TOWARDS A HEALTH SCIENCES EDUCATION CHARTER : BUILDING AN INDIA RELEVANT PARADIGM

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BACKGROUND PAPER FOR

FIRST ALL INDIAN PEOPLE'S MEDICAL AND HEALTH SCIENCE CONVENTION

ORGANISED BY

PEOPLE'S COUNCIL FOR EDUCATION & NITTE UNIVERSITY,

FEBRUARY 5-8, 2015

MANGALORE, KARNATAKA

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Introduction

The background note for the First All India People's Medical and Health Science convention, which was part of the announcement, identified a range of determinants to explain the crises in medical and health sciences education , in the country including

- ***"An exploding number of medical colleges, quantitative explosion at the cost of the quality.***
- ***A skewed distribution of these around the country,***
- ***Devaluation of merit in admissions, particularly in private institutions,***
- ***Increasing capitation fees***
- ***Admission of sub-optional quality of students with poor motivation,***
- ***An alarming shortage of teachers with those who exist being untrained in modern teaching learning technology ,***
- ***Gross shortage of patients in many institutions,***
- ***A less than desirable evaluation system,***
- ***Poor internship supervisions"***

It also highlights some of the lacunae in the content of health sciences education with a focus only on medical education which includes:

- ***"the curriculum is outdated , insensitive to modern concepts of the process of teaching and learning , rigid and discourages innovation.***
- ***-Humanistic approach , attitudes and communication skills- essential traits for a health professional are hardly assessed***
- ***Overburdening of the student with content information with a large body of knowledge pertaining to a basic sciences and clinical disciplines***
- ***Medical ethics, social science, communication skills, managerial skills, do not receive due***
- ***attention.***
- ***Environmental science does not find a place in the curriculum***
- ***Stress has been on acquisition of knowledge as against the development of skills***
- ***Knowledge dominated examinations rather than a skill oriented examination".***

Finally it also outlines some economic and political factors that have lead to the increasing commercialization and commodification of education especially medical education.

The note paints a bleak picture of the crises in health science education focusing primarily on medical education. While most of this is true and relevant to the large majority of medical colleges, and other health science institutions as well it does not indicate the slowly growing amount of institutional level innovation, relevant policy and curriculum recommendations and innovative experiments by main stream and alternative community based civil society oriented groups especially since the late 1970's when the

report of the Group on Medical Education and Support Manpower (Shrivastava Committee report, 1975) reviewed the situation 25 years after independence and called for a serious rethinking.

> ***" The greatest challenge to the medical education in our country, therefore is to design a system that is deeply rooted in scientific method and yet is profoundly influenced by the social, cultural, and economic settings in which it arise. We need to develop methods and tools of instruction, which have relevance to the resources and cultural paterns of each area. We need to train physicians in whom an interest is generated to work in the community and who have the qualities for functioning in the community in an effective manner. In addition to medical skills, they should be trained in managerial skills and be able to improvise and innovate."***

This urgent necessity for reform inspired many institutions, academics, civil society groups, researchers, and health activists to start reflective initiatives since the late 1970's. This quest was further strengthened by the report of a study group setup jointly by the Indian Council of Social Science research and the Indian Council of Medical Research in 1981 entitled " Health For All: an Alternative Strategy". This perceptive report noted –

> ***" The medical education system and the health care system have each gone their separate ways. There is little congruence between the role of the physician and the needs of the society, little equilibrium between medical education and health care. Medicine is still regarded essentially as an enterprise of science and technology; the physician is the repository of all knowledge and dispensation; specialization is the hall mark of progress; and the training ground is the teaching hospital."***

Both these reports encouraged and stimulated some new thinking and innovations and providing an overview of these will be the subject of this paper. We hope that it will help to move the deliberations of the convention from focusing only on a situations analysis and ongoing system failure – much of which has been already well documented especially since the 80's and move the dialogue among the participants of the convention to reflecting on the solution to the problems identified in the systems of health science education, building where possible new strategies, enhanced strategies, and innovative strategies by all concerned in their institutions and as citizens committed to the Health for All goal. Perhaps the task force setup by the convention organisors could help identify some key systemic changes and innovative processes that could form the substance of a charter of action. Health science education in the country will have relevance only if it is a core contributor to the unfinished agenda of the Health for All revolution.

The Society for Community Health Awareness, Research and Action of which the author has been a co-initator since 1984 and presently the advisor, has focused on Health Human power development and training strategies in health as a key focus of its activities and has also been involved in proactive efforts at policy advocacy, policy engagement, and policy action.

This background paper will be in five sections:

(i) The first section will highlight the key recommendations for reform from the Srivastava Report in 1974 till the draft National Health Policy document of the present government of 2015. (SOCHARA was involved with some of these reports especially since the NRHM Medical Education Task Force of 2006 of which we were apart)

(ii) The second section will highlight lessons from several studies and reviews undertaken by SOCHARA, since the early 1990's and also ideas from ongoing training strategies.

(iii) The third section will highlight initiative by SOCHARA in policy engagement with state and central policy initiatives in an effort to mainstream the ideas and framework into mainstream policy.

(iv) The fourth section will highlight initiatives by SOCHARA and others to evolve a countervailing policy movement towards health for all strategies and focus on the health science education related concerns and issues in this process. The work of these networks has now lead to a revival of focus on a community oriented, value based, rights inspired, health for all oriented educational innovations.

(v) Finally some key principles and axioms of a new framework for health science education development has part of a new health for all system will be enumerated from all these experiments.

Many of these experiments may be known to those who have focused on 'Praxis' rather than just situation and policy analysis, but it was felt that a paper highlighting this would draw key threads of all this grounded innovation to suggest the elements of a charter. This could be further evolved and endorsed by the convention gathering and a small task force take up advocacy, knowledge translation and policy engagement as a follow up to the conference.

In 1998, SOCHARA had contributed a chapter on Health Human Power Development In India for the report of Independent Commission on Health in India (ICHI). In this document we had concluded that –

> *"**For too long the medical profession and the medical education sector have been directed by professional control and debate. It is time to recognize the role of the community, the consumer, the patient and the people in the whole debate. …… What is needed is a strong countervailing movement initiated by health and development activists, consumer and people's organizations that will bring health care and medical education and their right orientation high on the political agenda of the country. All those concerned about 'peoples needs' and 'people's health' will have to take on these emerging challenges as we approach the end of the millennium"***
>
> Source: SOCHARA , VHAI, 1998

It is hoped that this background paper supported by the interactive discussions at the convention will help all of us including the People's Council of Education to initiate a strong countervailing process and movement which will stimulate a re-thinking in the direction content and relevance of health sciences education in the country making it more relevant to people's needs and health for All.

SECTION- I

RECOMMENDATIONS FOR HEALTH SCIENCE AND MEDICAL EDUCATION REFORM SINCE 1970'S

This section will highlight the key recommendations of all the major reports to indicate that many issues that we are going to debate and dialogue during the convention have also been concerns of expert committees and policy think tanks and these need to be also kept in mind as we proceed towards reform. From each report only the key principles and innovations will be enumerated.

1. THE REPORT OF THE GROUP ON MEDICAL EDUCATION AND SUPPORT MANPOWER 1975 (SHRIVASTAVA REPORT)

The key recommendation of the Shrivastava Report was the establishment of Medical and Health Education commission patterned after the UGC with the following mandate –

- Apex coordinating agency working in close and effective collaboration with all the National Councils – Medical, Dental, Nursing, Pharmacy etc.
- Membership would include representatives of all the councils and one third consisting of leading persons in the field of Health and Medical Education and services.
- Role should be promotive and supportive and should be responsible for planning and implementing in the Health and Medical Education.

The report also highlighted the following main directions of the change

- ✓ **"Redefining the objectives of Undergraduate Medical Education with a focus on skills that a doctors should have and a qualities that he should possess.**
- ✓ **Undergraduate medical courses to be given positive community orientation**
- ✓ **Premedical education to include exposure to humanities and deeply embedded in the framework of natural sciences, humanities and social sciences**
- ✓ **Community medicine to become the joint endeavour of all faculty of the medical college and not just the department of preventive and social medicine**
- ✓ **Provision of rural and urban field practice areas in which active health service programs are in operation**
- ✓ **Application of principle's of education science namely encouraging student to learn themselves, introduction of continues assessment, objective methods, small group teaching, integrated inter-discipline teaching and accent on the experimental method. Internship to play a key part in consolidation of skills and knowledge gained by medical students with six months spent in community health centres.**

- ✓ **Internship to be also carried out in district sub divisional, taluk, and outreach centres with occasional forays into the community.**
- ✓ **Continuing education of doctors, and health staff surveying in government or private as joint activity between the medical colleges, the professional health service and health service.**
- ✓ **A referral service complex to be built up between the primary health centres, taluk, and district hospitals, regional, and medical college hospitals, with living an direct links with the community around them as well".**

Finally this report emphasize the need to evolve a National System of Medicine for the country by the development of an appropriate integrated relationship between modern and indigenous system of medicine.

2**. HEALTH FOR ALL : AN ALTERNATIVE STRATEGY - THE REPORT OF A STUDY OF INDIAN COUNCIL OF SOCIAL SCIENCE RESEARCH AND INDIAN COUNCIL OF MEDICAL RESEARCH - 1980**

This report is the first report which tries to build a framework of an alternative model of health care in the country by suggesting a process towards the following features.

- ❖ **Combining the best elements in the tradition and culture of the people with modern science and technology.**
- ❖ **Integrating promotive, preventive, and curative function,**
- ❖ **Democratic , decentralized and participatory,**
- ❖ **Oriented to the people, ie, providing adequate health care to every individual and taking special care of the vulnerable groups,**
- ❖ **Economical, and**
- ❖ **Firmly rooted in the community and aiming at involving the people in the provision of the services they need and increasing their capacity to solve their own problems,**
- ❖ **Training the personnel, to produce drugs and materials and to organize research needed for this alternative health care system,**

It also emphasized the need for a comprehensive health policy that should cover the following dimensions –

- ➢ Philosophical
- ➢ Cultural
- ➢ Social
- ➢ Environmental
- ➢ Nutritional
- ➢ Preventive
- ➢ Curative

With specific reference to education in health sciences and training of health human power this report emphasized some broad general principles which represent the evolution of a new paradigm of thinking.

- Values system of medicine which is science and technology based should lay greater emphasize on cultural, social, and even moral aspects of its action and purposes.
- Not to over emphasize high technology and create a mystic about it but to evolve simpler technologies to deal with more complex problems.
- Training of personnel should be fully oriented to the people – their social, cultural and economic conditions and their health profile.
- Health services should be pyramidically organized with a large base in Primary Health Care and a narrow top in highly specialized institutions
- Preventive, promotive and curative problems should be defined at each level
- The skills services and facilities should be defined
- Selection of personnel and training should be on requirements on specific jobs and skills
- Selection at lower levels from community itself
- Training should be as close to workers as possible – jobs specific, decentralized, efficient and economic
- Services should be democratic and team sharing decisions and responsibilities.

With specific regard to health science education to support such an alternative it suggested the following

- No new medical colleges and no increase in intake of existing colleges
- No need to setup new additional institutions to train additional doctors through short term courses
- Training of doctors should be community oriented with an inter-disciplinary holistic approach
- The curriculum will have to be severely more practical and doctors should be able to confidentially undertake simple procedures at community level.
- Doctors should be oriented on training, organizing and assisting health team with practical field oriented training in epidemiology and health education working intimately with community
- Doctors should also be taught principles of sociology, human behavior, social /political structure of society and organization and management of health services.
- Training should be in close collaboration with health care services

To strengthen a more broad based health team the report also recommended

1. Specialist training from cadre of doctors with practical experience
2. Training in public health through a chain of public health schools established on regional basis
3. Continues education at all levels
4. Medical and health education commission to implement all these ideas and reforms which apart from counsel representatives will have senior persons from disciplines such as sociology and education and eminent persons from general community who command national respect.

3. NATIONAL EDUCATION HEALTH POLICY IN HEALTH SCIENCES, BAJAJ REPORT 1989, DRAFT

Not many readers may be aware that after the National Health Policy of 1983 was announced, several committees and initiatives were setup towards a more specific policy for health science education. This included a Medical Education Review Committee, 1983; a empowered committee 1984; Expert

Committee on Health Manpower Planning, Production and Management 1987; - all of which recommended the need for formulating a National Policy of Education in Health Sciences. Subsequently a consultative group under the chairmanship of Prof. J.S. Bajaj, Professor of Medicine of AIIMS, New Delhi was appointed to draft this policy. A draft National Education Policy in Health Sciences, 1989 was then presented to the Ministry and published in the Indian Journal of Medical Education for public debate. Unfortunately though this, first policy statement on health science education had many relevant and significant features it never become policy due to various political exigencies. However for this convention some extracts from this important milestone document have been included to help the direction of our discussions. This document is now available on the website – www.communityhealth.in in its full form and is compulsory reading for all those who are committed to praxis in health science education.

- The objectives that the National Health Policy seeks to achieve are the following:

1) Quantitative and qualitative development of appropriately trained health manpower for all categories of health care providers.

2) Definition of educational strategies and curricular reforms considered essential for the community oriented training of different categories of health personnel, with a view to establishing essential interrelations between functionaries of different grades.

3) Organizations of appropriate structure (s) in order to bring about necessary modifications in education depending upon the changing national needs, and on the outcome of research developments in the philosophy of learning process and technology of education;

4) development and implementation of a proper and adequate evaluation system for health professionals and health programmes;

5) development of agencies for implementation of various elements of national education policy in health sciences.

- The educational strategy should shift emphasis from subject and discipline based education to problem based learning. The maintenance of proper linearity and congruence between the reformulated objectives and competencies is an essential prerequisite for a major transformation of medical education to make it more humanistic, nationally relevant and socially committed.

- The curricular contents and the teaching learning activities must therefore be directed to achieve

1***) a proper balance between technological and humanistic medicine***

2) a more holistic approach covering promotive, preventive, curative and rehabilitative aspects of medicine

3) a proper balance between the tertiary care hospital based and primary care community based education.

4) a shift of emphasis from the use of teacher oriented to learner oriented methods which would include self initiated, self directed learning and self evaluation;

5) a progressive change from a narrow discipline oriented teaching to a problem oriented approach

6) a shift from theoretically oriented teaching to experimental learning

7) a major change from the practice of factual memorization and recall to the acquisition and practice of professional skills; and

8) a major shift in the medical teachers role from imparting a defined quantum of knowledge to that of a facilitator and motivation of community based student learning.

- The policy identifies various categories of health manpower development for comment and norms setting including :

Basic Doctors, first level specialist, super specialist, health planners and managers; basic nurses, post basic nurses, graduates in dentistry; continuing education in health sciences.

- The policy also identified in great detail the learning objectives for undergraduate medical education in light of all the shifts identified above It mentions that ***" the undergraduate medical education aims at producing medical graduates who have the capability of providing comprehensive health care to both rural and urban communities. Such care should not only be curative but also include promotive, preventive and rehabilitative aspects of health services in an integrated manner".*** It then goes on to identify all the requistic compentency that the graduate must have and all the areas the students should have an adequate understanding off (refer appendix of policy document for detail).

-The policy also identifies four key mechanisms of implementation which includes the following:

1." Education Commission in Health Sciences

2. University of Health Sciences

3. Linkages between health care delivery and education in health sciences

4. Optimal utilization of practitioners of Indian system of medicine and homeopathy. The policy notes significantly that " a healthy and mutual respect for qualified practitioners of medicine , irrespective of the system is an essential prerequisite for effective health human power utilization"

5. Medical education and research which includes mounting research and development in technology of education and in faculty development so as to make education in health sciences relevant and responsive to technological advances in this area".

- The final statement of the draft policy is a very meaningful one particularly relevant to the convention theme.

" The future: With a rich centuries -old heritage of medical and health sciences, the ancient medical system of India was a holistic nature encompassing all aspects of human health and diseases. With the dominant influence of western medicine, there have been a fragmentation of basic art of healing into specialties and super-specialties. The Education Policy In Health Sciences aims at reorientation and re-targeting of educational process, with a major focus on the base and basis of health care pyramid wherein primary health care providers shall act in concert with about one billion people at the end of the next decade, striving for the goal of health for all, Education being a dynamic process, must remain flexible to imbibe the demands of changes being continuously ushered in by socio-economic revolution and demographic evolution. Thus, the policy defines the

instruments of change in the hope that the future outcome, given the traditional wisdom, would be a change in a positive direction".

4. **TASK FORCE ON MEDICAL EDUCATION FOR THE NATIONAL RURAL HEALTH MISSION – MOHFW - 2006**

1. The task force was very focused in its recommendation to strengthen health human power development especially medical education through very focused recommendations. These included

- ✓ ***Medical education to serve the community would have to be socially oriented to primary health care***
- ✓ ***The pedagogy method would have to be problem based where the non clinical principles will be meshed with clinical training and the training would largely be in a decentralized setting outside a tertiary care hospital in close proximity with public health services and social environment.***
- ✓ ***Introduction of modules in the curriculum in communication skills; management skills; psychology, Political Science, Anthropology; and Sociology; Health economics; Ethics and Human Rights.***
- ✓ ***Inclusion of a six week rural orientation package in the MBBS curriculum which includes community orientation, first Aid, and NRHM Orientation.***
- ✓ ***Medical colleges must priotise the curriculum and enhance the skill development concentrating on hands on skill for providing service in the primary health care areas***
- ✓ ***Each medical college must undertake responsibility of managing one CHC and four PHC's and student can be trained in these centres for providing primary health care, administrative management, and fundamental skills such as basic nursing, laboratory skills, immunization etc.***
- ✓ ***Medical college should be made to shift to a integrated problem based pedagogy in a phased manner over time with examination systems focused on common conditions and hands on skill.***
- ✓ ***Introduction of evaluation at the end of internship***
- ✓ ***Creation of medical education cells promoting faculty development.***

The National Rural Health Mission Task Force also emphasized the need for experimentation with alternative models of undergraduate education and also recommended feasibility of short term courses including three year degree course for community health practitioners; two year course for graduates of AYUSH, Pharmacy, Dentistry and Nursing to produce community health practitioners; Strengthening of public health training for all categories of personnel; and experimentation with nurse practitioner course as well.

In order to strengthen the sustainability of health human power in primary health care the task force also recommended incentive schemes for encouraging rural service; changes in the age of retirement; reservation of PG seats for community practice, continuing education facilities; compulsory rural practice; and provision of better infrastructure for doctors and health staff.

5. **WORKING GROUP ON MEDICAL EDUCATION SUB GROUP : EDUCATION FOR COMMUNITY HEALTH FOR NATIONAL KNOWLEDGE COMMISSION 2007**

The National Knowledge commission report is mostly known for the recommendation about the National Regulatory Body which was based on the earlier recommendation of the Medical and Health Education Commission (Shrivastava 1975) and the Education Commission in Health Sciences (Bajaj 1989) The functions and composition of this body were also outlined. While this may be outside the perview of our current convention theme its description of the lack of such integrated regulatory authority is interesting.

"If a regulatory authority is not put in place, medical education will be like a ship sailing in troubled water without navigational tools. To ensure there is effective use of linkages that the recommendations in this report envisaged in the entire health system. There is a urgent need for a monitoring agency that ensures accountability in the system. In the continued absence of such a body, coordination between the different components of the health system will remain limited even when such linkage does exist at all. Such a body will function as the linchpin to an integrated health system".

Some interesting recommendations were included to give strong social and community orientation to health science education particularly medical education. These are significant and include :

- ***Strong social and community representation in the perspective in decision making bodies of the council (Regulatory Authority) so that people, the community and the social aspects are given importance and not made subservient to professional or commercial interests. Social scientist and people of social standing from other professions, voluntary agencies, consumer groups could be included in the governing bodies.***
- ***Mentored medical student research program to prepare them for both clinical and community studies***
- ***Teachers training centers in every medical school and faculty exposure to new pedagogy.***
- ***Curriculum to be revamped, to include skills in communication, management, analytical decision making, research methodology; introduction to social sciences, medical ethics, human rights and health economics and new frontier areas like bio-informatics, genetics and genomic and molecular biology***
- ***Integration of ICT in the learning process***
- ***Internship must be a period of acquiring and enhancing skill development and application of knowledge acquired, in community and hospital setting under supervision.***

Faculty development was also emphasized in the NKC report. An interesting suggestion was that **"All teachers should be encouraged to take part in camps and other clinical and field activities in the rural and urban field practice areas of the medical colleges and any programme links it establishes with the regional and district level health services- so that all teachers of all departments are more oriented to the primary health care and community challenges which the students will face as basic doctors"**

A separate section on students was also a part of the report and this included suggestions such as "students being part of curriculum committee and actively involved in the feedback system on the quality

of education being imparted by teachers: national and regional level creation of e-groups for discussion and counseling for academic and personal challenges".

The most important contribution of the knowledge commission is the discussion the report on an approach to creating health human resource for health care provision in rural areas as a challenge for a more broad health science education. The expert sub group noted the following:

"Starting from the bottom of the pyramid the Group suggests ways of creating the human resource needed on a sufficiently massive scale to meet the needs of the public health system. Amongst female workers it is ASHA, ANM, nurses, and nurse practitioners".

The sub group setup for this purpose suggested experimentation and reforms of various types moving away from past stereo typical limited roles. These included cadre of nurses for community health; ASHA and community health training through national open schools, ANM as a vocational course, Nurse diploma, and graduate nurses with training in rural health, multi-skilled health workers; hospital paramedics; AYUSH practitioners and their integration and public health training programs. The main focus of these recommendations was evidence based innovation of new categories and combinations more relevant to our community needs.

SECTION - II

HEALTH SCIENCE EDUCATION STUDIES AND INITIATIVES BY SOCHARA

Health science oriented educational strategies has been one of the key components of SOCHARA's agenda since many of its objectives have a focus on health human power training including the following

- ***To evolve educational strategies that enhance the knowledge skills and attitudes of persons involved in community health and development***
- ***To undertake research in community health policy issues including health personnel training……***
- ***To dialogue and participate with health planners, decision makers and implementers to enable the formulation and implementation of community oriented health policies.***

Like all its intervention and initiatives in health related problems and challenges over the last three decades, SOCHARA has underlining praxis more than just idea generation and emphasized learning by engaging and doing.

1. THE INSPIRATION FROM THE ST. JOHN'S EXPERINENCE IN PRE-SOCHARA DECADE:

Some of SOCHARA's initiatives were inspired by a decade of efforts to reorient medical and nursing education at St. John's Medical College, Bengaluru from 1974 to 1983. Some of the key co initiators of SOCHARA were faculty in the Department of Community Medicine in this college and participated in efforts towards social relevance and community orientation. Ten initiatives were significant in this pre SOCHARA phase- which was further built upon during SOCHARA's action initiatives . These were :

(i) **Community orientation camps** - (two weeks) during pre-clinical phase to help young medical and nursing students understand community structure, functions, dynamic and health situation and context even as they were exploring human structure and function.

(ii) **Creation of rural and urban field practice areas** - in which community participation and involvement in governance, planning and organization was emphasized to enhance community autonomy and initiative. This gave the young medical interns an experience of being village doctors working in collaboration with village organizations and Panchayat Raj Institutions. The Mallur Health Cooperative in Kolar district, Karnataka - the first milk cooperative in the country to run its own primary health care centre was one of the most well known of these field practice areas developed by the medical college during this phase and selected by ICMR as one of the 14 alternative approaches to health care in the country as early as 1976

(iii) **Socio- Epidemiological exercises** - that were built around case studies from real life situations and date from field initiatives to give students a feel of reality

(iv) **Simulation games** - that helped medical and nursing students understand and experience field realities in rural and urban slum communities. Three well known games were Monsoons, Chains, and Chikkanahalli evolved out of the well known SEARCH experiment in Bengaluru on learning facilitation for community development in which one of the co-initiator of SOCHARA was a key participant

(v) **Community based internship** - in rural areas, urban slums, tea plantations and other communities to enhance attitude change, and build skills and competence

(vi) **A three month Community Health course for lay volunteers**- based on the Janata Community Health Workers Manual (not doctors or nurses) to help them promote health, promote prevention strategies and act as a bridge /link between communities and available and accessible primary health care services.

(Vii**) Internship level field investigation and action oriented research** - that linked evidence gathering to community action, clinical camps and health promotion activities.

(viii) **Teaching of ethics** - as part of medical curriculum as a separate subject not linked to forensic medicine or community medicine

(ix) **Community health orientation course for doctors and nurses in communities**- to enhance outreach , community health orientation and community participation in there activities.

(x) **Rural placement scheme for medical graduates**- based on a two year bond for work in selected peripheral mission hospitals which was supported by mentors, continuing education and career counseling

The rich experience for a decade before the creation of SOCHARA was the background on which the co-initiators of SOCHARA who had been the faculty of the department – brought for further experimentation and exploration.

2. INSPIRATION FOR SOCHARA:

The formation of SOCHARA was inspired by some documents and inspiring academics whose perspectives will explain the framework of our initiatives.

a) The ICSSR –ICMR Health for All report 1981, mentioned earlier challenged the SOCHARA team by noting that " the attainment of Health of All goal depends, above all, on three things. (1***) the extent to which it is possible to reduce poverty and inequality and to spread education (2) the extent to which it will be possible to organize the poor and underprivileged groups to that they are able to fight for their basic rights; and (3) the extent to which we are able to move away from the counter-productive, consumerist Western model of health care and to replace it by the alternative model based in the community ....."***

b) Prof. Debabar Banerjee from the Centre for Social Medicine and Community Health inspired a new vision of health system development by identifying the need for **" a critical mass of community health physicians who will participate and build a health service structure, seeing it as a socio-cultural process , a political process and a technological / managerial process with an epidemiological and social perspective."** He had outlined a series of issues which would form part of any educational strategy for producing community oriented physicians in the country. This included historical perspectives, epidemiological approaches, political economy of health, and an understanding of ecological, social and cultural dimensions. This holistic approach inspired us in SOCHARA to evolve a framework that we now call – SEPCE analysis.

c) As SOCHARA evolved we were also inspired by Dr. N.H. Antia of the Foundation for Research in Community Health with his seminal work on People's Health in People's Hands who kept a close link with us and interacted with the team several times

d) Prof. Geoffory Rose well known epidemiologist of London School of Hygiene and Tropical Medicine also inspired his stand that **"the primary determinants of disease are mainly economic andsocial and therefore its remedies must also be economic and social ….. medicine and politics cannot and should not be kept apart"**

Over three decades SOCHARA initiated and or participated in the following crucial initiatives to evolve meaningful and relevant health science education strategies, framework and policies.

3. **COMMUNITY HEALTH: IN SEARCH OF ALTERNATIVE PROCESSES (The Red Book)**

We evolved a Community Health manual based on 10 axioms to help health action initiaters build community health reorientation of all their work including their training/learning strategies (The Red Book) These axioms include a focus on - ***"rights and responsibilities; autonomy; integration of health and development activities; building decentralized democracy at community and team level; building equity and empowering community beyond social conflicts; promoting and enhancing sense of community; confronting biomedical model with new attitudes, skills and approaches; converting super***

structure of medical /health care to be more people oriented; promoting a new vision and discipline and not a package of actions and building Health For All as a system".

4. THE MEDICO FRIENDS CIRLCE ANTHOLOGY AND ALTERNATIVE CURRICULUM:

SOCHARA co-initiators were also active member of the medico friend circle- a group of socially conscious medicos and non medico's working for an appropriate, rational just and humane health care system in India inspired by the late Jaya Prakash Narayan. In its second decade, the circle initiated an interactive participatory process to re-examine medical education and suggest remedial measures towards making it more India relevant, community and primary health care oriented, skills and competence generating and value oriented. SOCHARA played a key role in this process contributing the historical review, the construction of an alternative curriculum document (to be read in conjunction with the MCI recommendation of 1991) and a review of all the policy and experiment initiatives in the country which were geared to such re orientation. The mfc anthology was focused on producing a "**community oriented, socially conscious primarily health care provider"** and was probably the most comprehensive alternative framework to be evolved in the country. The premise of the alternative framework was also very provocative since mfc emphasized a shift in the paradigm.

" the community oriented, primary health care doctor is by no means a basic, second rate, or low skill doctor as his made out by the protagonist of the conventional curriculum. She/he needs greater competence and capability to work in the community and has to develop multidisciplinary skills, knowledge and attitudes far beyond conventional medical boundaries……. This shift of emphasis is basic to development of the community oriented doctors."

The mfc curriculum in the anthology also described the alternative in 10 sections which included objectives; admission criteria and selection of students; duration of course; overall design of medical curriculum; nature and organization of training centres; methodology of training; teaching of community health; selection and re-orientation of teachers, evaluation and examination; and internship. It also emphasized some additional features including encouragement in vernacular education; links with civil society in health and development; open attitude to plural health systems; a spirit of enquiry and critical analysis; a commitment to interdisciplinary and educational research and a networking with other groups interested in evolution of an alternative curriculum. The mfc concluded that the alternative approach would have succeeded if it could effectively demonstrate over a period of time that the graduates of such a college are emotionally, socially, professionally, technically more competent to work in the primary health care / community health situation than the graduates of conventional medical colleges.

5. **STRATEGIES FOR SOCIAL RELEVANCE AND COMMUNITY ORIENTATION: BUILDING ON INDIAN EXPERIENCE (NATIONAL SURVEY**)

SOCHARA facilitated a National Survey of Medical Colleges in the early 1990's to identify and document all initiatives by mainstream institutions towards social relevance and community orientation. Focussing initially on 25 institution out of 125 who responded positively to an initial enquiry, we zeroed down on 50 strategies that could be included under the objective of the study towards social relevance and community orientation. These 50 strategies enumerated in detail focus on six broad thrusts of reform in

Medical Education which are also relevant for re-orientation of all health science professional institutions These are

a) **Orientation to new education technology**: Improving padagogy of medical education by clarifying objectives, goals, methodologies at institutional and departmental levels and improving staff skills in modern education techniques.

b) **Widening Horizons** : Introducing new areas concepts and subjects such as behavioural sciences, ethics, first aid, nursing, epidemiology, management, health economics, rational therapeutics, emergency medicine, social obstetrics, social pediatrics, etc

c) **Improving skill development** : By providing greater time in the curriculum for inservice training including graded responsibilities to allow skill development

d) **Moving beyond the teaching hospital:** Exploring greater community based learning including experiences at different levels of health care, primarily at primary health care level and the periphery level

e) **Transcending compartmentalization** : Introducing efforts at integration of subjects and phases of medical education and including greater problem solving orientation. This also included foundational /orientation experiences that help to link up different aspects of teaching and give community orientation .

f) **Promoting self learning** : Improving opportunities for students who decide for themselves and explore new areas independently even outside the curriculum structure through elective and research projects.

- In the same study we identified six pace setter institutions and visited them to see some of the initiatives in action and also to understand through interaction and qualitative interviews the dynamic of change, leadership, and other contributing factors towards innovation which are described in detail in the report

- As a complementary initiative to this National Survey we identified 13 alternative health human power development initiatives - a few even linked to mainstream institution that organized community health courses to create a new potential health professionals at community level. We identified the key innovations from this 'alternative sector' of Health Science Education innovators which included an alternative philosophy of education (Paulo Friere – Pedagogy of the oppressed) : small groups techniques and methods; community based education; social analysis and community based problem solving; focus on skill development; participatory planning/evaluation; training in affective aspects of work; learning exercises, case studies, stimulation games.

- to enhance the sharing and differences of these experiments and experience . We also organized a Network of alternative community health course initiators and facilitated three network meetings- the first to get to learn from each other; the second to respond collectively to the draft National education policy for Health Sciences 1989; and the third to interact with mainstream medical college faculty and

content innovation in to mainstream health science education hoping to cross fertilize the alternative and the mainstream.

6. EVOLVING MEDICAL CURRICULUM THROUGH GRADUATE DOCTOR FEEDBACK:

We undertook another interesting action research using feedback from 50 young doctors who did two years rural service after graduation. We used a qualitative approach and questionnaire. We identified what should be taught and what was not so relevant in all subject in Medical Education from Anatomy to Surgery; in addition we identified skills, and competencies that these young doctors felt should be emphasized during clinical training and internship if professional competence in rural/community practice has to be enhanced. This included the following

a) Basic nursing procedure
b) Emergency medicine
c) Minor surgical procedure
d) Obstetrics
e) Local Anaesthesia
f) Running a simple laboratory and pharmacy
g) Basic Management skills
h) Basic Communication skills
i) Assessing community health needs and evolving simple community health strategies
j) training health workers

The graduates also gave very relevant feedback for change in curriculum structure and frame work which included the following key suggestions:

a) Introduce integrated teaching focusing on common on common problems/ clinical applications
b) Reduce unnecessary detail in theory
c) Reduce pre-clinical phase to 1 year
d) Teach Sociology/Psychology/Nursing procedures in 6 months gained from pre clinical reduction
e) Increase responsibility and decision making in ward work
f) Long and short postings – stress important of both
g) Final MBBS /Internship postings in ancillary hospital departments, pathology laboratory/ records department/ blood bank/ accounts section
h) Final MBBS/ Internship – involvement in training of health workers.

This action research report was probably the first and only time in 60 years of medical education development in the country where the consumers of medical education (young graduates) were invited to give constructive feedback and help build a more relevant training /learning experience through a research process.

SOCHARA is an action oriented society, so apart from distribution of the mfc book and the two SOCHARA studies extensively it also undertook a process of sustained dialogue to inform policy evolution.

a) It worked with a network of medical colleges- which included CMC-Vellore, CMC –Ludhiana and St. John's Medical College to evolve a more community health oriented alternative medical college curriculum, proceeding further than what all these three institutions had already experimented with and introduced into their college curricula .

The Miraj manifesto evolved from this and efforts to start a college following the mfc course was initiated in Miraj and in Ludhiana with SOCHARA offering to facilitate the medical education cell of either college if such a course could be initiated and university approval received for such innovation. However due to some legal hurdles and some changes through some Medical Education related government ordinances in the country, both these experiment could not be initiated. However the mfc anthology and the SOCHARA study reports became well known in circles of health professionals concerned about curriculum reform and change. **It should be noted that the mfc alternative curriculum is the only serious and detailed alternative evolved by a sustained interactive process in the country in the last sixty years and is still waiting for an experimental effort**.

SECTION - 3

MAINSTREAMING THE ALTERNATIVE :

Since the late 1990's following this research phase SOCHARA was invited to participate in several major Health Policy and health science education initiatives in the country at state and country level which were opportunities to introduce some elements of change and the framework of a new paradigm of health science education. It was a challenging experience because these initiatives were built on multistake holders dialogue often committed to agendas other than only primary health care and community health. However if the mainstream had to be challenged and the alternative paradigm not remain just an idea, micro experiment or remain among the converted few than engagement with larger government initiatives was inevitable. Some of these are now enumerated in this section with a focus only on Health Science Education concerns and recommendations

1. The Madhya Pradesh – Jan Swasthya Rakshak Scheme

The Madhya Pradesh Government initiated the Jan Swasthya Rakshak experiment as the first initiative after the Janata CHW experiment to evolve a new category of community based health worker to help the PHC system covered to the community and extend primary health care access and availability. SOCHARA was invited to conduct external reviews of the ongoing JSR experiment that attempted to cover the whole state . The reviews were done at two phases of the program.

a) From July to Dec 1997 a participatory interactive review was done primarily focused on the training of JSR through a field evaluation, peer review of the training programs and the workshop of interested and key partners to discuss review findings. From the findings a series of early level recommendations on the objectives, administration, selection, linkages, with all sectors logistic support communication, training venue and facilities, criteria for certification, supervision, monitoring and evaluation and examination were given. A peer group of trainers from the Hindi belt also did a detailed peer review of the JSR manual.

b) The second review was done in July to Nov 2001, two to three years after the program of training was completed and the JSR were in the field. Here an interesting tripartite framework of evaluation including community concerns, providers concerns, and planners concerns were used and a series of recommendations from this operation research were presented which included pace of program; role of ngo's; selection of JSR's; selection of women; Quack entry in selection; training issues; linkages and preventive programs; funding; JSR clinic and work spaces; use of infotech; role of rural family welfare training centres; and drugs used by JSR in their work. Both this studies were probably among the more rigorous operational evaluation of such large scale human health power development programs and have been used by others for similar evaluation. These studies were also by the Ministry of Health to introduce mid-course corrections and later led the state to the Rajiv Gandhi Mission on Swasthya Jeevan Guarantee Yojana Scheme – a precursor to the NRHM at central level.

2. The Chattisgarh – State Health Resource Centre and Community Health Worker Program (Mitanin Scheme)

The Chattisgarh state then followed with the development of the State Health Resource Centre and the a state wide community health workers program (Mitanin Scheme). SOCHARA was again invited in lieu of its JSR reviews to conduct a learning review and evaluation of the SHRC and (the Mitanin scheme). This interactive and participatory exercises helped in identifying its strength as well as challenges that would need to be tackled through further policy innovation.

The Chattisgarh experiment including the mitanin scheme was the precursor for the National Rural Health Program and the concept and evolution of the Accredited Social Health Activist (ASHA worker) and the principle and components of communitization – among the more relevant and innovative aspects of the National Mission.

3. The Karnataka Government Task Force in Health and Family Welfare

The Karnataka government set up a Task Force in Health and family welfare in 1999 to evolve policies for strengthening Public Health and Primary Health Care systems in the state – SOCHARA was an active member part of the 12 member task force and SOCHARA helped the facilitation of the process as a policy resources secretariat.

One of its key findings was that Human Resources Development had been neglected in the state through an overall neglect of planning and policy as well as deployment inspite of training of an Army of Health functionaries of all types and at all levels, through a wide network of training institutions including governmental, non-governmental and private. The neglect was symbolized by……

- ✓ ***a lack of clarity of the capacities and skills required by each member of the team***
- ✓ ***An inadequate estimate of numbers required to be deployed to enhance the efficiency and effectiveness of the system***
- ✓ ***The absence of any clarity in policies of nurture, career advancement and inability to maintain moral and motivation of the health teams***

- ✓ ***Little or no efforts in continuing education excepting some adhoc and sporadic efforts for the doctors***
- ✓ ***Lack of clarity in promotion policies and***
- ✓ ***The absence of social accountability.***

The most significant development leading to a crises – was the commercialization and unplanned and unregulated growth of health human power training institutions – medical, dental, nursing, pharmacy, other systems of medicine etc which had led to fall in standards, poor quality of training, and infiltration of market values into these mushrooming network of institutions. The key recommendations especially in the context of health science education policy were the following:

- ❖ ***Moratorium on new colleges***
- ❖ ***Medical, Dental and Nursing colleges should take up PHC's for training and service***
- ❖ ***Corruption at University Examinations to be addressed and eliminated.***
- ❖ ***appropriate training and retraining of heads of departments, medical superintendents,in management principles on a priority basis***
- ❖ ***Every professional college should have a educational unit to improve teaching capabilites and the Rajiv Gandhi University to organize teachers training programs***
- ❖ ***Promoting research in professional institutions***
- ❖ ***Using information technology for continuing education of health and all allied health professionals and***
- ❖ ***para medical personnel***
- ❖ ***Strengthening public health capacity in the state through short term orientation courses, longer certificate courses, by the state institutes, and regional training centres and post graduate courses such as DPH, MPH, and Doctorate in public health in collaboration with the Rajiv Gandhi University of Health Sciences.***

4. The Karnataka State integrated Health Policy

A very important and significant development after the detailed Task Force process was the development of the Karnataka State Integrated Health policy – the first of its kind at the state level in the country. The policy was passed by the cabinet in 2003 and was based on the following six premises which are very different from both the earlier National Health Policy 2002 and the current draft National Health Policy 2015. These are

- ***Build on existing institution capacities of public, voluntary and private***
- ***Pay particular attention to filling gaps and greater equity in health and health care***
- ***Use Public health approach focusing on determinants of health***
- ***Expand beyond curative care to strengthen primary health care strategy***
- ***Encourage development of Indian and other systems of medicine***
- ***View health as a reasonable expectation of every citizen***
- ***Work within a framework of social justice.***

Education for health personnel was an important part of the policy document and the key policy recommendations were as follows:

- ***Focus not only on medical education but on all allied health professionals and ISM's***
- ***Efforts to strengthen infrastructure and functioning of existing educational institutions of all systems***
- ***Colleges to take up PHC's for training***
- ***Closer working links encouraged between the university, educational institutions and health services for mutual advantage and development***
- ***improvement in pedagogy of health science institutions***
- ***State councils such as medical, nursing, dental and pharmacy to be strengthened and rendered more effective***
- ***A coordination committee at state level to bring all different councils along with government policy makers and university representatives to address issues including negative trends and make suggestion for regulation and correctives***

5. The Karnataka Task Force linked research projects

Nine research projects and reviews were undertaken by consultants for the task force and one of these was a review of whether Karnataka State needs more medical colleges. Taking a political, economy frame work this review studied the growth; regional distribution; commercialization ; supreme court judgement and after; adequacy of teaching faculty and hospital beds; ethos of higher education; and complexity of recognization and affiliations; brain drain (internal and external); corruption in medical education; the medicine industrial complex , private practice; teaching faculty vaccines; and quality control. The report suggested four key components as an agenda for action.

- ***Ban on medical college expansion***
- ***Educational transformation – focus on process and quality***
- ***Regulation of privatization in health care and medical education***
- ***Enhancing public debate on this issues.***

The report was also released to support a public initiative to counter the gross commercialization and devaluation of medical education in Karnataka.

6. The Orissa Integrated Health Policy

In 2002, the Orissa state also invited SOCHARA and other to help evolve an Orissa vision 2010 health strategy. This policy had two specific objectives in health human power development which were :

- ***To create good quality medical and paramedical professionals in the state who would also be skilled in communications, behavioral sciences, welfare economics, equity considerations, information technology, health management and rural services.***

- ***To maintain and update skills and knowledge levels of medical and paramedical professionals on sustained basis maximizing their job satisfaction and improving the work environment for optimum performances.***

Some practical suggestions were also introduced in the document for strengthening health science education in medical, nursing, and allied health professional training.

Medical Education

- ***Comprehensive faculty development programs***
- ***Standard of teaching to be improved through adopting better teaching methods***
- ***Community based educational methods***
- ***Introducing new topics in curriculum including medical ethics, behavioural sciences, health economics, history of medicine and AYUSH, local health traditions, alternative healing, health management, health informatics.***
- ***Comprehensive continuing medical education***
- ***Care in teaching hospitals to be improved***
- ***Improve quality of research.***

Nursing Education

- ***Strengthening infrastructure for basic nursing education***
- ***Strengthening nursing services in hospitals***
- ***Strengthening community field practice areas***
- ***Strengthening continuing education***

Allied Health Professional and Health Worker training

- ***Needs assessment and resource inventory***
- ***Voluntary and private sector partnership***
- ***Strengthening training for skills up-gradation and multi-skilling.***

7. The National Rural Health Mission Task force Engagement

When the National Rural Health Mission was announced in 2004 by the newly elected UPA coalition government 10 task forces were setup including one on Medical Education with several important terms of reference. Of these the most important ones relevant to health science education innovation and the recommendations that emerged are given below:

Revamping Medical Education in the context of NRHM

- ***Medical education to be make socially oriented towards primary health care with problem based and community centric pedagogy***

- ***Introduction of following in the curriculum – communication skills; management skills; psychology, political science, anthropology, and sociology; health economics; and ethics and human rights***
- ***Inclusion of six weeks rural orientation package in MBBS curriculum including orientation to NRHM components.***
- ***Prioritizing the curriculum and enhancing skill development***
- ***Colleges to manage CHC's and PHC's to give hands on training to students***
- ***Examination system to focus on common conditions and hands on skill***
- ***Period of internship to be focused on learning methods and modalities for actual practice with evaluation at the end of it.***
- ***Creation of medical education cells for faculty development***

Feasibility of short term and alternative courses

- ***Experiments of alternative models of under graduate medical education including mfc curriculum and new community model suggested in ICHI policy report.***
- ***Three year degree course for community health practitioners to provide primary health care***
- ***Two year bridge courses for AYUSH, dentistry, nursing and pharmacy students to become community health practitioners***
- ***Special short courses in skills for public health practice including child health, OBG, Rural Surgery, Anesthesia, and radiology.***
- ***Strengthening public health training by reservation of 25% of post graduation seats (Diploma and Degree for Public Health and PSM) complemented by creation of public health cadre at state level***
- ***Training for nursing personnel including nurse practitioner courses***.

Making rural service attractive for doctors.

- **Incentives schemes,**
- **Enhance emoluments**
- **Changing age of retirement**
- **Reservation for PG seats from state public health cadre**
- **Facility for continuing medical education**
- **Provision of infrastructure**

8. **The Karnataka Knowledge Commission (Jnana Ayoga) and the Mission Group in Public Health**

In 2012, SOCHARA was invited to lead the Mission Group on Public Health of the State Knowledge Commission and its report, **Towards a Community Oriented Public Health System Development in Karnataka,** health capacity building with a focus on Public Health capacity in the state was emphasized.

Some significant developments and recommendations included in this document were:

- ***A public health charter which would include capacity building in public health***
- ***Promoting Health pluralism and health integration.***

- ***Promoting, Accountability, Transparency, decentralization and communitization***
- ***The competencies in health relevant to the Indian scenario suggested cross cutting one including system thinking and critical analysis, leaderships, socio-cultural competency, equity, lifelong learning, governance and decentralization and conflict.***

9. **Rajiv Gandhi Institute of Public Health and MPH (Hons) course**

In 2014 the Rajiv Gandhi Institute of Public Health was established as a independent unit of the Rajiv Gandhi University of Health Sciences in Karnataka. A multidisciplinary and multi sectoral advisory committee and interactive dialogue in which SOCHARA representatives were active participants led to the evolution of a MPH Honors course which for the first time is introducing a range of new content themes, and competencies that are committed to a new paradigm of health and public health. These include the following:

- Value orientation in public health with focus on equity, rights, gender, quality, and integrity.
- Socio-cultural and community health competency
- Plural health systems,
- Public Health Law with ethics and human rights
- International and global health
- Leadership and governance
- Ecological sensitivity which includes occupational health, environmental health, and climate change
- Disaster preparedness and response.

In addition there is a special module on universal health policy in keeping with the country's new commitment to universal health coverage as a Health for All goal. Many of these modules are being evolved for the first time and a new teaching learning methodologies, a period of internship, credit based competency building systems, and strong competency training in qualitative and quantitative research are the additional innovative feature of this new course which is part of a mainstream health university – making it that much more relevant and significant. (see www.rguhs.ac.in)

This new course and this bold experiment of RGUHS is probably one of the most significant examples of mainstreaming of an alternative framework for public health and indirectly for health science education as well.

SECTION- 4

EVOLVING THE COUNTERVAILING MOVEMENT IN HEALTH AND EXPLORING HEALTH SCIENCE EDUCATION AND HUMAN POWER DEVELOPMENT CONCERNS :

1. **The Independent Health Commission of India by VHAI**

The Voluntary Health Association of Indian initiated the Independent Commission on Health for India and the ICHI report for the first time presented an alternative civil society policy recommendation to the planning commission and the government including Ministry of Health and Family Welfare.

SOCHARA facilitated the chapter on Health Human Power Development and evolved a 10 point frame work of recommendations which included :

1. National Health Human Power Development Commission to initiate a process of need based and data based, integrated planning responding to health care needs rather than market expectations.
2. Medical College ban till the problem of commercialization and capitation fees is adequately monitored and controlled
3. Experiment on Alternative Medical Education Proposals with MCI giving autonomy to a few select institutions to experiment with parallel curriculum for primary health care, public health and general practice.
4. Stricter Quality Control to prevent commercial distortation and fall in standards
5. Examination Reform by introducing safe guards that prevent operation of money /political influence and encourage proper selection /orientation of examiners and prevent irresponsible ethical practices.
6. Continuing Education linked to acrreditation, service promotion and career development and also linked open university system
7. Reorientation of Post graduate education towards goals of national health policy and primary health care
8. Strengthening Public Health in India by promoting large number of new courses and innovative training experiments and the development of an All India and State Public Health Cadre
9. Promotion of Health Research in health systems and health manpower development based on ethical guidelines
10. Regulation of Private Sector through setting up a national think tank to review health care and medical education under private sector and introduce regulation to maintain standards, technical excellence, and growth within contours of national health policy
11. Health Team Training with focus on all sectors of health human power and allied health professionals and health workers focusing on community re-orientation, quality enhancement, skill development, and also health universities.
12. A strong countervailing movement initiated by Health and Development activist, consumer and people organizations, professionals and researchers; to bring health care and health science education and their right orientation high on the policy agenda of the country with focus on peoples needs and people health and not the market of medicine.

2**. The Jan Swasthya Abhiyan**

From 2000AD SOCHARA has been deeply involved with catalyzing and supporting such a countervailing movement (see item 12 above) to enhance stimulus and pressure on policy matters in the country. In 2000 AD SOCHARA participated with 18 other national networks in creating the Jan Swasthya Abhiyan (Peoples Health Movement in India) and at the first Jan Swasthya Sabha in Kolkatta in December 2000, a India People's Health Charter was evolved. This included the following demand on health human power development relevant to health science education for primary health care:

- ***A comprehensive need based human power plan for the health sector be formulated that addresses the requirement for creation of a much a larger pool of paramedical functionaries***

and basic doctors, in place of the present trend towards over production of personnel trained in super specialist.

- ***The major portions of under graduate medical education, nursing, as well as other para medical training be imparted in district level, medical care institutions, as a necessary compliment to training provided in medical and nursing colleges and other training institutions.***
- ***No more new medical colleges to be opened in the private sector. No commodification of medical education.***
- ***Steps to eliminate illegal private tuition by teachers in medical colleges.***
- ***Atleast a year of compulsory rural posting for under graduate (Medical, Nursing, Para medical) education be made mandatory without which license to practice not to be issued. Similarly three years of rural posting after post graduation be made compulsory.***

3**. The Global People's Health Movement and International People's Health University**

Following the development of the people's health movement in India, SOCHARA also participated in the first People's Health Assembly in Savar Bangladesh in December 2008, initiated by international health network and representatives from 75 countries. A Global People Charter for Health emerged at this assembly as the manifesto for a global people's health movement. The peoples charter emphasizes that 'health is a social, economic and political issue and above all a fundamental human right. It also highlights that inequality, poverty, exploitation, violence, and injustice are at the roots of ill health and the death of poor and marginalized people. It encourages people to develop their own solutions and hold accountable local authorities, national government, international governments and corporations. The charter focuses on broad based action on health as a human right; action on economic, social, and political determinants of health; action on environmental determinants; action against war, violence, conflicts and natural disaster and finally promotion of people centered health care based on the Alma Ata principles. With specific reference to health science education the PHM calls on people of the world to do the following:

- ***Support, recognizes and promote traditional and holistic healing systems andpractitioners and their integration into primary health care.***
- ***Demand changes in training of health personnel so that they become more problem oriented and practice based, understand better the impact of global issues in their communities and are encouraged to work with and respect the community and its diversities***
- ***Dymistified medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people***
- ***Demand that research in health…… is carried out in a participatory, needs based manner by accountable institutions. It should be people and public health oriented respecting universal ethical principles.***

SOCHARA had the opportunity to host the global secretariat of the People's health movement from 2003 to 2006 and during this phase a major health science education initiative was made in the setting up of an international people's health university which runs short courses for health and development professionals to understand globalization, equity, and health for all principles enshrined in the charter.

4. The WHO SEARO dialogue on the New Epidemiology

In 2004, the Ministry of Health in the country organized the first National Consultation on public health training in India at which SOCHARA was invited to present a health science education frame work emerging from a large network of community oriented institutions which could be called an alternative health sector in the country. From this presentation two interesting developments in the mainstream policy circles took place.

a) The Public Health Foundation of India was initiated and a SOCHARA representative (the author) was invited to be a member of the founding governing body representing civil society and the alternative public health sector. SOCHARA has therefore seen its presence in this multi-sector stake holder public health system development foundation as a challenging effort to keep the focus on India relevant pro people, socially sensitive and community oriented initiatives, in all its efforts in services , training, research, and advocacy. PHFI has also been encouraged to establish solidarity and engage with the ongoing debates, networks, advocacy efforts, in the country. It was hoped that this would strengthen the social and community paradigms in its framework of developing a community oriented public health system. PHFI has been quite responsive to this engagement.

b) The South East Asia Regional Office of WHO recognized the alternative public health nature of the intervention by SOCHARA, People's Health Movement, CEHAT, VHAI and others in a very significant chapter on "Partnerships" in its South East Asia Public Health Initiative document which outlined a strategic framework for strengthening Public Health Education in the region from 2004-2008.

> ***" Many alternative institutions both, organized and informal have been actively Involved in public health work as well as public health capacity building. Sometimes they have been termed as alternative sectors……***
>
> ***For example in India, the following organizations, among others have been active in public health education and training some since the 1980's and other more recently….***
>
> ***VHAI, PHM, SOCHARA, CEHAT…..***
>
> ***These organizations have become active in public health development due to dissatification with existing government owned public health institutions which also have low status for public health and increasing inequality and social exclusion.***
>
> ***A wave of community health NGO movements have taken place to try alternative experiments and action and to build capacity from communities and grassroots workers.***
>
> ***Unless the national apex institutions or schools of public health recognize these alternative sectors as strong resources and involve them in training and research, a large portion of creative energy in public health will remain untrapped ".***

WHO –SEARO has continued to engage with groups like SOCHARA and PHM (JSA) and others to Learn lessons from the evolving alternative sector and include their perspectives in programmes and initiatives to strengthen health system development and capacity building in the region. Two gatherings

of public health academics and policy makers, epidemiologists and resource persons from other disciplines in 2009 and 2010 made some important statements.

The first was a consultation on Application of Epidemiological Principles of Public Health Action (2009) and the second one was a South East Asia Regional Conference on Epidemiology (2010). Two formulations in the proceedings that followed are very significant to Health Science education development in the region and in the country.

a) The 2009 declaration notes:

"The scope and reach of epidemiology which is an integral part of public health must be expanded to include the study of the social, cultural, economic, ecological, and political determinants of health and constitute the keystone for use of evidence for development of public health policy."

b) The author was invited to give one of the two keynote plenary inputs in the conference in 2010 where a shift in public health, health policy, and even health science paradigm was suggested to evolve more effective strategies towards the Health For All goal.

Paradigm Shift

- **" A shift in focus from individual to community**
- **A shift in dimensions from physical and pathological to broader psychological, cultural, economic, political, and ecological dimensions.**
- **A shift in technology from drugs and vaccines to education and social processes.**
- **A shift in the type of services from social marketing and providing models to enabling, empowering and autonomy building processes and initiatives**
- **A shift in attitude towards people as patients and passive beneficiaries to people and communities as active participants**
- **A shift in research focus from molecular biology, pharmaco-therapeutics, and clinical epidemiology to socio-epidemiology, social determinants, health systems and health and social policy research".**

The paradigm shift is just beginning to be recognized at all levels in literature, policy formulations and reports.

SECTION – 5

THE WAY FORWARD

The previous sections have given a birds eye overview of the innovative experiments, action initiatives, training strategies, policy efforts and a range of action towards a more India relevant people oriented Health Science Education development in the country particularly in the context of the unfinished agenda and continuing challenges towards universal health coverage and the Health For All goal. In response to the bleak scenario that the convention background note has presented, on the crises in

Health Science education, health care and health policy in India, this note is the next step towards finding a consensus towards problem solving and a way forward.

Those of us who are not satisfied with situation analysis and are keen on learning from 'praxis and creative experimentation' need to learn from all these micro level, dispersed and adhoc innovation outlined below. It is important to recognize at this stage that even these described in this paper do not do adequate justice to innovation in the country.

The note has not included so many more relevant ideas and experiments including

- ***the Kottayam Experiment in Integrated medical education in the early 1970's,***
- ***the new framework of the JNU group in the Centre for Social Medicine and community health (only passing reference to the inspiration from Prof. D. Banerjee has been made)***
- ***the work of Foundation for Research in Community Health and Dr. Antia and his team on Continuing Medical Education for ANM's and Health worker training;***
- ***the community health training experiments of the ngo network in the country;***
- ***the action initiatives and training and research strategies of the Foundation for Revitilization of local health traditions to mainstream LHT's and AYUSH in health policy (now metamorphosed into University for Transdisciplinary Research)***
- ***the community health learning programme and fellowships of SOCHARA;***
- ***the Public Health Resources Network initiative ;***
- ***the NRHM oriented fellowships;***
- ***the community health orientation of nursing education;***
- ***the experiments with nurse practitioners;***
- ***the 3 years course in B.Sc Community Health and so on.***

Unless such ideas, experiments and guidelines and policy formulations are subject to a collective study, assessment, and a Health Science Education charter is evolved - based on evidence based practice - a new framework of Health Science Education will not evolve in the country. Also this has to be part of a larger systemic response to Health for All and not just Health as market development.

While a Task Force at the convention facilitated by People's Council of Education, will try and distill out from all the papers and discussions, broad principles of a new Framework for relevant Health Science Education in the country. This framework of principles will have to gradually evolve into a charter for advocacy and action.

Finally this background lists out 10 new principles drawing from all the initiatives described in the note and places it for consideration at the convention.

1. Paradigm Shift.

Health, health care, health policy and health science education must move from a bio-medical, techno-managerial paradigm to a more wholistic framework that explores the social, economic, political, cultural, and ecological determinants of Health.

2. Health as a System

Health should be seen as part of a much larger system of development and in context of social-economic, political, cultural development in the country- a sub system of a larger system not a technical or policy silo.

3. Health is not Medicine

Health must not be confused with the more limited concept of ill being with a focus on medicine, medical care, doctors, nurses, drugs, hospital and dispensaries but must be understood in its widest sense as well being at individual, family and community level, so that work, water, sanitation, environmental, education, recreation and community development must be seen as integral part of this wellbeing.

4. Value oriented health sciences.

Health, Health Systems and Health Sciences must be deeply embedded in the values of Equity, Gender, Equality, Right to Health, Integrity, Quality and Solidarity if Health for All has to become a reality in the country and health sciences and health systems development have to be part of an integrated, holistic, inclusive development strategy.

5. Plurality in Health Science.

Health, Health Systems and Health Sciences must draw upon all systems of health and healing in the country which has a rich historical and cultural heritage. Building on local health traditions and folk healing practices and the positive contribution of all the AYUSH systems, we have a unique opportunity especially in South Asia to build a truly plural Health System not dominated by an ethnocentric allopathic world view.

6. Health Science must draw from all sciences

Health sciences must include the contribution of not only the biomedical sciences but also draw from all social sciences and the humanities. It must be built on collaborative dialogue from all the sciences to build a truly multi disciplinary, multi sectoral, view point. For too long the ethical , social, cultural, economic, political, and ecological determinants and contributions to health from these sciences have been disregarded in orthodox health science education, affecting the world view of the health care system and provider.

7. Health Science education must focus on all health professions and levels within the health system.

For too long the debate, dialogue and reform efforts in Health Science Education has been dominated by the focus on medical education. It is time to focus on the whole team and HSE at all levels- Nursing, Dentistry, Pharmacy, AYUSH, allied health professionals, para-medicals, and community health workers technicians and ASHA's – all of them need a new health science paradigm shift in their development, their training, strategies, and their continuing education.

8. Health Science education must be based on Research

Health science education must be research oriented and evidence based and action research, evaluation research, and social science research on all aspects, methods, and sectors of HSE must be encouraged.

9. Health Science Education and alternative pedagogy

Health science education must shift in its pedagogy to a more problem solving approach under shift from teaching and training to learning facilitation.

10. Health Science Education and Communitization

Health science education must be linked closely to the health needs – existing and emerging of communities, families, individuals, in society with continuous interaction and feedback from patients, people and communities in a learning environment based on dialogue.

At the convention we must build on all these ten axioms and identify many more which are relevant to our quest.

HEALTH FOR ALL AS A GOAL WILL BE A REALITY ONLY WHEN HEALTH SCIENCE EDUCATION AND ITS DIRECTION, CONTENT AND OBJECTIVES BECOMES AN INTEGRAL PART OF THE HEALTH FOR ALL PHILOSOPHY. THE CONVENTION IS ONE OF MANY STEPS IN THAT DIRECTION. ARE WE READY FOR THE CHALLENGE !!!.

SECTION- 6

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