are at a minimal level. There are about five Hakims (local health care advisors) practicing Ayurvedic Medicines, two private clinics (OPD), around five quakes, and no Rehabilitation center. Above-mentioned medical facilities are not sufficient to provide even basic health care to the population. Because of limited medical facilities the patients are suffering a lot both in curative as well as preventive side of medicine. An addition to the health care system is Sharif Medical Complex. This is a well-equipped hospital. But it is situated about 10 kilometers from the town, secondly it is very expensive and beyond the affordability of majority of the population of that area.

Map of Project Area

MOTHER AND CHILD HEALTHCARE CENTER(MCHC)

Every mother is entitled to give birth to a new life in a Safe Hygienic and Healthy Environment. Today, every 45 minutes, a woman in Pakistan dies from complications in pregnancy or childbirth. Every 4 minutes, a child less than 1 month old dies because their mother didn't have access to proper post-natal and ante-natal care. Our objectives are to reduce maternal mortality by promoting "Safe Motherhood" and to develop human resources for maternal health care.

PROBLEMS ANALYSIS:

- Various studies conducted in Pakistan reveal that the health of Children in the Raiwind community is abysmal and reflects the country of Pakistan as a whole. The latest estimate of infant mortality in Pakistan includes a rate of 71 deaths per 1,000 live births (2009). The number of children likely to die before 5 years of age is almost 87 per 1,000 live births (2009), compared with 94 per 1,000 in the 2007. 52% of children are malnourished, 25% of new-borns are under weight, 72% are immunized and around 55% have access to basic health services.
- Women are in double jeopardy, because they are socially underprivileged, get less medical care and food and give birth to 5 – 7 children on average.
- More than 420,000 children under the age of five years die every year in Pakistan. The child mortality rate is accompanied by a rate of maternal mortality that sees 30,000 maternal deaths a year, placing Pakistan among the six countries in the world which account for 50 per cent of all maternal deaths (the other five, as of 2008, were India, Nigeria, Afghanistan, Ethiopia, and the Democratic Republic of the Congo).
- In the villages, there is no proper sanitation. Dirty water runs into small drains or lanes. Some of them have a gutter system for toileting. The solid waste and the rubbish/animal dung are thrown into own heap of rubbish which is always shifted into fields as fertilizer.
- The children and pregnant women have to withstand the worst of this whole situation. As the women are already underprivileged – lack of health related facilities expose them further to the risks of diseases, complications of pregnancy, delivery and post-delivery (medical and Gynaecological) problems. Children are equally affected. Lack of immunization, proper food, healthy environmental conditions and safe water exposes them to a vicious circle of disease and malnutrition. Untrained persons attend the majority of births, which, too frequently, results in loss of life of the mother/baby or mental and physical disabilities in those who survive.
- There is a great need for Health Education in areas of high illiteracy as stated in the preface. Approximately 30% of children in the Punjab (covering Raiwind) are malnourished with diarrheal diseases and acute respiratory infections as the common killers of children. At present, the State Health program is not able cover all areas efficiently and often rural areas are left out. There is no basic health education curriculum for use in schools and very little is covered by the National curriculum. This means that in areas where there is poor water supply and open sewerage systems there is very little, if any, health education, taking place. These areas are in great need of Health Education and Promotion Centers.

JECUP's Initiative:

JECUP took initiative to give Healthcare support to the people by starting Mother and Child Healthcare Center (MCHC) in the area of Village Bhai Kot and surroundings. The center cater a population of approx. 30,000.

OUR SERVICES

- Providing comprehensive healthcare including education, treatment and rehabilitation. Triage services will be provided for patients with serious acuity. Comprising of preventive as well as curative services on primary, secondary, and tertiary level.
- Provision of medicine for patients, including patients with long term chronic diseases. A prolonged period to cause the effects of injury or ailment minimized to an easily manageable level.
- Promoting general healthcare with the emphasis on mothers and their children.
- Teaching and promote healthy and practical behaviors in regards to nutrition, breast-feeding, hygiene and sanitation.
- Providing Immunization services.
- Educating family planning principles and confidential support/counseling services including prevention practices and first aid.
- To teach and promote principles of mental, social and emotional health.
- Facilitating protocols and the delivery of services for post hospital patients to ensure continuity of needed care and rehabilitation.

TARGET GROUPS/BENEFICIARIES

Most residents of Bhai Kot and the surrounding villages are totally preoccupied with surviving on a day-to-day basis. The impact of poor health and sanitation compounds their struggle and inhibits meaningful progress that can be made if the acute and chronic matters of health could be addressed.

Direct beneficiaries

- Pregnant Women
- Women suffering from general poor health and gynecological diseases
- New born babies and sick children
- Male and community "leaders"
- Male family members patients through general physician
- Employees of the MCHC and their families

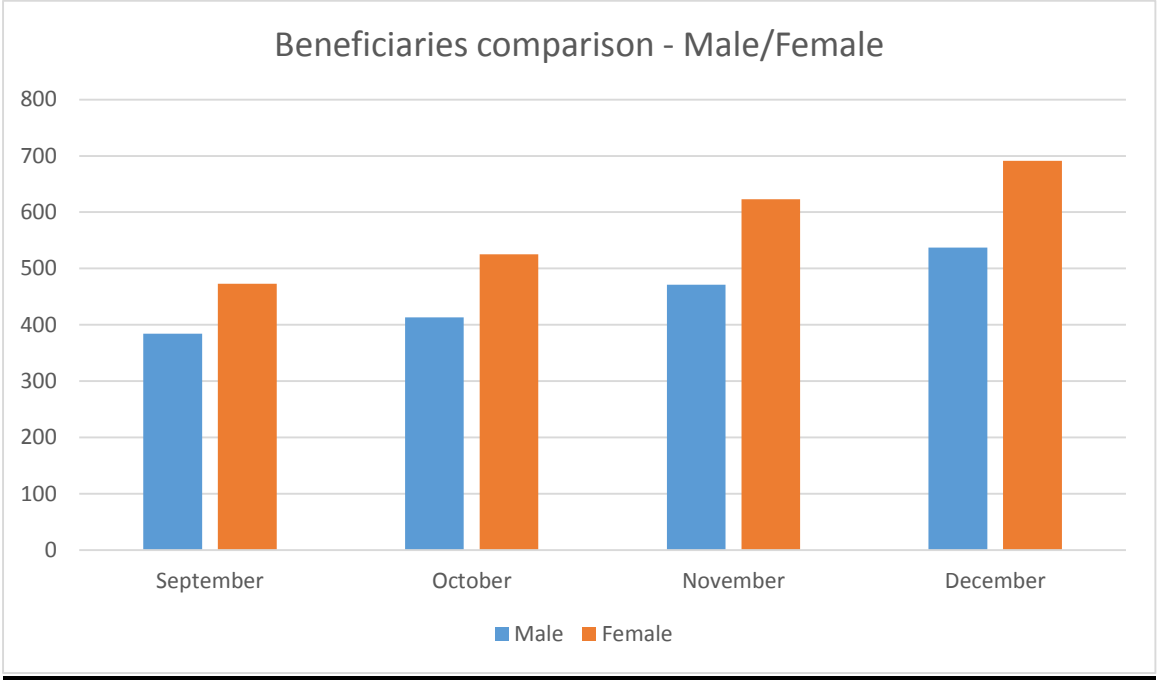
Indirect Beneficiaries

- Families and relatives of patients
- Community organizations/groups such as Community leaders, (Professionals, Youth, Women, Educators)
- Private clinics and General Practitioners in the area.
- Governmental Institutions
- Other similar organizations

PATIENTS TREATED THROUGH MOTHER AND CHILD HEALTHCARE CENTER (September – December 2014)

Duration	0-5		06-18		19-45		46+		Total		Total
	M	F	M	F	M	F	M	F	M	F	ALL
Sep.	61	71	82	96	144	193	97	113	384	473	857
Oct.	57	83	87	101	153	209	116	132	413	525	938
Nov.	73	109	94	127	167	226	137	161	471	623	1094

Dec.	**89**	**121**	**109**	**143**	**186**	**249**	**153**	**178**	**537**	**691**	**1228**
TOTAL	**280**	**384**	**372**	**467**	**650**	**877**	**503**	**584**	**1805**	**2312**	**4117**



IMPACT

- **4,117 patients were treated.** The patients got quality medical services free of cost from Mobile Health Unit which was not accessible before due to their weak financial health.
- The community received education about the prevention and precautionary measures with regard to common diseases and personal health and hygiene.

DISABLED SUPPORT CENTER (DSC)

A COMMUNITY BASED REHABILITATION (CBR) PROGRAM

Utilizing all efforts through therapies and exercises to bring down (minimize) physical and Mental retardedness of the handicapped children to the optimum level thereby enabling them to have a respectable life in the society (community).

Problem Analysis

In Punjab, very few organizations provide education and rehabilitation services to the Person with Disabilities (PwDs). As a result, access to physical rehabilitation services for PwDs has been severely limited. Majority of the PwDs are illiterate, poor, unskilled and untrained. They are unaware of their inherent rights and often depend on their family members for support. Deprived of education, training and opportunities, they have remained economically inactive and are usually considered the burden of the family, the society and the nation. They have very limited access to employment, entertainment and services provided by the state because of their limited training in labor skills and education.

There are quite a few Rehabilitation centers in larger cities of Punjab. Rural areas do not have any Rehabilitation Center. Many of the PwDs population living in rural and slum areas are either not aware of the education and rehabilitation services offered by the rehabilitation centers or do not have access to rehabilitation services. Therefore, how to increase awareness among the PwDs population living in the rural and slum areas about the various education, training, and rehabilitation services offered to them has also been a huge challenge.

(An integrated approach towards rehabilitation of Persons with Disabilities)

For many, disability is understood as a person's inability to perform a normal function, such as cannot walk or cannot see (physical disabilities). Others see them as persons unable to live in community, to produce, to contribute to social, economic, cultural development (mental, psychological, and intellectual disabilities). Many see disability as a social problem like a stigmatizing disease.

Community Based Rehabilitation is a right based approach or strategy to encourage inclusion and provide equal opportunities for a satisfying life to the people with disabilities. The related interventions are primarily done at community level using local resources for sustainable results.

Our Services:

Project aims to provide comprehensive rehabilitative services for all Persons with Disabilities (PwDs) in the selected project areas, ensuring equalization of opportunities, empowerment and social integration".

- To provide comprehensive rehabilitation services to children, youngsters and adults.
- To enable women through support and informal education to improve the situation of their handicapped children, their family and own status.
- To help change the attitude of the community towards the people with disabilities.
- To help build confidence and a desire to live respectably, among the people who became handicapped.
- To stimulate participation of women in community matters regarding the integration of their children and family, in a way that benefits all concerned.
- To provide orthopedic appliances to handicapped.
- To provide education service to the handicapped.

- To improve quality and adequacy of the program, its staff and activities compared to needs and priorities of children and their families.

TARGET GROUPS

a. Mentally Retarded (MR)
These Children are divided on broader scale in three categories.
   i. (a) Severely Retarded.
   ii. (b) Mild Retarded.
   iii. (c) Slow Learner.

(a) **SEVERELY RETARDED:** - These type of children need a program, which may make themselves, aware of cleanliness so that they can keep themselves clean, do not wet their clothes, can tie their laces, wear and change their dresses. They are also trained to cross the road, know their names and can recognize their parents etc.
(b) **MILD RETARDED:-** These type of children are helped to learn alphabets and counting up to at least 15. They are taught to read and write simple words. They are further helped to increase vocabulary by relating their studies with things and activities of their daily life.
(c) **SLOW LEARNERS:-** These kids have better performance ability then the above categories. Their education can go up to primary level. They are helped to read and write simple words, differentiate colors, shape & size and can solve simple puzzles etc.

b. Physically Handicapped
c. Families of Persons with Disabilities (PwDs)
d. Local Community
e. Professionals and Community Leaders
f. Similar organizations

SECTORS OF REHABILITATION:

Rehabilitation takes place in following sectors:

Physical	Making provision of surgical boots, braces, crutches, splints, walkers etc. In addition, patients get physiotherapy and other therapies as need may be.
Social	Training in Activities of Daily Life (ADL) using play way method, meeting other people and socialization.
Economic	To provide training in some useful skill so as to enable Handicapped to earn his/her living in a respectable way.
Education	Service will include basic/elementary education (like that in a formal school)

Rehabilitation Methods

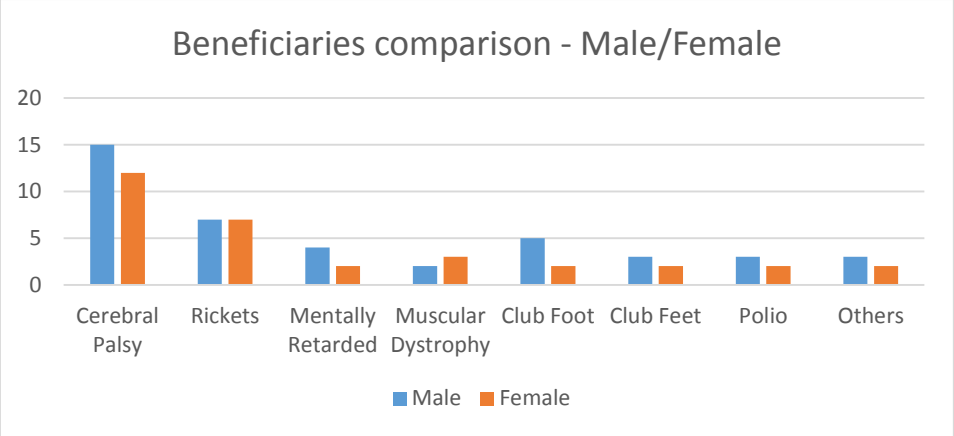
- **Assessment/Diagnosis:** Senior CBR Technician does assessment diagnosis independently and parents are interviewed. Afterwards a rehabilitation plan is made.

- **Heat & Massage:** These treatments make physiotherapy easier to perform and may relieve pain. Heat is generated by a simple heat box with light bulbs attached to the interior.
- **Physiotherapy:** CBR workers give the required Physiotherapy, massage, and passive and active exercises. The parents are taught to help their disabled children to do exercises.
- **Training of Caretaker:** The members of disabled families are being taught to help their children go through these exercises at home as well.
- **Home Based Rehabilitation:** The disabled children who are unable to visit the centerare provided treatment at their respective homes by our mobile staff.
- **Activities of Daily Living:** Activities of daily living include basic hygiene and grooming skills such as bathing, cooking, tooth brushing and washing clothes. Neglect of these activities can lead to medical problems. Many people with intellectual disabilities need support in these areas, and developing these skills can increase independence as well.
- **Community Involvement:**The community involvement is very important for us, so several meetings with Community groups should be held. As special meetings of the parents, community leaders, social workers, and others, go a long way to achieve this goal through regular meetings the opportunities are provided for discussing the activities of the program, accumulating parents' opinion about the program and informing them about Health Education topics, prevention of disease, vaccination programs, polio, CP and about other disabilities.
- **Disabled Interaction:**As a handicapped person becomes a useful member of the family and is more independent, family members realize the importance of rehabilitation program and change their attitude towards the handicapped.
- **Follow-up visits:** CBR workers pay regular visits to disabled children to provide the required facilities and family members are encouraged to pay special attention to the needs of the disabled child, such as repair of boots, braces walkers etc. This activity too, helps change the attitude of the community towards the disabled.
- **Family Counseling:** Workers will be assigned to find out the family problems and parents are encouraged to share their problems with them to find out proper solution. This activity not only help improve the situation of the handicapped and his/her family but also help the community to accept these handicapped as members of the community as normal individuals.
- **Health Education:** Health Education program is launched to create awareness about the prevention and cure from diseases such as Polio, Cerebral Palsy, Muscular Dystrophy, Rickets and other disabilities including the general diseases amongst larger groups of the communities.

During this period, a total of 104PwDswere assessed. 61 are receiving the services at JECUP's Disabled Support Center (DSC), 13 are served with home-based rehabilitation, 7 were referred and 23 did not come back due to different reasons. There is often a transport problem or negligence of parents.

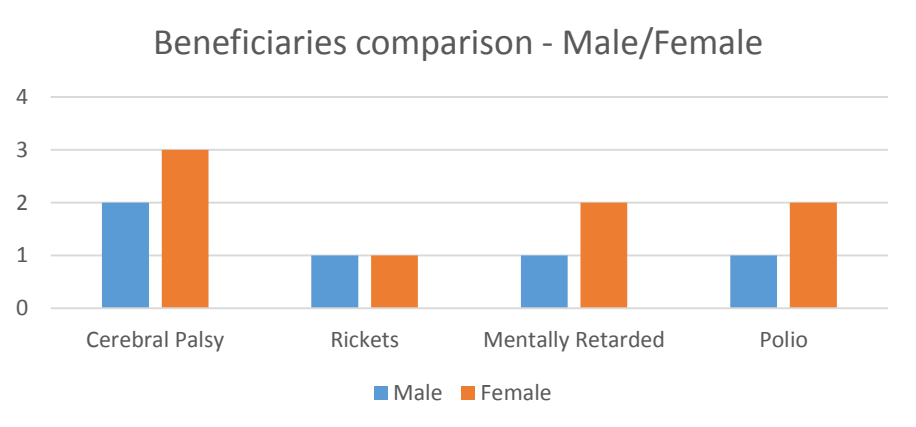
PWDs BENEFITTED THROUGH DISABLED SUPPORT CENTER (DSC) (September – December 2014)

Disease	M	F	Total
Cerebral Palsy	13	11	24
Rickets	5	6	11
Mentally Retarded	2	1	3
Muscular Dystrophy	1	2	3
Club Foot	4	1	5
Club Feet	3	2	5
Polio	3	2	5
Others	3	2	5
Total	34	27	61



PWDs BENEFITTED THROUGH HOME-BASED REHABILITATION (September – December 2014)

Disease	M	F	Total
Cerebral Palsy	2	3	5
Rickets	1	1	2
Mentally Retarded	1	2	3
Polio	1	2	3
Total	5	8	13



Dropouts

23 PwDs assessed did not return for different reason, mainly because of transportation and parent's negligence.

Disease	
Cerebral Palsy	9
Rickets	2
Mentally Retarded	3
Muscular Dystrophy	3
Polio	2
Others	4
Total	23

HEALTHCARE SERVICES AT BRICK KILN FACTORIES

Through Mobile Healthcare Unit (MHU)

BONDED AND FORCED LABOUR

Bonded labourknown as debt bondage, is probably one of the least known forms of slavery today but responsible for enslaving millions of people around the world. A laborer becomes bonded when his/her labor is demanded in repayment for a loan. This advance is known as `peshgi' in Pakistan. The person is then tricked or trapped into working for very little or no pay, often for seven days a week. A child is considered bonded labour when he/she inherits debt; when the child is used as collateral for a loan; and when the child takes an advance on expected future wages.

CHILD LABOUR:

The children start working along with their parents at a young age, between 6 and 8. They work long hours, starting at dawn during the hot season and working late in the afternoon with a short break during the day. There is typically no shade in the working grounds and they are exposed to the scorching sun in the summer and suffer severe cold in the winter.

The children of the working community have no choice but to work alongside their families. They work barefoot and continuously inhale fine dust from the clay and noxious gases from the coal burning kilns. They are assigned tasks such as helping in the kneading of mud, carrying of pieces of mud to the adult workers, spreading sand on the wetside and assisting in watering the soil for mud making. Efforts to break their isolation and end this extreme misery must be made.

FEMALE BRICK KILN WORKERS

Women make a significant contribution through family kiln labor across the country. They are usually involved in the making of mud bricks. Women have to work even during pregnancy. Along with this hard labor they have to do family chores, like preparing food for all the family members, collect wood for the fire, bringing water, washing clothes and arranging fodder for animals. They also have to take care of the sick and elderly of the family. Women are even exposed to sexual harassment if their male head of family runs away from the brick kiln.

The condition of pregnant women is also critical at the brick kilns. Young mothers and their children are at a severe disadvantage. There are high rates of child mortality. The consequences of poverty for the children in terms of nutrition and health care are profound, too. There are no family planning or health education services. Hence, health programs must reach out to women and girls at their workplace to increase their knowledge of options they may not know exist.

HEALTH SITUATION OF BRICK KILN WORKERS

Brick manufacturing involves three main steps: clay shaping with water (molding), drying with solar energy and firing with fuel (baking). Workers at brick kiln are involved in carrying the clay dust and bricks, molding or baking. Although all the workers are exposed to dust and smoke, molders are more likely to be directly exposed to dust and bakers have more proximal exposure to smoke. Also Smoke and dust from brick kilns is an important cause of air pollution.

Workers from different occupations are exposed to dust and smoke especially brick kiln workers are at a higher risk of developing chronic respiratory symptoms and illnesses. Besides environmental exposures, occupational factors also play an important role in affecting the health of the employees. Evidence suggests that factors like length of job, lack of protective equipment, type of work and type of burning fuel is associated with respiratory illnesses in different occupations.

Apart from this, sanitation is also a big issue in the vicinity. There are no toilets made for the workers, Fresh water is scarce for usage.

HEALTH EDUCATION:

Brick kiln workers face many serious problems like unclean water, population control, good hygiene, sanitation and basic education. Without proper awareness about these issues upgrading general health conditions is hard to achieve.

ACADEMIC EDUCATION:

Schooling facilities at or near the brick kilns, in particular, is the major reason for low literacy rate amongst the children of brick kiln workers. Parents are unable to afford educational expenses of children hence they have no choice, but to make their young ones work with them for more income.

JECUP'S INITIATIVE:

There are **13 Brick Kiln Factories** in the surroundings of Bhai Kot Village. JECUP is currently providing Medical care through Mobile Healthcare Unit (MHU) to the Brick Kiln workers at **2 Brick Kiln Factories**.

Targeted Brick Kiln Factories

S. No.	Name	Families	Population
1.	**Madina Bricks**	58	406
2.	**ShahzadNazir Bricks and Co.**	65	455
	Total	**123**	**861**

123 families are benefitting from MHU as it is providing comprehensive healthcare including education, treatment and rehabilitation to the destitute and underprivileged. Provision of medicine for patients, including patients with long term chronic diseases.

OBJECTIVES:

To provide comprehensive healthcare services of preventive as well as curative measures on primary, secondary, tertiary level.

To provide medicine for a prolonged period to cause the effects of injury or ailment minimized to an easily manageable level.

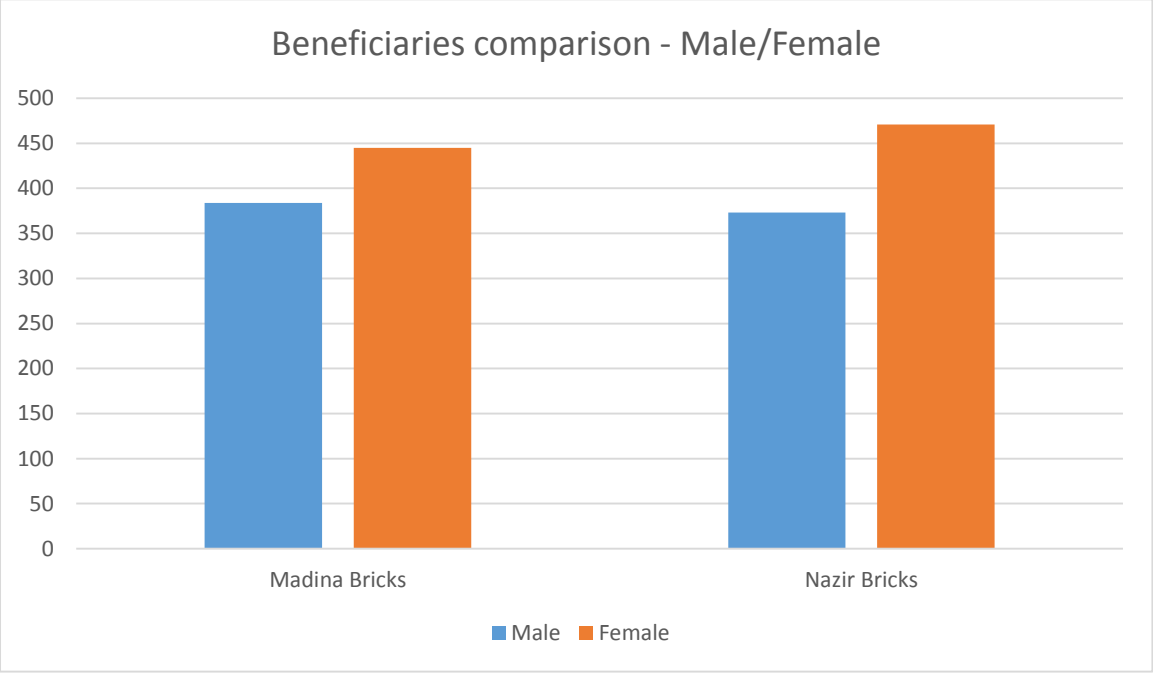
To promote healthcare while emphasizing maternal & child health.

To promote health education about immunization, sanitation and personal hygiene. It shall cover the physical, mental, and social health.

To collaborate with other organizations, institutions, hospital for referral. Poverty has been one of the biggest problems that Pakistan faces today. Nearly 75% of the population of Pakistan lives in villages. In such condition people are depressed of their basic necessities of life. Proper education and medicine are becoming distant from them.

PATIENTS TREATED THROUGH MOBILE HEALTHCARE UNIT (MHU) FOR BRICK KILN WORKERS (September – December 2014)

Brick Kiln Factory	0-5		06-18		19-45		46+		Total		Total
	M	F	M	F	M	F	M	F	M	F	ALL
Madina Bricks	77	89	93	107	118	133	96	116	384	445	829
Nazir Bricks	63	78	86	103	121	163	103	127	373	471	844
TOTAL	140	167	179	210	239	296	199	243	757	916	1673



IMPACT

- **1,673 patients were treated.** The patients got quality medical services free of cost from Mobile Health Unit which was not accessible before due to their weak financial health.
- The community received education about the prevention and precautionary measures with regard to common diseases and personal health and hygiene.

STRENGTHS AND WEAKNESSES OF THE PROGRAMS

Strengths

The following reveals the strengths of our programs

- The reputation of the program is well acknowledged in the area
- Provision of services at a low cost.
- Developing relationship in networking with other related projects.
- Being hope for deprived and under privileged population.
- A team of committed and dedicated staff and volunteers
- Good relationship with community leaders
- Donated premises from a local community leader

Weaknesses

- Not enough medical and rehabilitation equipment as per need.
- Lack of resources to make functional all activities as per need.

"FUTURE PLANS"

- Strengthening of the current activities through staff training and improved management and technical skills.
- Improve our links and networking/collaboration with similar organizations (national and international).
- Weaknesses of the program and targets are to be abolished
- Formation of self-help groups
- Formation of parent associations (PwD)
- Fundraising for expansion of MCHC, DSC and MHU programs
- Seeking Donors for equipment in-kind for MCHC and DSC
- To expand Brick Kiln Medical Services from 2 to 5
- Provision of safe drinking water and proper sanitation facilities for Brick Kiln Workers
- Growing in strength within other communities

ACKNOWLEDGEMENTS

We give thanks to the Lord for His guidance in the period gone by and look into the future era expectantly, hoping to continue the work amongst the under privileged and needy communities. May God's strength remain with us in doing His work.

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And last but not the least, our sincere thanks to the committed staff and volunteers without whom these projects could not have been a success.

Phaystle Walters
Coordinator

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