Celebrating the Health Movement Paradigm

Glad tidings help to dispel depressing thoughts. The panic caused by global financial crisis gets lightened by the news of the success of *Chandryaan Mission 1*, and the resounding victory of Barack Obama, at the US Elections marking racial equality and creating history.

Even after 62 years of Independence, healthcare continues to be inaccessible and unaffordable to people. A top-heavy, over-medicalized and over-westernized health care systerm serves an affluent minority ignoring the poor majority.

In 1981, the Indian Council of Social Science Research and the Indian Council of Medical Research formed a study group to review the health situation in India. The group prescribed a radical transformation of health and health care in India, to help the country reach the goal of Health for All (HFA) by 2000 AD. It recommended three complementary movements:

- "A mass movement to reduce poverty and spread equality and education…"
- "A mass movement to organize the poor and under-privileged to fight for their basic rights…"
- "A movement away from the counter-productive consumerist western model of health care to an alternative one based in the community..." This report was in response to the Alma Ata declaration of 1978, to which the Indian government had been a key signatory.

In December 1983, a small catalyst group of health professionals moved beyond the department of community medicine of a medical college in South India to start a study-reflection-action experiment with a dream to participate in the evolution of a health movement. This group soon became known as the Community Health Cell or CHC. Slowly from a little catalyst cell, they began a series of endeavours, to make this idea of a movement evolve in the Indian context through various collective and networking initiatives. Twenty-five years have passed and by December 2008, this group of enthusiastic health activists has grown into a dynamic force of change, inspiration and influence. Today, we have a whole range of local, national and global initiatives to which the cell has provided perspective, encouragement, support, enthusiasm and facilitation as and when required.

The creation of *Health Action* by Health Accessories For All (HAFA) as a relevant voice in the arena of health communication, from its predecessor Medical Service, the in-house journal of the Catholic Health Association of India (CHAI), was one of the initiatives influenced by this group, and all through these years CHC has remained a regular contributor to the magazine. By dedicating the December 2008 issue of *Health Action* to CHC, we would like to acknowledge this little group and its contribution.

This issue outlines step by step some of the many catalyst innovations of this group. It shares updates from the People's Health Movement (PHM) at global, national and state levels; it explores the new paradigm of health with a strong equity-rights-gender-and-social determinants-perspective; it looks at health challenges that include women's health empowerment, anti-tobacco activism, health as a human right, community monitoring, environmental and occupational health challenges, and challenge of governance. It also shares case-studies, personal journeys, stories from grassroots and policy responses at local and national levels. Every theme in this issue has been part of the CHC agenda. Every author in this special issue is linked to CHC – as team member, society member, fellow, associate, mentor or friend. We thank CHC for being a catalyst in their lives.

The year 2008 is special for global health. It is the year WHO reiterated its commitment to 'Primary Health Care - Now more than ever' through the World Health Report 2008. The WHO Commission on Social Determinants of Health published its report "Closing the gap in a generation: Health equity through action on the social determinants of health". The Global People's Health Movement released the "Health Watch 2 – An Alternative World Health Report" in partnership with Medact, Global Equity Gauge Alliance and Zed books. The Community Health Cell participated and contributed in different ways to all these significant reports. This *Health Action* issue celebrates the 25 years of this catalyst group and invites readers to promote the new health paradigm outlined by CHC through its praxis:

- From providing to enabling and empowering...
- From people as beneficiaries to people as participants...
- From individual focus to collective /community action...
- From professional control to demystification and autonomy-building...
- From health action to people's health movement...

Are we ready for this Paradigm Shift?

Rev Dr Sebastian Ousepparampil
Managing Editor

Seeking New Paradigms in Health and Health Research

An Overview of the CHC Journey 1984-2008

Dr Thelma Narayan

Evolving Ideas and Action towards a New Paradigm

The Community Health Cell (CHC) initiated in 1984 by a group of us in Bangalore started with the premise of building and strengthening a community health movement in India. This was an idea in formation that grew over the years. We chose not to establish a community health programme in a limited geographical area, but to be catalysts for community health among different sectors. We defined our community as community health and development practitioners, social activists, health workers, academics and researchers and those working in the health system. Thus it had as much diversity and complexity as most communities. The team also worked directly with both rural and urban communities.

Study, reflection and action marked the first seven years of work by the CHC team and friends. Networking and experimentation with alternative methods of teaching-learning and research were used to promote community health action with a wide range of partners. This included building links with NGOs, institutions, and national organizations in the voluntary sector such as the Medico Friends Circle (MFC), CHAI (then called the Catholic Hospital Association of India), the Christian Medical Association of India (CMAI) and the Voluntary Health Association of India (VHAI). Through collective work we hoped to strengthen the critical mass of organizations and individuals keenly interested to improve the health status of people in India, with a focus on the social majority, the poor.

This required a shift (*See Box)* from an individual-

The Paradigm Shift

Approach	Biomedical deterministic research	Participatory social/ community research
Focus	Individual	Community
Dimensions	Physical/pathological	Psycho-social, cultural, economic, political, ecological
Technology	Drugs/vaccines	Education and social processes
Type of service	Providing/ Dependence creating / Social-marketing	Enabling/empowering autonomy building
Link with people	Patient as passive beneficiary	Community as active participant
Research	Molecular biology, Pharmaco-therapeutics, Clinical Epidemiology	Socio-epidemiology, Social determinants, Health systems, Social policy

oriented curative and preventive health approach to a broader approach and resulted in the articulation of a Social Paradigm in Health. The individual person was always important but there was a need for a larger societal shift in power structures and in mechanisms of functioning for the dignity of the last person to be respected and for his/her health to be protected and promoted.

An internal-cum-external evaluation after the six-year experimental phase recommended the continuation of the work through a process of institutionalization. The Society for Community Health Awareness, Research and Action (SOCHARA) was thus registered in 1990. Another reflection evaluation in 1998 committed CHC-SOCHARA to building a broader alliance for health with a social justice perspective across sectors, and to developing teaching programmes with innovative methods so that a larger number of young professionals and activists from multi-disciplinary backgrounds could be oriented and supported to work in community health and public health.

Over the years, our understanding of the underlying health determinants deepened. Our research studies (listed later) and other involvements helped in our analysis of the health situation, leading to varied forms of public health engagement. The need for collective global action to address macro-policies that adversely affected health became clear. We, therefore, became actively involved in the International Poverty and Health Network established by WHO and in WHO meetings on health and equity. More significantly CHC-SOCHARA became very involved in preparations for the first global People's Health Assembly (PHA) held in December 2000 in Gonoshasthya Kendra, Savar, Bangladesh. This included participation in the conceptualization, planning and mobilization for the PHA in India, along with many other networks with whom links had been established over several years. Around 2500 health professionals and health and development activists were mobilized in four peoples' health trains to attend the first Indian National Health Assembly in Kolkota, in November/December 2000, where the Indian People's Health Charter evolved. *(see www.phm-india.org).* This was followed by over 250 health professionals and activists attending the first global People's Health Assembly PHA-1 in Savar, Bangladesh, in December 2000. Around 1400 people from 75 countries attended this assembly and adopted the *People's Charter for Health* which became a manifesto and a rallying document for constructive and critical health action at community and policy levels. CHC-SOCHARA continued proactive involvement in the evolving and expanding Peoples' Health Movement (PHM) in India and globally. The global PHM secretariat was hosted by CHC from 2003-2006 *(see. www.phmovement.org).* During this phase, the PHM secretariat also organized several advocacy events at the annual World Health Assemblies: the International Health Forum, at the World Social Forum at Mumbai in January 2004; the second People's Health Assembly at Cuenca, Ecuador in July 2005 and the first of many events of a new International People's Health University, linked to the global Peoples Health Movement. *(see http://www.phmovement.org/iphu/)*

Enlightened and spurred by our studies on health policy processes, organizational engagement with the state also increased in the decade 1998-2008. This focused on health policy and the strengthening of health systems using a comprehensive primary health care approach. Work has been done with the governments of Karnataka and Orissa, with the National Rural Health Mission, with WHO and with UNESCAP.

A Community Health Internship and Fellowship scheme for young professionals was launched in 2003 which continues as the Community Health Learning Programme. Links with public health educational institutions were strengthened. Since 2006, we are also trying to foster a Public Health Movement in public health education and among public health professionals. Different movements flow into the larger transformative process of social change. In April 2008, on the occasion of the silver jubilee of CHC, the Centre for Public Health and Equity (CPHE) has been established by SOCHARA to take forward the health policy and research work, along with continued support to the work of other organizations in an advisory capacity. Ground work is also being done for a Community Health Fellowship programme in Madhya Pradesh.

Engagement in Health and Health Research from a Civil Society Perspective and Base

The founding group of CHC held faculty and allied positions in the Department of Community Health in a leading medical college in South India before setting up CHC. With this academic background, we continued teaching, research and practice of Community Health through CHC but based on the social paradigm, with alternative methods and with a clear focus on contributing consciously to social change processes. Some of the major studies that we were involved with include:

- As conveners of the Medico-Friend Circle (mfc), we supported community-based studies after the Bhopal industrial disaster, taking the findings back to people.
- A two-year study of the *'Social Relevance and Community Orientation of Undergraduate Medical Education'* using multiple methods (including a literature review; feedback from young professionals; questionnaires and visits to colleges; and learning from community health projects) was conducted and followed up subsequently with the State Health University, government and some educational institutions over the years.
- CHC undertook the *golden jubilee evaluation of the Catholic Hospital Association of India (CHAI)* having 2500 health institutions spread across India then (3271 today). This was a participatory study with several components. As part of the Policy Delphi, study of future trends was done in 1991-92. A questionnaire to all members, and field visits to a 20% sample of around 400 institutions was done by forty trained investigators. Follow-up discussion meeting were held with 13 sub-groups among the membership and with regional groupings. The Association changed its name from 'hospital' to 'health association' and the Constitution was also reviewed and renewed. The bio-medical to health paradigm shift was accelerated. Community health work which had already been initiated was further strengthened by CHAI.
- A *health policy analysis of policy process and implementation factors* was undertaken as a doctoral study using the National TB programme as a case-study. This fed into our subsequent work with state governments in Karnataka, Orissa, Madhya Pradesh, and Chhattisgarh and with the federal government through the National Rural Health Mission which was launched in 2005. This also led to a two-pronged approach of strengthening the PHM and engaging with the WHO.
- CHC supported *environmental health studies* through a loose network that emerged around 2001. Team members continue to work in this area.
- A pilot study for the *health inter-network project* (HIN) was initiated by WHO.
- *Evaluation studies* were done of the *Jan Swasthya Rakshak* (Community Health Worker) programmes in Madhya Pradesh and of the *Mitanin* programme and State Health Resource Centre in Chattisgarh.
- CHC has also been a key contributor to the planning and evolution of the *Global Health Watch – I (2005)* and also a contributor to *Global Health Watch-II 2008. (http:/www.ghwatch.org).*
- *International studies* that we collaborated with included a study coordinated by WEMOS in the Netherlands on *Global Public Private Initiatives in Health.*
- Currently, we are the Asian hub for a study on *"Revitalizing Health for All – Learning from Comprehensive Primary Health Care"*. This study is supported by the Teasdale Corti project with the co-principal applicants/investigators being in the Universities of Ottawa, Canada and Western Cape, South Africa. It has a strong PHM presence of persons from the PHM Research Circle of which CHC is also a part.
- CHC members are part of the Global Forum for Health Research; the Measurement and Evidence Knowledge Network of the WHO Commission on Social Determinants of Health; the programme committee of the Bamako 2008 Global Ministerial Forum on Research for Health Development and Equity.

All the studies mentioned above were done based in the non-state civil society sector which offered a lot of freedom. Links were maintained as appropriate with government, academic institutions, NGOs and a number of individuals. What we consciously did not get into was publishing in mainstream journals by and large (though there have been some publications). We published reports for circulation locally where decisions and action were required. We have also introduced local language publications.

Enablers and Barriers to Civil Society Engagement in Health and Health Research

- Visionary, progressive, leadership in the civil service and the political establishment and in organizations provided valuable policy space for health research and its follow-up. With mutual trust and respect and contributions of time and effort from all sides a positive synergy develops. This enabling environment can be consciously built by groups who have an equity oriented, inclusive approach.
- However the sustainability of these arrangements can be fragile and short-term. Lobbies, and competing interests are always present. In environmental health research, this has led to court cases, setting up of counter expertise and other attempts to influence the policy process. However, all of this is positive as it leads to a larger public debate.

- If researchers see themselves only in their professional capacities as knowledge producers, then the studies get limited to publications and bookshelves and do not influence policy and political processes. Skills within the research teams or organizations for participatory, inter-disciplinary work, communication and engagement are required.
- An evolving system of engaged researcher's interacting and working with policy makers, practitioners, communities and civil society, transforms the knowledge production and utilization process.
- Information and communication technology when coupled with word of mouth communication at community level has been very much more productive.
- Status quo factors, a strong biomedical approach and unnecessary bureaucratic procedures are often barriers to the process of enquiry and action.
- Funding institutions and mechanisms can play a significant role in broadening the focus of health research to research for health, development and equity.
- Development of institutional capacity and human resources in research for health need to be prioritized as part of work on health and equity by all sectors including civil society. The development of civil society through public-public partnerships in the field research would help to strengthen the public health system which is essential to realize health rights.
- The provision of funds, mechanisms for professional support and legitimacy as well as institutional mechanisms to strengthen capacity and ability for sustained work by civil society-based researchers will bring in fresh perspectives from community based work.
- While qualitative research, inter-disciplinary and trans-disciplinary research, participatory action research and ethical issues in research are gaining ground, they are still relatively marginal. This needs to be reversed and balanced by pro-active policy measures. Civil society organizations can help to play a role in this.

Dialogue between Mainstream and the Alternative: The Challenge Ahead

Since 1998 in particular, CHC has begun a new journey of interacting with mainstream public health, community health and preventive and social medicine or community medicine departments to share the perspectives gathered from a wealth of interaction with public health and community health challenges in the government and non government (civil society) sectors.

The WHO- SEARO has recently made an interesting observation in its Report on Public Health Capacity-Building in the region recognizing the need for such interaction.

The challenge for CHC and CPHE, which is the new evolving jubilee unit, is to make this dialogue between the mainstream and the alternative, a creative engagement towards a new paradigm of public health and primary health care that makes 'Health for All' a reality someday. ■

(The author is Public Health Consultant, Coordinator, Centre for Public Health and Equity, and Co-initiator of Community Health Cell, Bangalore)

Partnerships with Alternative Sector

"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 1980s and others more recently:

- Network of Community Health Trainers: with inputs from many voluntary organizations, they have conducted short courses in community health development and management
- People's Health Movement
- Society for Community Health Awareness, Research and Action (SOCHARA-CHC)
- Centre for Enquiry into Health and Alternatives (CEHAT)

The list can be enriched by examples from other countries as well as with more examples from India. These organizations have become active in public health development due to dissatisfaction with the existing government-owned Public Health Institutions, usually run by conventional Preventive and Social Medicine Departments, and also having low status for public health and increasing inequity and social exclusion. A wave of community health NGO movements has taken place to try alternative experiments and actions, and to build capacity from communities and grass-roots 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 untapped."

Source: South-East Asia Public Health Initiative 2004-2008, WHO-SEARO

The Community Health Cell Journey
Step by Step
1982-2008

Dr Ravi Narayan

1982: The Seed of the Idea

The idea of a centre focusing on *Community Health* that would inspire '*enablers of health'* rather than *'providers of medicine'* was first evolved at the end of a year of travel and reflection, when two staff members from the Department of Preventive and Social Medicine of St. John's Medical College in South India traveled around the country visiting:

- A whole range of community projects that were searching for ways and means to make health and development more meaningful for people, especially the rural and urban poor….
- Alumni of the college working in small rural mission hospitals…
- Community health workers trained by the same college and working in their own project settings, and
- a whole range of health and development activists evolving alternative processes with the people.

At the end of an exciting year of travel and reflection that took them to the interiors Karnataka, Tamil Nadu, Orissa, Haryana, Gujarat, Rajasthan, Maharashtra, Madhya Pradesh and other states, an idea of an alternative space for experimentation was evolved that would provide opportunities for

- Community health-oriented efforts that would include healthy attitudes and learning from the people methodologies;
- Understanding of historical processes and overall social context in which 'health and health systems'

operate and new values and visions towards which they could move;

- Commitment to learning from field experiences (praxis) rather than just theory and
- An inculcation of participatory management techniques in planning and decision-making.

The key challenge was to build a new paradigm of health and health care moving beyond the bio-medical and techno-managerial framework that mainstream institutions in public health and community medicine had got trapped in. This new paradigm would support and build people's health and people's initiatives giving them greater autonomy over the structures and processes in society that can promote their health.

(Source: Notes on a year of travel reflection, 1982)

1983: Evolving a collective definition of Community Health

In 1983, the Department of Community Medicine, St. John's Medical College, Bangalore, hosted a dialogue between Catholic Hospital Association of India, Christian Medical Association of India, medico friend circle, Asian Community Health Action Network, International Nurses Services Agency, Indian Social Institute and other organizations to explore and evolve 'a new definition of Community Health' moving beyond its biomedical framework. The group that undertook the Bharat darshan (1982) formed the nucleus of a small team that facilitated this meeting and evolved the following working definition:

Definition of Community Health

- "Health is the total well-being of individuals, families and communities as a whole and not merely the absence of sickness. This demands an environment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as spiritual needs are met.
- 'Community Health should be understood as a *process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as a right.* Thus, it is beyond mere distribution of medicines and income-generating programmes.'
- "The present medical system with undue emphasis on curative aspects tends mainly to be a profit-oriented business. It concentrates on 'selling health' to the people and is hardly based on the real needs of the vast majority of the people in the country. The root causes of illness lie deep in social evils and imbalances to which the real answer is a political one – understood as a *process through which people are made aware of their real needs, rights, responsibilities and the available resources in and around them and get themselves organized for appropriate action…."*

Source: CHC Red Book,1986

1984: The Inception of CHC

A small team of health professionals moved beyond their medical college base to initiate a study-reflection action-experiment in community health which would try and study the evolving community health movement in the country and interact with key contributors and players to understand the dynamics of this new movement.

The experiment was designed to build the community health concept and help articulate some axioms and a framework of action by working closely and engaging with a wide range of community health action initiators in the country primarily in the non- governmental / civil society sector. It was also an attempt to build on the richness of experiences and perspective from the grass-roots and construct a collective theory and framework through praxis and participants observations.

The first year began in December 1983 itself with meetings on 'community-oriented medical education' at St. John's Medical College and on 'Rational prescribing and rational drug policy' at the Indian Institute of Science, which were organized during Dr. Zafrullah Chowdhury's visit to Bangalore in December 1983. As a pre-Alma-Ata Primary Health Care pioneer of the Gonoshasthya Kendra in Bangladesh, he was the first of many such pioneers with whom the CHC experiment established long term contacts. The CHC experiment built on the concept of taking a balloonist view of the wealth of Indian experience and not a myopic intra-cellular view of just a few projects or a few field

practice areas. In the first year itself CHC established a very close relationship with the Medico Friend Circle, Voluntary Health Association of India at national and state levels; CHAI, CMAI, ACHAN and a host of very diverse non – governmental organizations and developmental projects in Karnataka and beyond. In the first two years itself, the community health challenges explored included rational Drug Policy, Women and Children's Health, Mental Health, Bhopal Disaster, and Environmental Health. However, it was the open house and very flexible, interactive, participatory, "learning together" and "learning from field experiences" ethos of CHC that brought many field-level health and development enthusiasts and activists to the cell for hours and hours of discussion and hours and hours of working together which slowly established the credibility of the centre.

1985: Learning from the Bhopal Disaster

The Bhopal disaster was an unprecedented, occupational and environmental accident. Equally unprecedented were the imperatives for relief, rehabilitation and research. The newly evolving CHC in Bangalore had become the national secretariat of the medico friend circle in 1984 and editor/publisher of the mfc bulletin. In this capacity, CHC also facilitated the first epidemiological and socio-medical survey of the Bhopal disaster aftermath and produced three interesting publications – the survey report, the summary of the report and the people's education booklet with Eklavya entitled "Hamari Sehat, Hamari Ladai *(See Keeping Track).*

As a people-oriented community health resource centre, CHC also wearing the mfc cap, was involved in advocacy at various levels producing press releases, handouts, and organizing meetings and other forms of creative public education and mobilization for Bhopal.

In a comprehensive article in mfc bulletin (No. 12, April 1985) entitled Medical Research in Bhopal – Are we forgetting the people? CHC/mfc team in Bangalore raised the following appeal to government decision-makers, Medical College Professors, ICMR Scientists, Voluntary Agencies and others:

Challenges in responding to Bhopal Disaster

- "Need to evolve a bold, imaginative and open communication strategy to all the doctors and health workers (treating the disaster victims) who are presently starved of authentic technical/medical information hampering clinical judgment.
- Need to evolve a creative, relevant health education and awareness-building public education strategy to meet the expectations of the disaster victims and to help and reassure them through the crisis and prepare them for the eventualities.
- Need to ensure that research efforts are geared to supporting relief and rehabilitation efforts and not become esoteric exercises for institutional development and career advancement.
- Need for closer coordination between voluntary agencies, action groups, citizen committees, medical and health workers and the people oriented and socially sensitive sections of the medical profession and government authorities to ensure that the peoples' suffering are not exploited and made pawns in the games played by politicians, multinational companies, and misinformed professionals - all symptomatic of an exploitative social system…."

Source: mfc bulletin 112, April 1985

1986: The Red Book of CHC

The ***'red book'***, an informal cyclostyled collection of reflections circulated to all the groups that CHC interacted with over the first two years, attempted to articulate the new Community Health approach. This was not an easy task because in trying to understood the alternative paradigm, it was important to focus on the core commonalities of the projects and processes and not get distracted by the diversity and plurality of the nitty-gritty.

This book, the first major documentation effort, was circulated to a wide network of community health enthusiasts and action initiators in India for comments, suggestions and an invitation for interactive dialogue. The red report (as it was called because of a bright red cover) included a situational analysis of health care in India; methodological overview of the CHC team's process of reflection; a reflection of community health in India; a note on the movement dimension; an outline on the tasks for the future; and the reflection on the evolving dimensions of the community health approach. The report also listed out all the groups, initiatives and individuals CHC was in touch with; the key meetings; a reading list and additional

references and a list of materials generated by CHC in the first place. Ten axioms of the new community health approach were identified *(See Box).*

Ten Community Health Axioms

1. "Community Health is a process of enabling people to exercise collectively their responsibility to their own health and to demand health as their right.
2. The "community health" approach involves the increasing of individual, family and community autonomy over health and over the organizations, the means, the opportunities, the knowledge and the supportive structures that make health possible.
3. Community health approach includes an attempt to include health with developmental activities; orient the current medical programmes towards preventive, promotive and rehabilitative programmes, search for experimentation with low cost, effective, and appropriate technology in health care; the increasing involvement and participation of the community through formal and informal organizations in decision making; generating community support through cooperatives and informal and non-formal demystifying, and conscientising education for health.
4. Community health approach is essentially a democratic, decentralised, participatory, people building and people empowering activity and recognises that new value systems must pervade the interaction between the community and the health action initiators themselves.
5. Community health approach recognises that in the present iniquitous and stratified social systems there is no community in the real sense of the word and hence community health action will invariably mean the increasing organization involvement and participation of large sections of community who do not participate adequately in the decision making at present i.e.. the poor, the underprivileged and the marginalised.
6. Community health approach recognizes that the large majority, the poor and the disadvantaged are not themselves one community even though they are linked by their poverty and social situation. They have internalised various social cultural and religious and political differences that divide society at large and hence community health action must promote and enhance community-building.
7. The community health approach recognizes that the present over-medicalised health care system is characterized by certain features like hierarchical team functioning and non participatory decision making watertight division of responsibilities with overemphasis on the role of doctors. This must be countered by approaches that evolve new people and community oriented skills and attitudes.
8. Community health approach evolves action from the community outwards and upwards confronting the existing structure of health care to become more people oriented, more community oriented, more socio-epidemiologically oriented, more democratic and more accountable.
9. Community health approach is therefore not just a speciality, a new professional discipline, a new technology fix or a new package of actions.
10. Community health action is therefore closely intertwined with efforts to build an alternative social-political-economic-cultural system in which health can become a reality for all people".

Source: CHC Red Book,1986

1989: Medical Education Re-examined

In 1989, the medico friend circle (mfc) began the process to publish its major critique on Medical Education in India entitled *Medical Education Re-examined* in which CHC provided 3 key articles apart from editorial support. Six years earlier, the Conference on Alternative Medical Curriculum organized by the Gonoshasthya Kendra (GK), Bangladesh, in March 1983, had become the stimulus for initiating an MFC response and serious reflections on medical Education - a process which finally resulted in the Medical Education Anthology (MEA). The anthology was finally published 1992.

The first contribution was a historical review of medical education in India exploring 150 years of rhetoric and relevance. This was a background paper for the mfc annual meet in Calcutta in 1984 and published initially in the mfc bulletin *(Chapter1)*

The 1980s were a watershed period for reorientation

of Medical Education in India. From the National Health Policy of 1982, several significant initiatives emerged on the Indian scene which had relevance to medical education reform. The mfc discussions needed to be located in the wider context and environment of change. Therefore, CHC undertook a review of all these initiatives *(Chapter 14)*.

CHC felt that the 'anthology' of articles would not be taken seriously if it remained as a series of reflections by groups of radical thinkers and social activists. Therefore, an exhaustive exercise was initiated wherein ideas from all the existing articles were extracted and collated into The 'Framework of an Alternative' under the same headings and subheadings used in the MCI 1982 Guidelines. Therefore, an exhaustive exercise to collate an alternative curriculum using the MCI 1982 guidelines was undertaken *(MEA, Chapter 13)*.

The Alternative Medical Curriculum of mfc

(Some Extracts)

Preamble

- These recommendations of an alternative curriculum are designed for a 'model' or 'alternative medical college' that is seriously committing itself to producing a community-oriented, socially conscious, Primary Health Care provider, who would be competent to plan and implement health care services to meet the needs of the total population of a defined geographical area.
- The community-oriented, Primary Health Care doctor is by no means a 'basic', second rate, or low-skill doctor as is made out by the protagonists 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. Her/His specialist colleague, while certainly being necessary for delivering highly technical medical services, has the disadvantage that she/he can function only at secondary and tertiary levels with an array of infrastructural and technological and senior peer group support. This shift of emphasis is basic to the development or the community oriented doctor.

Objectives of education

The curriculum must ensure that the student of the course should at the end of the training

- be able to analyse social/societal/community realities and social processes and able to participate in change.
- be able to make a comprehensive community diagnosis of health, understanding the socioeconomic-cultural-political roots of disease.
- be able to plan and execute comprehensive health programs for a defined population.
- be able to use clinical and preventive skills to meet the needs of the people and to manage effectively all the more common diseases and health problems.
- be able to have developed managerial skills and ability to plan and integrate various programmes.
- be equipped with knowledge and skills related to health care training and supportive supervision of health team personnel.
- be able to train and supportively supervise community health volunteers.
- be able to plan and execute 'education for health' programmes for the public/community on health problems and health issues.
- be able to identify areas of relevant field research and carry out such simple community based research projects.
- be able to constantly upgrade and improve her/his knowledge and skills through continuing self education.
- be able to function effectively and find solutions to problems with whatever resources available, using her/his ingenuity, innovativeness and initiative.
- be able to work and participate in a health / development team de-emphasising his/her role as a leader from the top.
- be able to' face challenge and frustrations which will be pan of community health work and be willing to undergo a certain amount of professional/social isolation.
- be able to have an insight into non-material rewards which are more satisfying in the long run.
- be able to have internalised the multidisciplinary nature of health problems and the collective/societal nature of their solutions.

Source: Medical Education Re-examined, Chapter 13, mfc 1991

1990: Towards a Health Policy for Hospitals with a Mission

The Catholic Hospital Association of India (CHAI) — the largest network of health care institutions — reviewed its mission and evolved guidelines for its members in a challenging and changing Indian social context in the late 1980s. In 1990, the Commission for the Health Care Apostolate of the Catholic Bishop's Conference of India prepared a document on the Health Policy of the Church in India which, for the first time, went beyond the 'caring' role of health care and recognized its 'enabling' role as well. CHC team members were involved as resource persons in both these consultations and both Primary Health Care and Community Health were clearly defined, not as synonyms, but as two complementary thrusts with a district policy focus *(See box).*

Health Policy of Church in India

Primary Health Care	Community Health
Definition: Primary health care is essential health care based on practical, scientifically-sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination' – *Alma Ata Conference, 1978.*	*Definition:* Community health is a process of enabling people to exercise collectively their rights and be responsible to attain and maintain their health.
Policy: Our health care services will get involved in primary health care, particularly in the rural areas and urban slums. They can also function as referral centres, supportive of primary health care.	*Policy:* The health care apostolate goes beyond the curative and preventive aspects of health care and reaches out to the society to promote health of the people, joining with them in their efforts to attain a more just society for better health and based on gospel values.

Source: Health Policy of Church in India, CBCI, 1992

1991: A Community Health Trainers' Dialogue

The CHC brought community health trainers of the voluntary sector in India together to help build collective perspectives and enhance the 'working together' ethos of this sector quite often during its history. In 1991, all the 'Community health trainers' met for three days to discuss the draft National Education Policy for Health Sciences in an interactive participatory meeting organized by CHC in Bangalore. For the first time, a gathering of 'Community Health Trainers' working beyond mainstream institutions and focusing on challenges of community health training relevant to grassroots realities, made a thought-provoking statement of shared concern and collectivity, building the framework of an alternative paradigm of training. This is probably the only significant collective statement of trainers in the country and it represents the distilled wisdom from grassroots community health training experience.

Statement of Shared Concern and Evolving Collectivity, (Extract)

"Considering the goal of Health for All, the *policy for education for health* must

- see health as a constituent part of human development and as an integral instrument of building a just and equitable society;
- aim at building and sustaining a health system that is people-oriented, helping the people to cope with their problems in health and is also available and accessible preferentially to the poorest sector;
- strive to enable and empower them to participate in their own health care by sharing in decision making, control, financing and evaluation with regard to their choice of health system;
- be in consonance with the culture and traditional practices when these are constructive and beneficial;
- Use the resources better, with appropriate technology which serves the people….."

Source: Community Health Trainers' Dialogue, 1991

The Statement went on to identify three challenges for trainers which included integrating health and community development, exploring plurality of health systems and practices and evolving multi-level strategies of health human power development with content for all levels including ethics, values, behavioural and social sciences, management, health economics and ecology. It also outlined training strategies that were based on competence base learning, value orientation, cultural sensitivity, systems of health care and medicine, training of trainers, participatory methodology and participatory evaluation.

1992: Predicting Future Health Scenario by Health Policy Delphi

In the early 1990s, CHC used the Policy Delphi of Research to determine future trends in the Economic, Social and Political spheres that would have an impact on health and also to predict the future health scenario and the potential role and challenges of civil society sector in health, including the role of faith-based organizations. Forty panellists representing different disciplines and sectors participated in this interactive policy research exercise, and seven challenges and ten potential responses were identified in the early 1990s. A decade later, as we entered the new millennium, this Health Policy Delphi proved to be unusually prophetic and predictive. The health problems identified were: (See Box)

Policy Delphi Predictions for 2000 AD and Beyond

Health Problems

- Increasing environmental pollution and deterioration of ecology
- Increasing challenge of providing basic environmental sanitation
- Urbanization and its consequences/contribution to health of the urban poor
- Increasing importance of ethical issues in medicine and medical care
- Irrational therapeutics in the context of a growing abundance of drugs
- Increasing population growth coupled with high illiteracy and inadequate health resources
- Increasing violence in society and its consequences on social health

Health Responses

- Health care planning to meet the challenges of priorities, equity, limitation of resources, rural-urban disparities, role of technology, access, roles of different sectors - government, private and voluntary sector
- Costing and financing of health care including cost-effectiveness, self financing, affordability and managing cost escalations and commercialization.
- Human health manpower development complicated by over production and overspecialization of the wrong categories of health workers for secondary and tertiary levels.
- Rational drug policy to deal with availability, distribution and adequacy orf essential drugs side by side with the control of misuse and overuse of drugs.
- Challenges of providing basic needs and primary health care for all
- Needs, priorities and appropriate choices for secondary and tertiary health care
- Health education to promote positive health attitudes and capacities towards primary health
- Integration of medical systems, both western and indigenous.
- Research in alternative approaches, behavior and social determinants, women's health and holistic health care
- Promotion of holistic health care and positive wellness models

Source: Seeking the signs of the times, CHAI 1992

1993: Strategies for Social Relevance and Community Orientation in Medical Education

The Community Health Cell (CHC) facilitated a Medical Education survey on Strategies for social relevance and community-orientation building on Indian Experience. This included two studies: the first study was to identify socially and community-oriented initiatives in medical colleges all over the country. One hundred-and-twenty-five medical colleges were sent letters, 30 responded and around 50 initiatives were identified. Six colleges including AIIMS-New Delhi; JIPMER Pondicherry; CMC-Vellore; SJMC-Bangalore; MGIM-Sevagram; and CMC, Ludhiana, were visited and we had interactive discussion with faculty, interns and students often at the site of some of these initiatives – camps, special courses, internship postings and so on. This was then reported in a detailed publication.

The second study was a 'feedback study' undertaken with young graduates of medical colleges who had spent at least 2 years in a PHC or peripheral health institution. The study collated feedback on every subject from Anatomy to Surgery and on many additional aspects of medical education. Fifty young graduates were identified for this study from the postgraduate entrance examination centres at St. John's and CMC-Vellore and a mfc meeting in Sevagram. It was the first example of building curriculum-reform using feedback from medical graduates who had actually worked in peripheral health institution.

As the studies progressed, an annotated bibliography of all the historic and significant documents and publications identified by the study was also prepared.

A Medical Education Review Meeting was organized in July 1992 to take stock of the study findings and build a collective commitment to a Medical Education Alternative. The invited participants included Medical college faculty from 10 colleges in the country. NIMHANS, Bangalore, VHAI, CHAI, CMAI, KSSP and FRCH also participated. Dr. Zafarullah Choudhury of Gonoshasthya Kendra also attended. The proceedings of this significant meeting recorded the tasks and challenges ahead at individual, institutional and collective levels. The three publications from this study were finally printed and widely distributed in 1993. The Rajiv Gandhi University of Health Sciences used these reports extensively in the earlier years as it evolved its own vision, mission and curriculum. The National Rural Health Mission and National Knowledge Commission reports on Medical Education also referred and quoted from these reports. Many initiatives to start alternative medical education experiments, notably the Miraj experiment, the CMC Ludhiana initiative with Punjab University and others took inspiration from these reports but could not develop due to local and policy constraints.

Initiatives for Reorientation of Medical Education – I

1. Community-based orientation camps in first, third and final years
2. Reorienting pharmacology to rational therapeutics, essential drugs concept and clinical orientation
3. Community-based family care programme
4. Special training programmes in;
   - Health education, Management
   - Health Economics Epidemiology
   - Ethics Nursing
5. Rural / urban slum health visits / camps
6. Curative – preventive General Practice Unit (CPGP)
7. Training in
   - Emergency medicine Social paediatrics
   - Social obstetrics
8. ROME Scheme – mobile hospital scheme
9. Posting to government PHCs and sub-centres
10. Involvement of interns in special field situations
    - Epidemic control Disaster relief
    - Plantations NGO health and development projects
    - Immunization programme Family planning motivation
11. Internship training in specific additional skill
    - Rational drug use Management
    - Ethics Health education
    - Epidemiological projects Clinical research
12. Internship training in GOPD (General Practice Unit)

Source : Strategies for Social Relevance, CHC, 1993.

1995: Participation in the Independent Commission on Health in India

The Community Health Cell (CHC) participated in the Independent Commission on Health in India (ICHI), which was organized and facilitated by the Voluntary Health Association of India . In this process CHC was an organizational participant and contributed to a special chapter on medical education. Moving beyond the earlier research focus on

successful experiments and innovative experiences in medical education, this report studied the problems of medical education in its evolving complexity. The whole mosaic of issues including declining ethical standards, the lure of the free market economy, the lack of administrative and political will, weak regulatory bodies and forces of commercialization, privatization and over-emphasis of high-tech care were explored. A prescription for change based on seven issues and a twelve-point programme was evolved. However, the most interesting feature of the report was the twelfth point in the prescription entitled the people's health movement factor which predicted a development that took place a few years later. This prescription noted :

"For too long, the Medical Profession and the Medical Education sector have been directed by professional control and debate. It is time to recognise the role of the community, the consumer, the patient, and the people in the whole debate. Bringing Medical Service under the purview of the Consumer Protection Act has been the first of the required changes. Promoting public debate, review and scrutiny into the planning dialogue for reform or reorientation has to be the next step. This could be brought about by the involvement of people's/ consumer's representatives at all levels of the system – be it service, training or research sectors. However, all these steps can never be brought about by a top down process. *What is needed is a strong countervailing movement initiated by health and development activists, consumer and people's organisations that will bring health care and medical education and their right orientation high on the political agenda of the country."*

Prescription for change in Medical Education

- Ban on medical college expansion
- Strengthen of MCI and regulatory mechanisms
- National Health Human Power Commission
- Strengthening medical education systems reform
- Examination reform
- Establishing framework for creative autonomy and experiments
- Continuing education
- Social/community orientation of post graduate education
- Research in health human resource development
- Regulation of commercialization of medical education
- Promoting health team training strategies
- Promoting the people's health movement as a countervailing current

Source: Perspectives in Medical Education, VHAI/ ICHI, 2001

1996: Building an Appropriate Malaria Control Strategy

At the request of the Voluntary Health Association of India, CHC chaired an expert group on malaria to build an 'appropriate malaria control strategy' based on an independent civil society watch and exploration of the malaria situation India and drawing on the field experiences and perspectives of an increasing number of community health action initiators, field workers, activists, trainers, researchers and awareness-builders tackling the malaria challenge as part of their community health action programme.

The report published by VHAI presented the findings and recommendations in five sections which included (a) Socio-epidemiology of malaria, (b) Rational malaria control (c) Malaria and primary health care (d) Towards a relevant malaria policy (e) A complementary strategy and alternatives for action. The whole report was contextualized against the emerging public health crisis in India and the lessons from history of malaria control.

Towards an Appropriate Malaria Control Strategy, (Extracts)

The Public health crisis in India

"The Re-emergence of *Malaria,* as a significant Public Health problem in the country since the 1970s is leading to an urgent reappraisal of the country's public health policy and a deeper understanding of the larger `Public Health crisis'. Some elements of this crisis include:

- Socio-epidemiological imperative
- Political Economy of Health
- Challenge of Decentralization
- Threat of the new economics
- Urgent need for Right to Information
- Need to widen dialogue in planning process

Lessons from History

The history of Malaria Control in India has been a history of concerted public health action under the leadership of committed `public health' policy planners, supported by International public health cooperation. At this juncture, it is important to review the past and draw out certain lessons for the future which include:

- Recognizing the potential of Sustained Public Health Action
- Need for competence in a diversity of approaches
- Need for a synergy between the political and public health leadership in the country
- Need for solutions to emerge in response to local realities and constraints
- Need to recognize the 'economic advantages' of national health programmes'
- Need to recognize key factors that have proved to be significant to the malaria situation in the past"

Source: Towards an Appropriate Malaria Control Strategy, VHAI/ SOCHARA,1997

1998: Understanding the Health Policy Process

From 1994 -1998, a research team from CHC/SOCHARA undertook a comprehensive public health policy review using the national tuberculosis programme as a case-study. This doctoral thesis used both qualitative and quantitative methods and included in-depth interviews with 90 TB patients and 211 persons from different levels, of the health care systems and society, besides field visits to health institutions at different levels. The study explored the problem of tuberculosis at different levels of analysis highlighting also the shift from a biomedical paradigm to a social paradigm.

"TB control programmes conventionally frame the problem within epidemiological, biomedical and public health-based programmatic parameters, including case-finding, case-holding, default, relapse and treatment failure. Beneath these useful articulations lie conflictual societal relations and interests from local to global levels, which become apparent in decision-making, sectoral action, non-action and shades of implementation. However, societal and political economy issues which critically affect health policy processes including TB control receive inadequate policy attention, adding an additional layer to an already complex problem. These factors are not simple or static; the strength of the dominant paradigms and the power or (perceived) powerlessness of various actors (policy makers, implementers and patients) influence the understanding of the problem and the choice of solutions".

Different types of causal understanding can lead to different strategic approaches to intervention, with the recognition that a broader number of allies need to work together to address this major problem. *(See Table).*

This doctoral thesis was the beginning of a new perspective in CHC journey and the whole trend towards the engagement with state policy and the social determinants of health which became the hallmark of CHC initiatives since 1999, could be linked to the inspiration from this thesis. As we understood the deeper causes of ill health we strengthened our relationships and networking efforts with all those groups in civil society addressing those challenges. The broad coalition that emerged as the peoples health movement in India was alleast one of many effects of this study and its findings.

Table: Tuberculosis and Society-Levels of Analysis and Solutions

Levels of analysis of tuberculosis	**Causal understanding of tuberculosis**	**Solutions/control strategies for tuberculosis**
Surface phenomenon (medical and public health problem)	Infectious disease/ germ theory	BCG, case-finding and domiciliary chemotherapy
Immediate cause	Under-nutrition/ low resistance, poor housing, low income/ poor purchasing capacity	Development and welfare – income-generation/housing
Underlying cause (symptom of inequitable relations)	Poverty / deprivation, unequal access to resources	Land reforms, social movements towards a more egalitarian society
Basic cause (international problem)	Contraindications and inequalities in socio-economic and political systems at international, national and local levels	More just international relations, trade relations etc.

Source: A study of Policy Process and Implementation of NTCP in India, Doctoral thesis LSHTM, Narayan , T. 1998

1999: Towards a Poverty Agenda for Health and Development

A South Asian Dialogue on Poverty and Health was organized by CHC in collaboration with the Advisory Group of the International Poverty and Health Network and the Health in Sustainable Development Cluster of the World Health Organisation, Geneva from 15th – 18th November, 1999 at The National Institute of Advanced Studies, Bangalore (India). The dialogue was attended by 48 participants of whom 33 came from the South Asian Region including Bangladesh, India, Maldives, Nepal, Pakistan, Sri Lanka and National or Regional Networks. As an expression of global solidarity, 15 came from other countries like Kenya, Congo, France, United Kingdom, Peru, USA and International agencies including WHO-Geneva.

The 3 – day dialogue consisted of sessions on the following themes : Orientation to Dialogue and Group Inventory on expectations and issues; Global, Regional and National Concerns impacting on Poverty and Health; Health and Poverty Eradication :- Perspectives of the World Bank and WHO; Health and Poverty Eradication : Action Initiatives and Strategies – local, national, government and NGO; Policy Issues for Equity in Health and Poverty Eradication; Experiences from the South and the North; Action Plan – 2000 AD and beyond.

The 3-day dialogue was also interspersed with small group-discussions on the following themes : Socio-Economic Deprivation and Ill health; Ill health leading to Poverty; Feminization of Poverty; Globalisation and Health; Poverty, Ecology and Health; Disaster, Poverty and Health; Strategies at Local/Community level; Strategies at National Level; Strategies for SAARC Region; Strategies for WHO/IPHN; Strategies for International Donor Agencies.

Finally, by the end of the intense dialogue – both through small group level and plenaries, a statement of shared concern and collective commitment emerged which addressed the Poverty and Health agenda locating it in the context of integrated development *(See box).*

Statement of shared concerns and commitments of the South Asian Dialogue on Poverty, Health and Development (Extracts)

We are concerned with

- The deepening social and economic inequalities between and within countries and peoples;
- The adverse consequences thereof on health across the globe;
- The nature and direction of change in health services and health policy;
- The major policy shifts in diverse sectors impacting on health such as agriculture and industry;
- The broad policies of globalization, economic liberalization and privatization under the aegis of international financial institutions which are weakening state commitment to the health and development of large sections of the people who are poor;
- The health sector reforms comprising a package of programmes involving cutbacks in public sector health expenditure and strengthening of vertical donor driven programmes which have considerably eroded the reach and effectiveness of already weak public health systems;
- The unregulated growth of the private sector which has undermined poor people's access to health care services and exacerbated regional, class and gender inequities;
- Widely prevalent hunger and a heavy burden of preventable communicable diseases, trafficking of women and children and growing sex tourism;
- Increasing military expenditure for internal and external conflicts, and nuclearisation in the region which have all meant a neglect of the social security sector;
- Increasing loss of traditional knowledge bases, skills, values and culture;
- Pauperisation of indigenous peoples and women, and environmental deterioration;

We recognise

- The strength and potential of poor people themselves, especially women, who through community based effort, peoples movements and local governance systems address these problems;
- The positive role played by the state including its public health interventions in improving health status of the people;
- The solidarity among different global,regional, national and local networks for health and development.

We declare our commitment to

- Tackling basic determinants of ill health and underdevelopment
- Tackling ill health with a focus on the marginalized
- Building empowerment strategies
- Promoting sustainable development
- Promoting good governance

Finally we conclude that

- Health is a fundamental human right and an integral part of human development;
- The corner stones of all our efforts towards health for all must include the values of equity, social justice, empowerment ,humane governance;
- We shall work towards a movement for removing ill health and eradicating poverty which will address efforts at local -national, regional and global level tackling the broader determinants of ill health and the inequitous global systems so that they can be changed to support the health for all goal.

Source: Proceedings of South Asian Poverty and Health Dialogue, IPHN , Bangalore Nov 1999

Many key participants of this CHC facilitated dialogue, participated a year later in the first People's Health Assembly at Savar, Bangladesh and there is some some striking convergence between this consensus document and the People Charter for Health.

2000: The People's Charter for Health — India and Global

Soon after the IPHN Dialogue, CHC-SOCHARA became very involved in preparations for the first global People's Health Assembly (PHA) held in December 2000 in Gonoshasthya Kendra, Savar, Bangladesh. This included participation in the conceptualization, planning and mobilization for the People's Health Assembly in India, along with 18 other networks with whom links had been established over several years. After an initial mobilisation at state level with five little booklets prepared for public education and district and state level meetings and kalajathas , around 2500 health professionals and health and development activists were mobilized in four people's health trains to attend the first Indian National Health Assembly (NHA 1) in Kolkota, in November/ December 2000, where the the Indian People's Health Charter evolved. *(see www.phm-india.org).*

This was followed by over 300 health professionals and activists from India attending the first Global People's Health Assembly. (PHA-1) in Savar, Bangladesh in December 2000. Around 1400 people from 75 countries attended this assembly and adopted the People's Charter for Health which became a global manifesto and a rallying document for constructive and critical health action at community and policy levels. *(see. www.phmovement.org)*

Indian People's Health Charter- 2000 (Extracts)

"We assert our right to take control of our health in our own hands and for this the right to:

- A truly decentralized system of local governance vested with adequate power and responsibilities, provided with adequate finances and responsibility for local level planning
- A sustainable system of agriculture based on the principle of land to the tiller – both men and women – equitable distribution of land and water, linked to a decentralized public distribution system that ensures that no one goes hungry
- Universal access to education, adequate and safe drinking water, and housing and sanitation facilities
- A dignified and sustainable livelihood
- A clean and sustainable environment
- A drug industry geared to producing epidemiological essential drugs at affordable cost
- A health care system which is gender-sensitive and responsive to the people's needs and whose control is vested in people's hands and not based on market-defined concept of health care. . . . "

For the complete charter visit: http://www.communityhealth.in

2001: Participating in the Karnataka Task Force on Health and Family Welfare

The Community Health Cell (CHC) had the unique experience of participating actively as a key resource-group in primary health care and public health in the Task Force on Health and Family Welfare set up by the Karnataka Government in 2000 which finally reported in 2001. The participation of CHC included the following:

- Three members from CHC /SOCHARA were on Task Force including Dr. H. Sudarshan (Chairman), Dr. Thelma Narayan and Dr. C.M. Francis.
- The CHC was an informal resource centre providing policy evidence and perspectives and much of the background material from our library and documentation centre.
- The CHC/ SOCHARA undertook some of the policy research studies that supported the task force process on themes which included study on externally-aided projects and integration/sustainability in health service delivery, regional disparities in health, health training and promotion and medical education.
- CHC also supported the development of the final report, especially 3 key chapters including issues of concern and agenda for action, Draft State Integrated Health policy and Karnataka Vision 2020.

The final report had a strong focus on primary health care and public health and was significantly titled –

'Towards Equity, Quality and Integrity in Health' and became a major inspiration for similar processes in other states and at the national level as well. The Chapter on Issues of Concern was particularly significant since for the first time in a public policy report on health the issue of corruption was mentioned as of foremost importance.*(See Box)*

Issues of Concern and an Agenda for Action

" There are some major concerns and cross-cutting themes that affect all aspects and sectors of health care. These need to be tackled on an urgent and sustained manner through what we have suggested as an Agenda for Action. Many of these factors are not specific to the health care systems itself they are also problems of the larger society within which our efforts in health care are located. Therefore they impinge and distort our efforts to evolve a health care system that is committed to equity, quality and integrity with a special focus on primary health care and public health. We need to tackle them seriously.

- Corruption
- Distortions in primary health care
- Implementation gap
- Human resource development neglected
- From exclusivism to partnership
- Health research
- Neglect of public health
- Lack of focus on equity
- The ethical imperative
- Cultural gap and medical pluralism
- Ignoring the political economy of health
- Countering the growing apathy in health

Source: Report of Task Force on Health and Family Welfare, Karnataka

2002: Towards an Integrated State Health Policy

The most important outcome in the process of engagement with the Karnataka Government Task Force on Health and Family Welfare for CHC was the opportunity to facilitate the evolution of an Integrated State Health Policy which was committed to the principles of Primary Health Care and Public Health. It was probably the first time that a health policy in India and that too at state level was committing itself so strongly and confidently to the principles of the Alma Ata declaration and endorsing the need for strengthening public health systems and inter-sectoral development moving away from the verticalization and selectivization of public health and primary health care policy. The policy also was rooted in the challenges of equity, gender, and social determinants of health *(See Boxes).* The process of health policy evolution was facilitated through a stake-holder consultation and then finalized by a cabinet decision so that it became a definitive framework of state policy beyond specific phases of governance and hence a more sustainable process in the long run. Both the task force document and the state policy became forerunners of various similar policy initiatives in other states and at the National level itself. The Orissa state integrated health policy also evolved in a somewhat similar process and CHC was also involved with it.

The Karnataka State Integrated Health Policy (Extracts -I)

Principles

The State Health Policy would be based on the following premises:

- It will build on the existing institutional capacities of the public, voluntary and private health sectors.
- It will pay particular attention to filling up gaps and will move towards greater equity in health and health care, within a reasonable time frame.
- It will use a public health approach, focusing on determinants of health such as food and nutrition, safe water, sanitation, housing and education.
- It will expand beyond a focus on curative care and further strengthen the primary health care strategy.
- It will encourage the development of Indian and other systems of medicines.
- It views health as a reasonable expectation of every citizen and will work within a framework of social justice.

Perspectives and goals

- To provide integrated and comprehensive primary health care
- To establish a credible and sustainable referral system
- To establish equity in delivery of quality health care
- To encourage greater public private partnership in provision of quality health care in order to better serve the underserved areas
- To address emerging issues in public health
- To strengthen health infrastructure
- To develop health human resources
- To improve the access to safe and quality drugs at affordable prices
- To increase access to systems of alternative medicine

The Karnataka State Integrated Health Policy (Extracts -II)

Public health approach and primary health care strategies

Public health and primary health care work in synergy, particularly emphasizing principles of:

- Inter-sectoral coordination at all levels, especially at the district and below;
- Community participation through Panchayati Raj institutions and other mechanisms and fora for involvement in decision making concerning their own health care;
- Equitable distribution of good quality care;
- Use of appropriate technology for health ……..

…..The Primary health care strategy does not focus only on the primary level of care, but also on the secondary and tertiary levels. Public health recognizes and attempts to address the socio-cultural, socioeconomic and demographic factors that affect health status and implementation of health programmes….."

Source: Karnataka State Integrated Health Policy- 1983

2003: Community Health Fellowship Scheme – Building the Next Generation

The Community Health Cell (CHC) since its inception had been providing support to different kinds of enthusiasts ranging from young medical interns, non-resident Indians in the middle of their careers, medicos who were keen to explore community-based experiences and approaches in health care and/or alternative paradigms before opting for careers either in clinical or community settings. Some of these support-seekers were planning for postgraduate courses in public health as well.

The support had been quite informal, ranging from use of library and documentation resources to involvement in CHC meetings, workshops and other activities. Some had long interactive discussions in order to settle anxieties and carrier options. CHC arranged project visits, meeting peers by interning them for some period of time on informal basis by finding funds through its own resources. However, it always perceived human resource development as a very important aspect of their work. The genesis of Community Health Fellowship Scheme (CHFS) also lies in this unplanned yet important engagement of CHC with different categories of persons looking for associations for a defined time to evolve perspectives and find new objectives in community health. The year 2003 was an important milestone for CHC with the establishment of the formal community health fellowship scheme. The objective of the CHFS was to promote careers in community health by offering a semi-structured, flexible, creative placement opportunity through CHC in partnership with select community health projects in different parts of India.

It was envisioned that flexibility will provide for the individual needs and pace of the fellows. First task of the fellowship would be to focus on strengthening motivation, interest and commitment of persons to community health. This was planned to be done through involvement of affective domain, self learning with sharpening of analytical skills and deepening the overall understanding of the societal paradigm of community health. In 2006, the Fellowship Scheme was evaluated and a second phase entitled Community Health Learning Programme (CHLP) was started in 2008.

(For further details, read Naveen Thomas's reflections later in this issue and also visit www. sochara.org)

2004: The Mumbai Declaration

Since 2001, the annual World Social Forum (WSF) as a counter current to the World Economic Forum, began to be held, bringing together civil society and social movements to explore and celebrate alternative socio-economic and cultural perspectives in the belief that the present economic order was affecting the unity, diversity and equity of the globe. From 2002, an International Forum for the Defence of the People's Health began to be organized as a pre-forum event at each of the social fora. In 2002 and 2003, at the WSF at Porto-Alegre, Brazil, the Global People's Health Movement participated in the forum and endorsed the evolving declarations. However, from January 2003, CHC began to host the Global PHM Secretariat on behalf of the movement in India and so became the key organizer of the International Forum for the Defence of the People's Health at the World Social Forum, when it was hosted in Mumbai in January 2004. Over 700 delegates from 44 countries were present who evolved the Mumbai Declaration

(See Box). The highlight was a delegation from the WHO,Geneva, symbolizing the new profile of the movement and its capacity to engage and impact on health policy dialogue and debate at international level.

The Mumbai Declaration, 2004 (Extracts)

The International Forum for the Defense of the People's Health recognised the particular discrimination suffered by many groups which makes achieving Health for All even more difficult. These included women, people with disabilities, sex workers, children living in difficult circumstances (including street children), migrant workers, Dalit people, Indigenous peoples in rich and poor countries, and all those affected by wars, disasters and conflicts.

The Forum demanded Health for All, Now! and reiterated that Another World in which health is a reality for All is necessary and possible.

The Forum brought together all the concerns and experiences shared into a Declaration for action, entitled "The Mumbai Declaration". This Declaration is an update on the state of people's health across the globe at the beginning of 2004 and calls on the People's Health Movement, Civil Society and Governments to evolve action in six key areas to achieve the goal of "Health for All Now!" dream.

- End corporate-led globalization
- End War and Occupation
- Implement Comprehensive and Sustainable Primary Health Care
- Confront the HIV/AIDS epidemic with Primary Health Care and Health Systems approach
- Reverse environmental damage caused by unsustainable development strategies
- End Discrimination in the Right to Health.....

Source: The Mumbai Declaration , PHM , 2004

2005: The Second People's Health Assembly and the Cuenca Declaration

During the phase when CHC was hosting the global secretariat of the People's Health Movement, many significant developments took place. Of these, the most significant was the second 'People's Health Assembly' (PHA2) which was hosted in Cuenca and led to evolution of the Cuenca Declaration which became an updated manifesto of the Global's People's Health Movement incorporating the newer challenges and responses to developments on the International health scene since 2000 AD.*(See Box)*

The Cuenca Declaration, 2005 (Extracts)

Preamble

Overwhelmingly we reaffirmed the continuing importance of the *People's Charter for Health (2000)* and saw it as a rallying document for the ongoing struggles of the *People's Health Movement* globally and within countries.

The vision endorsed at PHA2 is for a socially and economically just world in which peace prevails; a world in which all people, whatever their social and economic condition, gender, cultural identity and ability, are respected, are able to claim their right to health and celebrate life, nature, and diversity...

.....Establish the Right to health in an era of hegemonic globalization

For full text, see www.communityhealth.in

2006: Traditional Medicine and Right to Health for All

Integration of Alternative Systems of Medicine with Primary Health Care and Public Health Systems has been a major interest and commitment of CHC all these years. In 2006, CHC was the key facilitating organization for a South Asian Regional Conference on Traditional Medicine and how it could contribute to the Health for All movement. This conference was organized by AIFO, Italy, in collaboration with other Itlaian organizations and the International People's Health

University of the PHM with technical collaboration from World Health Organization's, SEARO office. Delegates from Bangladesh, Bhutan, India , Nepal and Srilanka gathered in Bangalore for an intensive review and sharing of experience leading to a significant concensus statement and call for action *(See Box)*

Consensus Statement of the South Asian Regional Conference on Traditional Medicine and Right to Health for All (Extracts)

"…..Traditional knowledge systems of which Traditional healing and health systems are a part, are organic expression of the cultural diversity and of the land, forests, language and life of communities. Traditional knowledge has evolved in specific contexts and needs to be appreciated in the light of its own world view. Traditional knowledge includes both the codified and the uncodified systems of healing.

Historically indigenous communities all over the world have been systematically destroyed by the designs of colonization. This has been accompanied by a process of devaluing their cultures and knowledge systems.

Vision

We reiterate the vision set out in the People's Health Charter for, "Equity, ecolgically-sustainable development and peace" and, "a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives."……..

Traditional Systems and Health for All

The contribution of the Traditional systems to Health for All should not be conceptualized only from the perspective of a therapeutic alternative, or their healers merely as human resources to universalize western bio-medical interventions focused on disease.

It is their holistic conceptualization of health and healing, with the emphasis on harmony and the conceptualization of health as a dynamic balance, their respect for the environment and for fellow humans and their respect of the laws of nature rather than the laws of the market that make these systems important for the achievement of Health for All.

Source: South Asian Regional Conference on Traditional Medicine, 2006 , www.aifo.it

2007 - Promoting the Right to Health

From 2007, CHC, as it enters the next phase of its development, has began training on the right to health in both English and Kannada as its contribution to the Right to Health Movement. CHC's efforts are being streamlined in joining the advocacy efforts towards establishing Health as a fundamental Human Right under the institutional Human Rights framework and under the constitutional framework of India. This has included,

- National Training on "Health as Human Right"
- State level training on " Health as Human Right"
- Right to Primary Health care campaign
- Building activists for the Right to Health Movement.

The conceptual framework of "Health" and "Human rights"

- The role of state in ensuring health and improving health equity among its citizens (in reference to the constitutional law of India and International commitments).
- Understanding the political economy of health including: neo-liberal economic order and the effects of liberalization, privatization and globalization on health of people particularly on health equity among populations.
- State health policy and programmes.
- Health systems.
- Access to essential medicines and health.
- Understanding the social paradigm/social determinants of health.

Source : HHR section, CHC Annual Report 2007

2008 The Silver Jubilee Year Begins…..

It is 25 years since CHC began as an idea and evolved gradually in to a cell promoting community health action through civil society and government initiative and evolving educational strategies, community-oriented research initiatives and engaging with the public health system and health policy development at local, state, national, regional and international levels. During this journey the small cell has grown into one of many hubs of a growing national and global movement and the journey has been very exciting and challenging. As we move beyond the bio-medical and techno-managerial paradigm to a new model of health in the social/ community paradigm, CHC discovered the challenges of equity, rights, gender, and social determinants. Its partners move beyond the health professionals to other sectors and disciplines and to people's campaigns and movements. All through these years, step by step as described above CHC has sought to bring health and development activists from diverse backgrounds and sectors to a joint commitment to collective action symbolized by declarations, calls for action, and collective initiatives including campaigns and movements. As we look back over the years and look around us drawing inspiration from so many who have journeyed before us, those who have been fellow travellers and those who have caught the infection of community health from us and are now moving on to new challenges, it is a time to pause, reflect, learn and celebrate together as an important milestone is reached and a renewed journey begins... ■

(Dr.Deepak Kumaraswamy- Research Assisstant, Centre for Public Health and Equity,Bangalore. Mr.Mathew Alex, Secretary, Centre for Public Health and Equity, Bangalore helped Ravi Narayan in doing this write-up)

Keeping Track of Important Resources in Community Health

Dr. Vinay Viswanatha

1. ***Community Health: Search For A People-Oriented paradigm- Video***

(Part I and II) (English, 51 minutes)

These videos (Part I and II) are meant to be used during Community Health Training programmes to help participants understand the concept of community health from the experiential sharing of experts from various parts of the country, who have been engaged in community health activities for the past several years.

Price of VHS cassette:Rs.400/- (Postage Rs.50/- extra). Available at Health Accessories for All (HAFA),157/6, Staff Road, Gunrock Enclave, Secuderabad,500009,AP, Phone: 040-2848457,27848293.Email:chai@pol.net.in

2. ***Health for All now! The People's Health Source Book***

Authored and Published by: The National Coordination Committee of Jan Swasthya Abhiyan (People's Health Movement-India)

The People's Health Source Book is a compilation of five booklets on the situational analysis of Indian and global health sector scenario in the context of globalization and a searing critique of the global and national health and development policy trends.The book is a popular education material with cartoons to understand community health and public health.

The titles of the five booklets are:

a. What globalisation means for People's Health?
b. Whatever happened to Health for All by 2000 AD?
c. Making life worth living! (Basic Needs and Intersectoral issues)
d. A world where we matter! (Health of marginalized groups)
e. Confronting commercialization of health care!

Price:Rs 150/-(Postage charges extra). Available at AID-India, 242, Avvai Shanmugam Salai, Gopalapuram, Chennai 600 086, India. Ph: +91 44 28115058,28350403. Email:aidindia@vsnl.net.

3. ***Health for All NOW! Revive Alma Ata***

Compiled and edited by Narayan R. & Unnikrishnan P.V. Published by : Books for Change, Bangalore.

This book is a collection of research articles, statements, reflections and a critique of global and national health policies and practices with reference to Alma Ata Decaration of 'Health for All by 200 AD'. This book was released on the eve of the 25th Anniversary of Alma Ata declaration to celebrate '(Comprehensive) Primary Healh Care' and an effort towards revitalizing the goal of Haelth for All as an important agenda internationally and nationally across the world.

Ful Text is available at http://ww.phmovement.org/

If you are interested in ordering copies, please write to secretariat@phmovement.org.

Price: Rs. 50/-(Postage charges extra)

4. ***Jaaarogya Kalaajaatha:*** A booklet in Kannada of the songs and street plays of the health movement)

Compiled by: Janaarogya Andolana- Karnataka (JAAK)

This is a collection of 24 songs and 11 short plays in Kannada, all of which are related to health and related issues that are designed to mobilize people for health action with a spirit of solidarity. These songs and street plays have been extensively used in Karnataka for building People's Health Movement and spreading the word across the state.

Price : Free (Postage charges extra). Available at JAAK Secretariat, C/o Community Health Cell, 359, Srinivasa Nilaya, Jakkasandra 1st Main, 1st Block, Koramangala, Bangalore, Karnataka, India 560034.

Ph: +91 80 2331518 Email: jaaksecretariat@gmail.com

5. ***Arogyada Hakku*** **–** CD/Cassette - 57 minutes with Booklet of Health Songs in Kannada,

Producer: Janaarogya Andolana -Karnataka (JAAK)

This is a collection of 14 songs in Kannada related to health issues and people's right to health. These songs have been extensively used in Karnataka for building People's Health Movement and spreading the word across the state.

Price: Cassette: Rs 30/- CD : Rs 50/- (Postage charges extra). Available at JAAK Secretariat, C/o Community Health Cell, 359, Srinivasa Nilaya, Jakkasandra 1st Main, 1st Block, Koramangala, Bangalore, Karnataka, India 560034.Phone:+91802331518

Email: jaaksecretariat@gmail.com. ■

(A former community health fellow of CHC, he is currently working as Research and Training Officer at CHC)

Health as a Social Movement

Right to Primary Healthcare Campaign: Jana Arogya Andolana Karnataka (JAAK)

E Premdas

The Karnataka Chapter of People's Health Movement known as Jana Arogya Andolana Karnataka (JAAK) has raised the issue of revitalizing health systems and people's participation in the process, from its inception in the year 2000, when CHC, BGVS and other networks came together to form the JAAK. The Movement strongly emphasizes that Health has to go beyond service delivery shown as a goodwill gesture by some NGOs or charity organizations, and that it has to be the right of people who also have to own up the responsibility in the process. There have been three state health assemblies in Karnataka in the year 2000, 2005 and 2007. A huge number of health awareness materials was generated and workshops conducted to put the Right to health issue onto the agenda of social movements and voluntary organizations.

Intensive efforts have been galvanized since 2006 to take the 'Right to Primary Health Care Campaign' with specific focus on revitalizing Primary Health Centres. JAAK in the past two years has invested time and resources in intensive training to build activists of health rights in 18 districts of the state as an effort to strengthen the movement at all levels. The District Forums of JAAK have become active in organizing and leading many processes.

Training of activists on health as human right

Following are some of the strategies adopted and events that happened in consolidating the processes of health movement in Karnataka.

Right to Primary Health Campaign

- *Health Awareness Materials:* Realizing the need that many grass-roots level activists and organizations needed to know more about the public health system, the entitlements therein, and its way of functioning JAAK developed print and audio-visual materials on health rights. There were a number of handouts, reading materials, CD and audio cassette on the right to health songs and a documentary on the campaign done in Belgaum District of Karnataka with the leadership of JAGRUTHI, a voluntary organization.
- *District-level workshops and trainings:* This was a key strategy adopted to ensure both spread and depth to JAAK's work in the state. A two-day training and workshop at the district level involved an in-depth understanding of the concepts of health rights, and entitlements and the realization of rights is possible only in the public health system. The training also involved an understanding of the public health system and the services available at various levels and the

newly initiated NRHM and its components. The training concluded with an action plan by the participants where many decided to visit as many PHCs in their districts to know more about their current status and to mobilize people around getting PHCs to function and be answerable to people. These workshops also helped people working in other development sectors to integrate health rights issues into their work. These workshops have been completed in 7 districts where on an average 40 activists from various organizations participated.

✸ *State capacity-building workshop*: As part of the continued strategy to build perspective of the health activists, state workshops have been held where participants from various districts participated and developed district-level plans to address health rights issues.

Health Rights Demand Day – in districts of Karnataka

The district-level workshops and trainings culminated in a major campaign to revitalize primary health care in the state. People's anger at the state of the public health system, particularly in rural areas, and the government's apathy became a rallying point for people to come together. They themselves undertook a survey of 93 PHCs from 12 districts in the state that revealed:

- Severe staff shortage in all categories –doctors, nurses, male health workers, ANMs, block health educators and others
- Shortage of essential medicines and equipment
- Lack of basic amenities –toilets, electricity, drinking and running water, beds and dilapidated buildings
- Irrational geographic distribution of PHCs – where villages close to a PHC were assigned to another PHC which in some cases was as far as 50 km away
- Last but not the least, rampant corruption.

These findings galvanized people into action to save the seriously ailing health system. They:

- took delegations to the District Health Officers
- used Right to Information Act to get adequate information on the functioning of the health system and to pressurize the system to function
- carried out signature & letter campaigns and flooded the health directorate with complaints through post, email and fax
- held constant dialogue with the local health authorities and Panchayat members
- held press conferences and public protests

Two Major coordinated events of the campaign to demand health: The Right to Primary Health Care campaign saw the fire catching up in the districts and led to large-scale state-wide mobilization of people culminating in the health rights demand day that was organized simultaneously across 12 districts on 1st February , 2007 and in 17 districts on 29th October, 2007.

Health Rights Demand Day, *February 1, 2007*. About 3000 people across 12 districts held rallies, addressed press conferences, submitted memoranda to the CEO of the ZP and the DHOs. The DHOs were asked to give answer to the problems in a time-bound manner. Right to Information (RTI) was used to follow up on the memorandum. The memoranda included among others addressing the issues of staff vacancies, inadequate supply of essential medicines, repair of the building and providing of basic facilities like toilets, drinking water, maintaining cleanliness, and electricity. This was the first ever large-scale effort to bring the agenda of health rights for public discussion and debate. It also came at a time when there was no sign of NRHM in the state even though it was two years since its official launch in the country. Many issues such as toilets, repair of buildings, and cleanliness of the PHC started improving though not to the desired extent.

Health Rights Demand Day - October 29, 2007: Buoyed by the building up of the momentum, *on* October 29th 2007, more than 6000 people from 17 districts took to the streets at the same time to claim their right to health and to protest against a corrupt, inefficient and apathetic public health system in the state. This second major public mobilization saw that the participation had not only doubled but had drawn many social movements and newer networks like sexual minority groups, Dalit

women, persons with disability, groups working on child labour and bonded labour indicating JAAK's concerted action and growing strength. They demanded:

- Recruitment of and equitable distribution of health staff in rural areas
- Increased budgetary allocations for buying drugs and providing diagnostic facilities and improving basic infrastructure
- Operationalizing 24 x 7 PHCs
- Regulation of private health care sector, stopping privatization of government health services
- Ending corruption in public health system
- Providing adequate housing and facilities to government health staff
- Making public system more accessible and responsive to the needs of people living with disability and HIV/AIDS
- Effective implementation of NRHM

Electoral Advocacy

Prior to the state elections in May 2008, JAAK developed a Policy Brief detailing the poor health status of the people of Karnataka, deficiencies in the public health system and a long list of failed promises. The health policy brief was discussed and debated by the JAAK at a state-level meeting that was held in April, 2008. At the state as well as district levels, JAAK representatives met many contestants in an effort to get them to put health on their electoral agenda. The leaders of major political parties were contacted by JAAK and were given the policy brief educating and asking them to include health rights in their party manifestos. The policy brief in Kannada and English was widely quoted and circulated in the press.

The policy brief and the electoral advocacy has had a substantial impact in Karnataka for the first time as the issues raised in the policy brief were discussed in the state legislature; especially, the issue of the vacancy of 4,480 ANMs was seriously debated. Subsequently the government has taken steps to fill in these vacancies, has proposed 150 ambulances for rural emergency services and is working towards upgrading PHCs and CHCs in the state. However, serious shortages of staff, essential medicines and equipment continue.

Meeting with the Lokayukta

Roping in Lokayukta to Address the Issue of Administrative Reforms in Health System

On 21st July, 2008, JAAK held a dialogue with the Lokayukta of Karnataka , Justice Santosh Hegde. While briefing him on the denial of health care to the poor due to the malfunctioning of the system, he agreed that there were several problems in the health system and he also clarified the limits of his office and the constraints he was facing in booking the guilty. The Lokayukta assured that his office would definitely take action against errant public servants if the complaint was specific in terms of who did what, when and where. Justice Hegde indicated that he and his team would be visiting 17 district hospitals and begin investigations soon. He urged citizens to come forward to protest against poor services and demand their entitlements in the public health system.

As per the outcome of the dialogue, JAAK has informed all districts to use the Lokayukta office in the following ways:

- A 24 hour-helpline set up by Lokayukta: 080-22375014
- To have regular meetings with the Lokayukta officals at the district level
- To lodge official complaint in forms 1 and 2 on any denial of health care or corruption in the health system.

People's Health Watch

JAAK has started to document cases of denial of health care and its serious consequences. The documentation includes a video recording of testimonies by individuals (by alive) and/or their families of their travails of seeking care in government as well as private health care facilities. There have been reports of denial of health care from Davangere, Raichur and Bidar.

Of serious concern are deaths of three pregnant women in Bidar — all in a span of one week in July 2008. These deaths never made the headlines in any newspaper. No one took up cudgels on their behalf. Perhaps such deaths have become so

(Continued on page 35)

Realizing Health for All

CHC's involvement with Makkal Nalavazvu Iyakkam

K. Ameer Khan

Community Health Cell (CHC) has been actively involved in the initiation, support and facilitation of the People's Health Movement. As one of the co-initiators of the movement at the international level that hosted the international secretariat early in the life of the PHM, CHC team members are on the National Coordinating Committee as well as the National Organizers' Committee of the *Jan Swasthya Abhiyan* (JSA is the Indian chapter of the People's Health Movement). More recently, the CHC teams in Karnataka and Tamil Nadu have been hosting the secretariats of the respective state chapters.

Early days of PHM

One of the first meetings that launched the pre-assembly process which led to the formation of the Jan Swasthya Abhiyan and the People's Health Movement was held in Chennai. It was facilitated by the Tamil Nadu Science Forum, the All India People's Science Network and CHC. During the pre-assembly mobilization activities, the Tamil Nadu Science Forum coordinated the various PHC-level surveys and other activities including the first People's Health Assembly, prior to arranging a trainful of activists to Kolkata for the first National Health Assembly. A few members of that group also joined the national contingent to the first International People's Health Assembly in Savar, Bangladesh, where the People's Health Movement was launched. This set of activities galvanized the interest of civil society in Tamil Nadu in health. This mobilization also marked the ascendancy of the *rights approach to health* in civil society work.

State Health Assembly of PHM in TamilNadu in March 2007

Right to health care campaign

After National Health Assembly-1 in Kolkata, JSA initiated a national campaign on 'Right to Health' in 2004. As part of this campaign, JSA in partnership and with support from the National Human Rights Commission (NHRC) organized a series of public hearings on 'denial of health care' across the country in 2004. There were four regional and one national-level public hearings. CHC took responsibility to conduct public hearings for the southern region. Through this opportunity, CHC facilitated the Makkal Nalavazvu Iyakkam (MNI) constituents to collect evidences, case-studies on the denial of health care. The MNI members motivated the community to present their testimonials in front of the NHRC's judges. A total of 65 case-studies of health care denial from Tamil Nadu alone were presented. Based on the hearings, NHRC evolved an Action Plan to realize the 'Right to Health'. This was submitted to the Central and State governments. Each state government was supposed to report back every two years regarding the progress made towards the

implementation of the action plan. MNI was requested to submit a response to the Tamil Nadu Government's report that was submitted in 2007. The CHC team played an active role in the evolution of this response.

Tsunami solidarity meeting of PHM in Chennai

As part of the People's Health Movement's response to the Tsunami and after, in 2005 an international conference was organized in Chennai to show solidarity to tsunami victims. The conference demanded more transparent and quick relief for the victims. It analyzed many aspects of disaster relief and placed under the scanner the role of civil society organizations, funding agencies and the government. It emphasized that the primary focus needs to be on protection of the coastal people's rights.

NHA– II and building social sector alliance

In 2006, the JSA announced the holding of the Second National Health Assembly (NHA), in March 2007. Around this time, in 2006, CHC took the responsibility of co-convenorship of the Makkal Nalavazhvu Iyakkam in TamilNadu.

The MNI had detailed discussions and evolved a new strategy for mobilization, and later on as part of the process came up with a new organizational framework too. The core strategy followed was to build towards the formation of a social sector alliance at the district level. This recognized the presence of different campaigns organized by different groups around different issues. All the groups including MNI were struggling to achieve a common vision of the social, economic, political and civil rights of the people. It was thus logical to come together to support each other. This formed the basis of both the short-term and long-term strategies of the MNI.

Four broad themes were chosen through discussion at different regional and state-level meetings. It was decided to collect evidence across the state based on these themes. The themes were food security, environmental security, public health services and the issues of people living with HIV/AIDS. The district groups were given freedom to choose one theme from among the set of themes based on the district's priority. A set of core values and skills, which the movement wants to achieve, included people's participation, surveys and using the findings of survey for mobilization and a rights approach to health. They provided the common threads in this campaign. This helped to bring

a wide variety of groups into the movement. This also ensured ownership of the campaign at the district -level since they had chosen the theme.

Surveys were conducted in most of the 17 districts that had groups coordinating at the district-level in at least one of the four themes. In this entire process, many state-level workshops, TOT programme for the activists, and steering committee meetings were held across the state. The meeting venues were spread over across the state to seed the ownership of the movement within all the members.

The Iyakkam conducted the state health assembly in March'07 where case-studies were presented. More than 250 people and many groups took part in the Assembly. Prior to the Assembly, MNI held a press meet at which it released its demands that were based on the mobilization activities done in the state.

MNI and NRHM

After this campaign, in 2007, MNI took responsibility for facilitating the "Community Monitoring and Planning (CMP)" pilot project process of National Rural Health Mission (NRHM) services in Tamil Nadu. The CMP process is one of the strategies to strengthen the health system with community participation.

Motivating communities to take part in the improvement of the health care system and make the health care providers to accept the community participation is a difficult process.

As a pilot process, MNI initiated the CMP activities in 225 villages across the Tamil Nadu state.

This process which started in May 2007 concludes in December 2008. Through this process, MNI is hoping to create a framework for mobilizing communities, spreading awareness regarding their rights, instilling confidence in them to demand their rights, collecting

(Continued on page 38)

Lessons learnt from the Adivasis of Gudalur, Nilgiris

Dr. N. Devadasan* & Dr. Roopa Devadasan**

We narrate a few anecdotes and our experiences while working in Gudalur, Nilgiris, Tamil Nadu. We hope they will provide the readers with some insights into community health. And we write this in the hope that it will touch some reader somewhere.

Illiteracy is not equal to stupidity

Both of us, urban products, were growing up with the image that the average villager was poor, illiterate and ignorant. So, initially, when we went into Gudalur, it was with a slightly patronizing attitude – "*here are we doctors coming to help you adivasis*." However, during the initial months and years, as we visited their homes, ate their meals and listened to their stories we clearly realized that "*Illiteracy is not the same as ignorance or stupidity*." A story to illustrate this point *(See Box)*.

We realized that as doctors, we ONLY knew how to treat patients. But our patients knew how to grow their own food, build their own houses, understand the behaviour of animals and create lovely ornaments. They would not know how to read and write but each one was a farmer, an engineer, a naturalist and an artist, all rolled into one. After this, we stopped thinking of the rural people as ignorant and stupid.

Listen to the people; they have their reasons

As doctors we were taught to question patients about their ailments, diagnose and then treat. As products of CMC, Vellore, we were also taught the importance of explaining about the illness and the treatment to the patients. However, the general attitude that we imbibed was that we (professionals) talked and they (patients) had to listen. But the following theory proved us wrong.

During our initial visits to some of the villages, we noticed burnt-down huts. "*Was this due to some accident? Perhaps sparks from the hearth lighting up the thatch roof?*" "*No*", was the calm answer. "*These are huts where women have died during delivery*." We were shocked. Maternal mortality and that too so many? This was unacceptable to us. Our initial assumption was that it was because the adivasis did not care for their women. What else could explain the fact that these women died just 15 km from the 100 bedded government hospital?

When we talked to the relatives and the elders, they were emphatic; "*we will take them anywhere, but not to a hospital. We have seen too*

Village meeting in Gudalur

Kullan refused to go to school

Nunjan, an adivasi, wanted to educate his son Kullan in a good school. So with great difficulty, he bought new clothes, a slate and a piece of chalk and took his son to the nearest private primary school. After enrolment, Kullan was sent to Class I along with the other new students - most of them children of farmers and traders. While all the other children were familiar with the alphabet, Kullan had no clue. He also did not know what to do with the slate and chalk since having seen these objects for the first time yesterday. Also the teacher was asking him something in a strange language (Tamil). The teacher got angry at Kullan's silence, slapped him soundly and made him stand in a corner. The next day, Kullan refused to return to school. On enquiry, Nunjan found out the trauma that his son had undergone. Consoling him, Nunjan accompanied his son to school. He then enquired from the teacher as to why his son was slapped. The teacher broke into a tirade of abuses: "Your son is ignorant; he is six years old and does not know the alphabet, he does not understand Tamil; he is a cretin; keep him at home. There is no point in sending him to school."Nunjan listened to all this patiently then called the teacher outside. Pointing to a nearby tree, he asked, "Sir, what is the name of that tree?" The teacher answered brusquely "how will I know the names of trees? I am a teacher, not a botanist." Turning to his son, Nunjan posed the same question. Not only did Kullan know the name, but also mentioned the illnesses which could be cured by eating the leaves of the tree, the birds which usually nest in this tree and the fact that the wood from this tree is useless for firewood purposes. After translating all this to the teacher, Nunjan gently asked him, "Do you still think that my son is a stupid, ignorant, cretin ... ? He knows how to treat cuts and wounds, he can collect honey, can identify edible mushrooms and can help in the construction of my house. Yes, he does not know the alphabets, but that is precisely why I sent him to you, so that he can learn your skills and knowledge. Kindly teach him these things." Humbly the teacher guided Kullan into the class.

many of our people walk into the hospital and end up being carried out – dead." Attributing this to the 'superstition' of the community, we decided to visit the General Hospital to look for ourselves. And our eyes opened.

One hundred beds, but just two doctors, one of whom was more under the influence of alcohol than the Hippocratic Oath. Labour rooms were staffed by *ayahs* because the doctors do not 'do' obstetrics and the nurses did not want to soil their white uniforms with blood. Labour rooms that could do with a good wash and a coat of paint.

Who monitors the delivering women? "*Oh, when the patient's attendant informs us about an impending delivery, the ayah conducts the delivery. Sometimes, if she is not fast enough, the baby ends up in the bucket below*," laughed a nurse. "*What about regular vaginal examination, monitoring the foetal heart rates, assessing the colour of the liquor?"* The nurses looked at us very strangely – obviously we were talking in some foreign language. In the wards, we saw evidence of such neglect: asphyxiated babies, mothers still mourning their still-born children, a very short woman who had ruptured her uterus and a maternal death in the mortuary. The doctors shrugged their shoulders, "*we are not gynecologists, the government has not posted a lady doctor here, so what can we do?"*

Now we understood the adivasis' superstition. It was not baseless. They had come to us with faith, but we had failed them. And then we chided them for believing in spirits and gods. We have seen too many such instances where the people have been right and we have been proved wrong. So now whenever people tell us something, however atrocious it may sound, we try and understand the story behind the statement. We have learnt to listen.

Health workers can make a difference, but only if …

We were fresh out of CHAD, the community health department of CMC – Vellore, when we started our work at Gudalur. We were bought up on a diet of "Where there is no doctor," "Limits to medicine" etc. Village health worker and power to the people was the "in thing." Accordingly, we trained illiterate village health workers (VHWs) on basic preventive care – immunisation, antenatal check-ups and growth-monitoring. And then expected them to perform miracles! But they came back and told us that they were not being accepted as healers in their community (though they were selected by the community). On listening to the people, we found out that as a healer, the community expected the VHW to cure and not just pontificate about hand-washing or the importance of eating good food or that health is their right.

So we gradually trained the VHWs on the use of ORS, paracetamol, common antibiotics and other medicines. This increased their credibility tremendously. However, the downside was that they tended to forget the lessons and mix up the tablets and dosages. We tried many tools

like pictures, role plays, repetitions etc. Finally we resorted to regular supervision and that helped them retain their neo-knowledge. Every month, one of us would visit a VHW and accompany her on her rounds and OBSERVE how she was interacting with the community, passing on health messages and treating patients. This supportive supervision was an effective measure to ensure that a patient with fever received paracetamol and not mebendazole. During these visits, we also ensured that their supplies were replenished.

All this improved ANC coverage, immunisation cover rose from less than 5% to 80%; and diarrhoeal deaths became history. But as the VHWs grew in their knowledge, so did that of the local community. Soon the adivasi mother would come and ask for "MFI" for her pregnant daughter; or "amoxicillin" for her baby's "pneumonia." This was the effect of demystifying medicine to the community.

All this improved ANC coverage, immunisation cover rose from less than 5% to 80%; and diarrhoeal deaths became history. But as the VHWs grew in their knowledge, so did that of the local community. Soon the adivasi mother would come and ask for "MFI" for her pregnant daughter; or "amoxicillin" for her baby's "pneumonia." This was the effect of demystifying medicine to the community.

While we were happy, it also meant that if the VHW had to continue being respected as a healer, then her knowledge needed to be kept one step ahead that of the community. Maybe, we were wrong, but we felt that there were limits to which an illiterate woman and a full-time homemaker could be trained through monthly classes and field visits. Even the community echoed our concerns and thus was born the *concept of a medical assistant*. These were young tribal youth, who had at least reached Class X level and knew basic English, Maths and Science. We trained them over a period of one year to support the VHW in her work, especially the curative aspect. Today, these medical assistants do the work of a PHC medical officer, providing preventive and curative care for the population under their centre. They treat patients (from pneumonias to TB, from duodenal ulcers to amebiasis), refer the complicated patients to the hospital and babies to the government ANM for immunisation. They also supervise the VHWs, interact with the community and also with other departments like the ICDS, water and sanitation and even revenue officers.

From all this, we learnt that just training VHWs (ASHAs in today's context) and letting them lose into the community will not make much of a difference. For them to be effective, VHWs need to be SUPPORTED, SUPERVISED, and SUPPLIED (with medicines) regularly. And that MEDICAL ASSISTANTS can be a way out of the current crises of vacant PHCs.

Preventive vs hospital: Is it an either / or situation?

We trained during the height of the primary health care movement. While everybody talked about the eight elements of primary care, most health activists (us included) conveniently forgot one of the elements – "appropriate treatment of common diseases and injuries." We were heady with the preventive and promotive mantra. Curative care was bad, preventive care was the only answer. However, soon the community showed us the fallacy in our thinking. After two years of only preventive care, we were accosted with the community's reality at a meeting. A sage old man told us in no uncertain terms: "*You tell us that our pregnant women need to get a check-up so that they will not die during delivery. But at the time of delivery, you send us to the government hospital or a private hospital where the care is inadequate. You tell us that we need to immunise our children, but when they get severe pneumonia, you send us to the nearest hospital which we cannot afford or where they treat us like dirt because we are adivasis. Our people have listened to these messages many times. We also need to have our own hospital that will treat our people with care, with good medicines and will charge us reasonably.*" We baulked at the idea of starting a hospital. "*C'mon, we are preventive people, we don't operate hospitals. It is against our ideology – Curative was bad!*" Also, hospitals are capital-intensive and take a lot of time and human resources. What will happen to all the field work?

But as more and more villages started raising this issue, we started considering it seriously. Remember, we had learnt to listen to the people. And with the grace of god, two doctors (Dr Nandakumar Menon and Dr Shylaja Menon) joined us and were happy to take the idea of the hospital forward. We rented a building and the Gudalur Adivasi Hospital came into being in December 1990. Of

course, it proved to be capital-intensive, it did affect the field work at times, it did take up a lot of energy and time of the doctors, but it also was a tipping point. Suddenly, the credibility of the health programme shot up. Women who earlier would never take MFI tables now started lining up at the GAH for their deliveries. Adivasis who were traditionally afraid of 'operations' were willing to undergo a Caesarean or a herniorapphe.

And, once again, we learnt that ideologies are not important. What is important is to listen to the people. And that CURATIVE AND PREVENTIVE CARE are both necessary for the people. And that the divide between curative and preventive is an artificial one created by us health activists. Washing hands prevents diarrhoea. ORS prevents dehydration. IV Fluids prevent death. Which is curative? Where do we draw the line? And when we look at successful community health programmes, be it Jamkhed or SEARCH, or CINI or … all of them have a referral hospital to back up their primary care programme.

People can manage and monitor health services

Today, community-based monitoring is the buzz-word in NRHM. The adivasis taught this to us two decades ago. They taught us that though illiterate, they are capable of keeping tabs on the immunisation status of their village children; that they are able to analyse an infant death by raising the pertinent social and cultural factors that contributes to that death; that they are able to question an ANM as to why she did not bring the vaccines last Wednesday. Other than this, we also discovered that they are able to design a patient-friendly hospital; able to hold the doctors and nurses accountable to the community and manage a health insurance scheme effectively. Their leaders today negotiate with insurance companies, read the monthly computerised HMIS reports and berate the staff if his/her performance is below par.

And this is the most important lesson that we learnt – THERE ARE NO LIMITS to what a community can do as long as we believe in them and are willing to work with them.

We are grateful to all the adivasis of Gudalur who taught us more than we ever learnt from books, colleges and universities. ■

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(Continued from page 29)

routine that the government does not think they warrant an enquiry. NRHM and its host of schemes like Janani Suraksha Yojana, Madilu and whatever else are reduced to a mockery in the state. Pervasive and rampant corruption, gross neglect, callous attitude and irresponsible behaviour of health care staff seem to be the hallmarks of the health system that result in the deaths of innumerable mothers and infants. As per the investigation of the JAAK Racihur District Forum and their study conducted in 32 villages of 5 talukas, in the years 2006-08 about 96 cases of neonatal deaths (most of these deaths have occurred from 3 days to 3 months after birth) and deaths of 12 mothers have come to light. On 29th October, 2008 a mother, admitted in the Rajiv Gandhi Superspeciality Hospital (Raichur) in a very extreme anemic state, died soon after delivering her child. The child too died soon after. JAAK is now planning to create documentation of these cases for further advocacy.

JAAK Solidarity with Other Campaigns

Health as a social movement can be built only by building solidarity with other campaigns and social movements. JAAK has been actively collaborating with Free Dr. Binayak Sen Campaign, campaigns of National Alliance of People's Movements (NAPM) against SEZ, campaign to promote communal harmony, campaigns of people with disability for accessible and affordable health care and Novartis Boycott Campaign led by the Drug Action Forum – Karnataka.

Lessons Learnt and Way Forward

The so-called 'progressive' state of Karnataka has so far shelved NRHM and only after three and a half years, one is getting to see some things happening. While this is a symptom of the apathy in the entire system, mobilizing people towards this has given us some hope. People have started addressing issues of systemic failures in the district and the taluka levels. Dialogues of people with the PHC staff have happened. The letter campaigns, demonstrations, RTI and such other measures have raised the issues of state accountability. Positively, changes in staff attitude, Zilla Panchayat and Panchayat taking responsibility for repairs of PHCs and sub-centres are seen in many places. Most importantly, in some places, people have started cleaning up the sub-centres which were otherwise used to stock grains, to house animals and as sanitation place. ■

(The author is Coordinator, Community Health Cell, Bangalore)

Journey into Community Health

Health-Promoting Schools in Hanur, Karnataka

Dr Sr Aquinas

Thirty years have gone by since the Alma Ata Declaration in 1978 which set the goal for "Health for All" by the year 2000, to be realized through comprehensive primary health care approach. Much before, the Bhore Committee (1946) had laid the foundation of primary health care in India, drawing upon the experience of early health work with its emphasis on prevention and promotion. The Millennium Development Goals (MDGs) set by the UN constitute the most ambitious commitment that world governments have ever made to improve the quality of life of the world's poorest by 2015. The 8 MDGs focus on reduction of poverty as well as the causes and consequences of poverty. This includes reducing child mortality and improving maternal health, combating HIV/AIDS, malaria, tuberculosis and other diseases and bringing sustainable access to clean drinking water, and developing a global partnership for development.

Ground reality

We all know what is the ground reality today despite all these glorious attempts, visions and goals set by the world bodies. Alma Ata declared "health is a fundamental human right" whose attainment requires a multi-pronged attack on the social determinants of ill health and disease. The gross inequality in the health status of the people that we see today is politically, socially and economically unacceptable. Health care is getting more and more commercialized – it is a profitable business, patients are now the "clients" and clinical services are the "product lines". The rights of the pharmaceutical firms to their intellectual property precede the "fundamental right to health care". Where then are we headed to? If disease is the product of social and economic inequality, then ill health of our people cannot be solved by merely provision of health care but by bringing about better conditions of work, housing, sanitation, nutrition, education etc.

Light a candle, not curse darkness

Instead of cursing darkness, it is always better to light a candle. Holy Cross Comprehensive Rural Health Project (CRHP) in Hanur, Chamarajanagar District, Karnataka, India, is one such attempt to address the issue of poor health status of the rural poor in Chamarajanagar district. It was born out of the sincere search of a physician into the grass-root realities (how the poor are being deprived of today's health care system due to illiteracy, ignorance and economic poverty) existing in rural areas,. Holy Cross CRHP adopted an integrated approach to health from its very beginning in 1997. It accessed the remote villages through mobile clinics, trained many village women as village health workers, trained TBAs, organized and empowered adolescent girls, farmers, formed youth clubs and village development committees, economic empowerment of women through self-help groups, and facilitated non-formal education of working children. One of its novel strategies is 'Health action through health promoting schools'.

Discussion with the School Health ommittee

Health-promoting schools

"Good health supports successful learning. Successful learning supports health. Education and health are inseparable. Worldwide, as we promote health, we can see our significant investments in education yields the greatest benefits" (WHO).

Disadvantages of rural schools:

- Child-friendly environment and high educational standards are rather difficult to achieve in poor rural schools
- Lack of facilities, space, essentials, teaching aids, transport or conveyance, ill- motivated teachers, lack of parental support and encouragement due to poverty
- In order to reach an equivalent standard of achievement, the average cost per student is higher for rural schools than for urban schools.

How do the health problems affect school performance?

- Vitamin A deficiency - 8.5 million school children are at risk of respiratory tract infections and blindness as a result of Vit. A deficiency.
- Almost 3 million children below 15 yrs are HIV infected. More than 13 million children above 15 yrs age have lost one or both parents due to AIDS. This number is expected to double in 10 yrs.
- Diarrhoeal diseases and respiratory tract infections are common among young children. Girls often miss school because they are expected to help take care of their preschool brothers and sisters or an older relative.

What is a health-promoting school (HPS)?

- **A health-promoting school (HPS) views "health" as physical, social and emotional well-being. It strives to build health into all aspects of life at school and in the community.**
- *HPS is all for health*, fostering it with every means at its disposal
- *HPS involves all school and community members* in efforts to promote health
- *HPS* strives to set an *example* through environment, nutrition, safety, sports and recreations as well as by the way it educates children and spreads activities beyond the classroom and into the community
- *HPS takes action* to improve the health, mental and emotional as well as physical, of the whole school community.
- *HPS develops Life skills* in children and promotes ways of giving them responsibility, raising their self-esteem and recognizing their efforts and achievements.

Key features of health-promoting schools:

- Engages Health and Education officials, teachers and their representative organizations, students, parents, and community leaders in efforts to promote health.
- Strives to provide safe, healthy environment
- Provides skills-based health education
- Provides access to health services
- Implements health- promoting policies and practices
- Strives to improve the health of the community by focus on community health concerns and participating in community health projects

How does a HPS improve health and education of children?

Our investments in education pay off only if children attend school. Schools can do their job only if children who attend school are capable of learning. Investments in education are more likely to pay off if the school uses its potential as an organization to promote and protect health. Everyone gains when schools promote health. Educated and healthy people are an asset to the community as a whole and they contribute to the development of the nation better.

Components of Health-Promoting Schools Programme

- Basic health instruction
- Health ideas and skills reinforced across the curriculum
- Good health practiced in and around school
- Health knowledge and skills are spread to the community
- School health services

The Holy Cross Health Promoting School Programme

This programme was initiated in 25 Government Primary schools (Upper and Lower) in Kollegal Taluk with an idea to cover later all the Government schools in the Taluk, where the poor and poorest children attend.

The goal of Health Action through HPS:

To help schools become places where good health is practised and from where good health is promoted for the benefit of the communities they serve. Health is defined as involving all aspects of physical, mental, emotional and environmental well-being, with the first emphasis on prevention.

Objectives- General:

- To improve the health of children in the selected schools, their families and their community.
- To nurture close links with teachers, health team of Holy Cross CRHP, Govt health facilities, and undertake health promotion activities by spreading health messages and good health practices from school to home and to community.
- To involve parents more closely as partners in school/ family health activities.
- To use active teaching methods which develop life skills.

Getting started, building local support

A health-promoting school is a chance to join a

worldwide health movement. Creating a health-promoting school requires broad support and there is a role for everyone for building support for a Health-promoting school.

Some of the Activities:

- School Health Committee is formed in each school after orientation and discussion with the school and the Grama Sabha. The committee consists of representatives of children from each class, representative of teachers, of parents, of school development & management committee in the village, and project staff. The committee meets and prepares action plan for short terms and for one year.
- Each school plans activities for the school and also plans activities to be achieved together in collaboration with all the schools involved in the programme.
- The action plan includes child-to-child activities to impart the knowledge children gain on health, child-to-adult activities to impart the knowledge to family members and collective efforts in the school and in the village.
- The findings of School Health Check-up are presented to the Parents Committee and remedial actions were taken together.

School children on a rally to promote awareness

- School register is maintained to know the reasons of absenteeism due to health.
- Networking with other health-promoting schools through newsletters for exchange of ideas.

Fundamentally, **we see a health-promoting school as a process to promote health among students, staff, families and community members.** It is one of the ways the Holy Cross CRHP is reaching out to touch the lives of common people and the society in a holistic way and bring out their hidden potentials and ability to find solutions to their problems and misery. ■

(The author is Head, Holy Cross Congregation for South India, and member, Executive Committee of SOCHARA)

(Continued from page 31)

relevant information and in preparing village level health plan as a logical continuation of the monitoring activities.

Dr.Binayak Sen release-campaign

Dr.Binayak Sen, health rights activist, who has been working with the poor and marginalized in Chhattisgarh State was arrested by the state government accusing him of having links with the naxalites. World-wide protests were launched by many groups to release him. As a part of that, MNI along with other groups, organized protest meetings and demonstrations, press conferences, public meetings and a cultural evening to protest his arrest. In addition, medical camps for the poor and marginalized as a symbolic way of continuing his work was facilitated. This campaign will continue till he is released from the prison.

Protecting public vaccine production units and strengthening rural health services

Recently, MNI initiated two campaigns: one was to restore vaccination at the village level and the other to reopen and restore production of national institutes of vaccine production. The TamilNadu government ordered vaccination only at the PHC level in response to the death of 4 children following immunization, in April'08. Reflecting on the opposition to this move which will mean long travel at personal cost as well as large indirect costs, a state level campaign against this government order was launched in partnership with various groups.

The second campaign is against the central government order of closing three public vaccine production units from January'08. The three units are BCG Lab in Chennai, Pasteur Institute in Cunnoor, the Nilgris, and Central Research Institute in Himachal Pradesh. A state-level campaign was initiated to demand the central government to restart the production of vaccines in the above three public units.

Through these two above campaigns, MNI reached many new groups and people to make them aware of their health rights and bring them into organized action to achieve these health rights. As part of these campaigns, MNI along with other groups motivated people to send more than 50,000 postcards each to Prime minister of India and Chief Minister of Tamil Nadu. ■

(Training and Networking Officer and former fellow, Community Health Cell,Tamil Nadu)

Our Health in Our Hands

Story of Women of Jagrutha Mahila Sanghatan

JMS Team

Raichur District of Karnataka is one of the 5 districts known as 'Hyderabad Karnataka' since it was ruled by the Nizam of Hyderabad for over 300 years and is a backward pocket in an otherwise-projected economically developed state. The occasional cry for a separate state of 'Hyderabad Karnataka' or for a special status under article 371 of the Constitution of India indicates the political neglect and backwardness of the area. The human development index (HDI) of Raichur is low, lower than the sub-Saharan African countries. The Nizam's rule has left a lasting legacy of feudalism and many of the Dalit households are landless. Dalit women are a substantial labour force in agriculture, the main occupation.

The denial of health rights to Dalit women can be gauged by the prevalence of untouchability (segregation of wells, water sources etc.), very frequent social boycotts of Dalit women when they are appointed as cooks for the midday meals in schools, sexual assault in the form of rape or parading them nude. The literacy rate of Raichur District is 35.96 percent (one of the lowest in the state),for SC/STs it is 21.25% (31.87% -Male and 10.61%-Female).The indicators of literacy, maternal mortality and gender-related indices reveal the gloomy story of the political economy of the determinants of Dalit women's health.

JMS evolves

In this context of general backwardness of the area and the socio-cultural oppression of Dalits, and the triple suppression of Dalit women as agricultural labourers, as Dalits and as Dalit women, the work of Jagrutha Mahila Sanghatan (JMS) evolved. JMS is a collective of Dalit women agricultural labourers struggling for their social, political, and economic rights. JMS strives towards being a symbol of empowerment of rural women through mobilization for respect, basic rights and dignified existence while simultaneously promoting initiatives for economic self-reliance.

Community Health Workers preparing herbal remedies

Jagrutha Mahila Sanghtan (JMS), which began in 1999, has now grown into a collective owned by the women themselves. It is organized through its basic village units wherein women agricultural labourers are mobilized in the village as *Sanghas*. The Sanghas are actively involved in micro-credit, ensuring access to facilities from the state, resisting acts of violence within homes and the larger community, and perspective-building on various issues. These 50 *Sanghas* in 50 villages in the Talukas of Sindhanur and Manvi collectively comprise the constituency of JMS which draws

its decision-making body from 2 representatives from each village, called as Karyakarthas. The Karyakarthas meet monthly and determine collectively on decisions regarding the direction and completion of the work. Ten women who grew as leaders in the process of capacity-building are now in charge of the villages and are working full time as 'sanchalakis' (conveners).

In building the collective of women for their dignity, 'Sangharsh' — building of a healthy community and 'well-being' through struggle for dignity and social justice, and '*Navnirman*' — reconstructive efforts for a life with dignity formed two pillars of the strategy adopted by JMS.

Sangharsh — struggles and campaigns

Revitalize the Public Distribution System: The Public Distribution system was plagued with issues of corruption, siphoning off of food materials and kerosene, bogus cards, tampered weights and measures, and the practice of untouchability. JMS undertook a detailed survey of the PDS stock in 20 fair price shops of their own areas and had dialogue with shop owners demanding accountability and transparency from them. The results of the survey was submitted to the food inspectors at the Deputy Commissioner's office in Raichur. Women went from village to village, distributing pamphlets, posters, writing on walls, making jeep announcements, and singing songs with social messages. In each village, public meetings and local agitations were held to check corrupt practices and make the system accountable. It was through this campaign that the public became aware and got sensitized to their rights.

***Right to Work – Campaign for the effective implementation of NREGS*:** Raichur was one of the pilot districts for implementation of NREGA (National Rural Employment Guarantee Act). Since 2004, JMS has been part of the collective engaged in mass action in the district demanding effective implementation of NREG Scheme. JMS has spread the message of the various rules and regulations regarding NREGA, facilitated the registering of accounts of labourers in banks and getting labour identity cards for members of our Sanghatan. The women went on hunger strike in front of the District Commissioner's office for 3 days forcing the administration to take action.

Sanchalakis of JMS dialoguing with the Medical Officer of PHC

***Campaign for Revitalizing Primary Health Centres*:** In spite of the National Rural Health Mission (NRHM), the status of the PHCs in Raichur — shortage of staff, the crumbling or non-existent infrastructure, lack of basic facilities to the staff, shortage of medicines, and corruption all existed as it were. JMS studied the PHCs and became part of the collective action at the District level through the district forums of the Jana Arogya Andolana Karnataka (JAAK- Karnataka Chapter of People's Health Movement). They also participated in the state-level meeting of JAAK and met with the Director of State Health Services, Karnataka. The issues found in the surveys of PHCs and sub-centres were submitted to the Director.

They are part of the National Alliance of People's Movements (NAPM) and have participated in national rallies in solidarity against anti poor and anti development policies.

Navnirman – Creative Reconstruction

Education for Social Transformation: Chilipili School – a school that breaks myths: A large number of children in Raichur are out of school due to a number of factors- including the children of the women in JMS. Many of them were child labourers in the farms of the landlords. A school for these children named *'Chilipili Child Labourers' Special School'*, was started. The school used the pedagogy of conscientising education of Paulo Freire, creating opportunities for training and mainstreaming children from the villages. The school was shifted from village to village every two years so that all children are benefited. This has been recognized as one of the model schools in the district by the National Child Labour Project and has been converted as residential schools.

The teaching methodology attempts to instill creative expression and a questioning mind among children. Teaching material and content was developed keeping in mind that these children have had rich life experience, language skills and tremendous knowledge of the natural environment. Therefore, teachers start with what the children already know and then explain concepts through their own life contexts. Since 2000, about 300 children have been mainstreamed in the government schools, some of them pursuing their graduate studies. Their progress has challenged the bias that the Dalit children have no capacity to study and the children have redefined and redesigned education as education for life.

Our health in our hands – an experiment with 'Barefoot Doctors' in Primary Health Care: Sixteen women from 7 different villages volunteered as community health workers. In the last 6 years, they have been extensively trained on health— knowing their own bodies, knowing illness and factors causing illness, the use of herbal medicines for common ailments, preventive health and understanding gender dimensions of health. They started by building herbal gardens in villages, preparing herbal medicines and sensitizing the women about the connection between nutrition, hygiene and health. Using the slogan "Our Health in our Hands" the Aarogya Karyakarathas have become healers for their community. They run a clinic during the weekly village market day in Pothnal Village to counsel and heal people with illness. The weekly clinic is very popular among the poor — on an average, every year 3000 people access these services.

Menstrual issues like white discharge, irregular menstruation, vitiligo, kidney stones, gastric issues, ulcer, jaundice etc are treated effectively using herbal medicines. The women also exhibit and sell their herbal products in various exhibitions. The products include pain oil, skin oil, aloe-vera oil for hair, choornam for cough / respiratory problems, aloe-vera tonic for anemia and medicine for paralysis/stroke.

Sustained Livelihoods and Chirugu Enterprise: As agricultural work is very unpredictable and provides very little income, the landless labourers invariably fall into debt and migrate to survive and earn more money. The migration alienates them further leading to a vicious cycle of debt. To tide this crisis, certain skill-building and enterprising ventures were initiated to fetch supplementary income and sustain livelihoods and hopefully prevent migration of the Dalit households.

*Terracotta Unit :*Over the course of the past 4 years, 24 women from 2 villages (Pothnal and Amreshwar Camp) have developed their artistic and creative skills to create an entire brand of Chiguru terracotta jewellery and home decorations. For the women in the unit, terracotta jewellery making provides a stable income of Rs 50/day year round. The otherwise socially excluded women feel their dignity reaffirmed through this creative expression of theirs. They were trained by professional terracotta artists with focus on developing strategies for the unit to use their art to promote community responsibility. The Chirugu unit has been part of Dastkar network and has been participating in exhibitions all over the country. The terracotta products range from ear pendants, wall hangings, necklaces, bracelets and door curtains.

Bio Fertilizer (Neem) Unit :The Jhansi Rani Mahila Sangha of Muddanaguddi village, started the production of neem fertilizer from neem seeds collected during the lean summer season. The unit of 20 women produce about 50 tonnes of unadulterated neem fertilizer which is supplied to the Organic Farming Association of Karnataka and to various other groups. The unit was awarded *'the Citigroup/UNDP 2005 Micro Entrepreneur Award'* for southern India — a certificate and a cash award of Rs. 2 lakhs by Shri Kamal Nath, Union Minister for Commerce and Industries in New Delhi. This unit is completely managed by women including raising finances, keeping accounts, planning and coordinating.

Organic Farming and Land Development: Dalits have such an intricate relationship with the soil and land on which they till –at the same time they are denied ownership of land. A Dalit man or woman feels dignified to own a piece of land to work on it. The government distributed fallow and uncultivable land to the Dalits. JMS identified about 100 acres of land of 45 Dalit households across 4 villages for land development: to improve the quality of the land through organic farming. The community has organized and is quite enthused to take this work forward. ■

(JMS Team — Devaputra, Chaurappa, Ratnamma, Susheela, Subash, Sakina ,7 Sahchalakis and others. Compiled by E Premdas, Coordinator, CHC, Bangalore)

Governance and Partnerships in Community Health

The Karuna Trust Experience

*** Dr. H. Sudarshan ** Dr. Prashanth N. S.**

India, a nuclear power with an anaemic mother; an irony of sorts for a country which claims 9% economic growth and yet is grappling with problems of access to health care. Inequities in this vast country range from a curious mix of technology of tomorrow in the software capital of Bangalore to the problems of malnutrition and infant deaths a few hundred kilometres outside the city. Economic growth and increasing globalization have brought their own problems in urban areas, while the rural areas are still 'stuck' within an unresolved 'backlog' of partially successful disease-control programmes. The double load of chronic non-communicable diseases and infectious diseases continues to form a significant health burden for the people.

As one of the signatories of the Declaration of Alma-Ata, and an early convert to comprehensive primary health care, India has developed a huge public health infrastructure. However, the Indian health care system is a heterogeneous one with a mix of unorganized and largely unregulated private for-profit sector, corporate sector and a burgeoning non-profit network, working alongside a large public infrastructure. While there have been huge investments in building up public health infrastructure, there has been a disturbing under-utilization of this infrastructure. Health sector reform has been taken up over the last decade calling for large-scale private sector involvement in the form of contracting in/out of services, franchising and sometimes, even privatization.

An ANM hands over bangles and flowers to a pregnant woman during a function to spread awareness on reproductive and child health, held at a PHC run by Karuna Trust

Privatisation or partnership?

Core social sectors like health, education, social, child and women welfare should not be privatized. When the 8 – 10% GDP growth has not percolated to the poor and the gap between the rich and poor is increasing steadily, these sectors are primarily the government's obligation. However, partnering with non-profit NGOs to strengthen the public health system and address gaps and problems in these sectors in the form of public-private partnerships (PPPs) is called for.

The term 'private' has classically been used to lump together both the for-profit and the not-for-profit sector. However, the distinction between the two is very important. The Indian non-governmental organization movement, which includes over a million organizations,

with over half of them working in the rural areas, is visibly not-for-profit. Lumping them along with for-profit sectors in areas such as contracting may not be suitable. A more suitable way of looking at these heterogeneous entities is to divide them based on not only their ownership (Government or private), but also on their goals. This distinction is all the more important for partnerships in primary health care, which hardly sees any participation by the for-profit sector. Such partnerships with the not-for-profit sector cannot be treated as simple contracts with outputs and need to be seen in a more long-term, dynamic perspective.

The Vivekananda Girijana Kalyana Kendra(VGKK) founded in 1981 and Karuna Trust(KT), founded in 1986 are non-profit, voluntary organizations that have taken up this role of identifying gaps in the public health care delivery system and partnering with the Government to address them. A total of 26 PHCs spread across 24 districts of Karnataka have been handed over to Karuna Trust. The trust takes up the poorly performing PHCs in these districts to strengthen the primary health care services, improve quality of care as well as address gaps in these PHCs through innovations. In 2001, a community health insurance programme was piloted in partnership with United Nations Development Programme (UNDP) and National Insurance Company, with a low premium of 22 rupees/person/annum providing for wage loss compensation in case of hospitalization as well as reimbursement of out-of-pocket expenses. The scheme has now been expanded to cover 25 PHCs of KT in Karnataka. Other innovations include mainstreaming of traditional medicine in primary health care. Twenty PHCs of Karuna Trust have the facility for promoting validated traditional medicines for routine primary health care problems at the PHC. A demonstration garden at the PHC includes commonly used herbs, and a nursery at the PHC provides SHGs and other individuals with saplings for their home herbal gardens. Tele-ECG facility through dial-up internet connection at remote places allows early detection of ischaemic heart disease making timely referral possible. In collaboration with ISRO, 17 PHCs have been upgraded as Village Resource Centres with facilities for telemedicine, tele-education, weather advisories and training programmes for rural people on livelihood, agriculture etc.

The concept of PPP includes partnering with a diverse set of for-profit and non-profit entities. However, for primary health care, it is clear that partnering with non-profit and community-based organizations to strengthen and supplement the public health care system is necessary. In Tumkur, KT, in partnership with other institutions with public health expertise, has formed an entity called Swasthya Karnataka, to build capacities of district health staff in planning, managing and monitoring the district health system as a whole. This programme will provide critical, need-based support to district health staff to strengthen the public health system. In collaboration with Community Health Cell and other NGOs, Karuna Trust has taken up community monitoring exercise under the National Rural Health Mission (NRHM).

Partnering with non-profit, public-oriented NGOs to address critical gaps in the public healthcare delivery system is an important step, and KT and VGKK have made strides to this end. Good NGOs should not be mere 'contractors' of services; they must be involved in planning, monitoring and implementation as well, keeping public goals in mind.

Corruption has roots in many areas—from recruitment to transfers to medical reimbursement or procurement—and is found at all hierarchical levels, from peons to investigation officers. A typical case of corruption in health services is that of doctors with their own private practice, pharmacies and blood banks, and these same doctors usually refer patients to their private nursing homes. All these have led to the doubling of market cost for various healthcare services, i.e. diagnostic or surgical emergency services.

Good governance

The Government of Karnataka constituted a Task Force on Health and Family Welfare under Dr H Sudarshan's chairmanship (vide Government Order No. HFW 545 CGM 99) on 14th December 1999. The mission of the Task Force was to make recommendations for improvements in public health and on major issues like population stabilization, departmental

management and administration, educational system reform covering both clinical and public health sectors, and developing a plan for monitoring implementation of these recommendations. The final report of the Task Force highlighted twelve major issues concerning health care and placed corruption right on the top. The Task Force concluded that corruption in health services is the major issue of concern, even in Karnataka. The others were neglect of public health; distortion of primary healthcare; lack of focus on equity; gaps in implementation; ethics or lack thereof; human resource development; gaps in culture and medical pluralism; movement from an exclusive toward an inclusive approach; ignorance of health's political economy; research; and the growth of apathy within the system.

New technological innovations are not enough to improve health outcomes - good governance is also necessary for progress in health services. Through good governance, quantum jump in healthcare outcomes can be achieved. Good governance, as a concept, becomes most important in the light of corruption, which serves only to eradicate health systems. Every year, Transparency International (TI) comes out with the Corruption Perception Index (CPI), ranking various countries around the world. More than two-thirds of the 158 nations surveyed under the 2005 TI-CPI scored less than 5 out of an optimal clean score of 10, indicating serious levels of corruption in their system. The CPI for India was 2.9, with a rank of 88th worldwide. Iceland had the lowest level of corruption, while Bangladesh and Chad were found to be the most corrupt countries.

Epidemic of corruption in health services

Corruption has roots in many areas—from recruitment to transfers to medical reimbursement or procurement—and is found at all hierarchical levels, from peons to investigation officers. A typical case of corruption in health services is that of doctors with their own private practice, pharmacies and blood banks, and these same doctors usually refer patients to their private nursing homes. All these have led to the doubling of market cost for various healthcare services, i.e. diagnostic or surgical emergency services.

Health sector corruption can be divided in the following ways:

- Corruption in Civil Works: found in construction and repair of PHCs, CHCs, Taluka and District Hospitals.
- Corruption in Administration: found in offices at the level of District Health, Directorate and Secretariat for reasons related to recruitment and posting in cities/ hometowns; promotion and transfer; leave sanctions; medical reimbursement; monitoring of external private practice; absenteeism; suspension; and reinstatement.
- Corruption in Medical Education: in sanctioning of new Medical, Nursing, and Indian Systems of Medicine & Homeopathy(ISM&H) Colleges; in seat increases for Nursing Colleges; in admissions; in examinations, via bribes for Undergraduate and Post-Graduates examiners; and in recruitment of teaching staff and registration.
- Corruption in Hospitals: varied forms of corruption are perpetrated by administrative hospital staff—in the conduct of private practice; referral to nursing homes that are owned by spouses or relatives of medical staff and business partners; referral to private hospitals; ownership of private pharmacies by staff; blood banks; and excess of staff assets over income and chronic absenteeism, sometimes over years. Corruption is also found in admission processes; issuance of medical certificates; in technical services such as laboratories, X-rays, or scanning; transporting of patients; elective or emergency surgical services; and blood transfusions. Interestingly, corruption insinuates itself into the natural cycle of life and ironically the lifecycle approach to corruption is what is seen in our country today: it is present at birth, when a relative must pay Rs.200/- extra to see the newborn, and it is also present at death, when a bribe must be paid for the postmortem.

The Medical Officer of a Karuna Trust PHC addresses pregnant women during a function to spread awareness on antenatal and post-natal issues

Corruption in private sector

In this regard, private hospitals are not very different from the public sector. Many multi-national companies have started giving bribes as a means of acquisition of

contracts. Commissions and incentives are given to doctors for prescription of specific tests/drugs. It is also a standard practice to give 'cuts' for prescription of expensive diagnostic investigations like CT scans and MRIs. In some cases, laboratories run only a few tests and fill in normal values for the rest based on a code with the prescribing doctor, and collect charges for all the tests. Extensive organ-trading has occurred earlier in Bangalore and throughout Karnataka: around 400 transplants among unrelated people were reported in 1999-2002 after organs were bought from poor people.

Reforms in health services

After a review of the situation, a few health sector reforms were developed to reduce corruption. Reforms by the Drug Logistic Society led to improvements in obtaining essential drugs that made such drugs available in all PHCs and hospitals. Significant improvements were observed in the number of health staff staying in headquarters through the presence of efficient District Health Officers with leadership qualities. Corruption was reduced in equipment purchases due to enhanced vigilance, and at the same time there was quality compliance with inspection notes.

More reform for good governance of health services has been initiated in a variety of ways, with a pro-active Lokayukta visiting all the 176 Talukas and institutionalizing the reforms. Vigilance cells in health department and the DME were developed to build capacity, while e-governance initiatives (such as computerization and web display of transfers, recruitment, policy-based promotion, and purchasing) play a significant role in preventing corruption through transparency and accountability. In all, the author had visited over 1500 Primary Health Centres (PHC) in Karnataka and not a single Medical Officer could tell the budget of their PHC. Capacity-building in health and hospital management, leadership, decision making, and problem solving are very important in improving the systems within our healthcare institutions. In addition, initiatives for staff welfare, improved community participation and monitoring through hospital and health committees, citizen's charter, report card system, and public grievance redressal are other measures to counter corruption at the grassroots level.

Prevention of corruption

The prevention of corruption is however a bottom-up process, beginning with a People's Movement against corruption. It is common knowledge that corrupt people have better networks than people with integrity. There is thus a dire need for networking of people with integrity. In addition, stress on value-based education, awareness of the Right to Information Bill and Transparency Act and consumer forums needs to be strengthened. Simultaneously, there is a need for electoral reforms so that the gains in the grassroots are not lost at the policy-makers level.

Partnering with non-profit, public-oriented NGOs to address critical gaps in the public healthcare delivery system is an important step, and KT and VGKK have made strides to this end. Good NGOs should not be mere 'contractors' of services; they must be involved in planning, monitoring and implementation as well, keeping public goals in mind.

As in many other countries, corruption in India is just a passing phase, as evidenced by the changes of the past few years. Today, with the same budget of 80 crore, it is now possible to provide primary care in most hospitals in Karnataka. In a few districts, with good leadership, doctors are staying at the headquarters. This is a good sign for our country. Also, various technological packages may produce marginal gains in health care. However, through good governance, 20-30% improvement in the health outcomes may be attained.

As the Chairman of the Task Force, and later, as the Vigilance Director of the Karnataka Lokayukta, the first author's involvement with these institutions helped in disseminating the learnings of Karuna Trust and VGKK, and in fact, they are vibrant examples of partnership in action in primary health care and good governance. There is a need for organizations like Community Health Cell and Karuna Trust to engage on a long-term basis with the State to strengthen the public services and governance. ■

*(*Padmasri Awardee, Honourable Secretary, Karuna Trust, and Treasurer and Executive Committee member of SOCHARA.*

***Coordinator, Health and Biodiversity, Karuna Trust, Karnataka)*

Awareness and Advocacy

A double-edged sword for tobacco control

S J Chander

The Portuguese introduced tobacco in India some time during the 16th century. Gradually as its use spread across the country, it became one of the valuable commodities in barter trade. In the absence of scientific knowledge on its ill effects and addictive nature, its use gained social acceptance across all social groups in the country. In spite of scientific knowledge available at present in volumes on the implications of various aspects of tobacco consumption and cultivation, its control has become a bigger challenge as a result of the tobacco industry globally backing the issue.

Western countries have achieved notable success in tobacco control through legislative measures. Higher literacy level and civic sense have helped in implementing the legislative measures better there. It would take a long time to achieve tobacco control through legislative measures in countries like India as the prevailing socio-economic conditions would not allow effective implementation of legislative measures. Therefore, one should not think that there is no need for legislative measures. Considering the great need for awareness on the ill effects tobacco consumption and cultivation in the country, the current legislative measures by the government will go a long way in creating awareness among millions who are both literates and non-literates in the country. Civil society organizations, as they create awareness and carry out advocacy measures, should actively support the initiatives of the government for tobacco control through legislative measures.

Reasons for its consumption

Currently, in India, there are over 250 million people across all ages and socio-economic background using tobacco products of various forms. The reasons for tobacco use vary across cultures and age-groups. The young use tobacco products out of curiosity, peer pressure to make others, especially movie stars, to overcome stress, to deal with boredom, for relaxation and to show that they have grown up. Adults who regularly use tobacco products use them as a result of addiction. The craving compels them to use but they attribute many reasons for its use such as it helps them to overcome tension and stress etc. Once, a young student during a campaign that Community Health Cell carried out among college students said that he knew that a cigarette contained tobacco and tobacco contained nicotine but he did not know anything about nicotine. When asked why he was smoking, he had no answer. It is fun and fashion for millions of youngsters such as this student. It would be worth the effort if one could stop young people while they are experimenting with tobacco products and before it becomes an addiction. On another occasion, a smartly dressed business executive when asked about the cigarette in his hands, he said that he knew about the harmful effects of tobacco and quit smoking six months ago but started again. Mark Twain rightly explains the nature of tobacco addiction in these words. *"I know how easy it is to quit smoking, because I have done it a thousand times"*. The tobacco industry is solely responsible for creating a socially acceptable environment for tobacco consumption through its various expensive strategies.

Rationale for its control

Tobacco as a crop needs to be eliminated though not instantly. Its cultivation and consumption has multiple implications on the individuals, their homes and the nation. Tobacco has been a source of livelihood for a few millions in the country, currently there are about six million Indian farmers engaged in tobacco farming and about 20 million people work in tobacco farms. About 250 million people in the country consume tobacco. They are susceptible to various health risks that tobacco consumption poses. About nine-lakh people die due to tobacco-related diseases in India every year. In 1999, the Indian Council of Medical Research (ICMR) estimated the cost of tobacco-related illnesses at Rs. 277.6 billon. However, experts are of the opinion that it is much higher as this figure was arrived at from a small sample.

How could one estimate the cost of loss to the family when the main breadwinner dies due to a tobacco related illness? Hanumathappa, a thirty-six year-old man, was admitted in a government hospital with one of his legs amputated as a result smoking bidi. The findings of research tell that nicotine clogs the arteries. As result of clogged arteries, a smoker has high chances of being affected by gangrene and heart attack. Hanumanthappa's other leg also had developed gangrene and it was about to be amputated when I met him. He was aware of the cause of his health condition: with folded hands he said *"I would never touch bidis in my life again"* but it was too late. I came to know that he passed away a month later, leaving behind his young wife and two small children. This is just one story. There are thousands of such deaths taking place in the country every year and many of which go unnoticed.

Tobacco cultivation contributes to serious environment degradation. It is estimated that to cure 1 kg of tobacco, 6 kg of wood is used. Immeasurable amount of deforestation already has taken place in many parts of the country by cutting down trees for curing tobacco. Research also reveals that those who work in the tobacco-farming suffer from green tobacco sickness (GTS). And those who work in curing the plants also suffer from various ailments as a result of inhaling the vapour. Who bears the cost of treating these illnesses and who compensates the loss of wages when the labourers are unable to work as result of GTS and other sicknesses? The argument that elimination of tobacco will lead to loss of livelihood for millions may be true, but consider the following argument; if people lose jobs they can be replaced with political will, if we people die due to tobacco related illnesses, can we replace lives?

Who bears the cost of treating these illnesses and who compensates the loss of wages when the labourers are unable to work as result of GTS and other sicknesses? The argument that elimination of tobacco will lead to loss of livelihood for millions may be true, but consider the following argument; if people lose jobs they can be replaced with political will, if we people die due to tobacco related illnesses, can we replace lives?

Control measures

But for the efforts of the World Health Organization (WHO), the tobacco control measures across the globe would not have gone a long way. Apart from taking up the issues at the ministerial level, WHO gave a lot of space for civil society organizations to actively contribute through the network Framework Convention Alliance (FCA). The Community Health Cell is a member of the alliance. Since 1999, CHC has been actively involved in tobacco control activities both at local and global levels. It is making various efforts to take the issue across professional groups, students and the rural and urban poor communities. The groups have shown tremendous interest. Thousands of college students came forward to form the network of student's action against tobacco in Bangalore and canvas for government action to protect them from the aggressive marketing strategies of the tobacco companies targeting them. Over a hundred high schools and hundreds of street children have participated in various programmes to create awareness on tobacco and advocacy on tobacco control. Many of them have been the change agents among their friends and family circles. Once a little girl narrated how she was instrumental in helping her father quit smoking after a session on tobacco with her class. When she came to know through the session that tobacco consumption could lead to many serious health problems, she simply appealed to her father *"Daddy, I do not want you to die of heart attack, I need you"*.

CHC has also carried out awareness programmes in industries such as Mico-Bosch and the Larsen & Tubro in Bangalore. Some of the industries like Mico-Bosch

(Continued on page 56)

Revitalizing Primary Health Care through Women's Empowerment

Sudhamani N

The World Health Organization has defined Community Health workers as workers who live in the community they serve, are selected by that community, are accountable to the community they work within, receive a short, defined training, and are not necessarily attached to any formal institution (WHO Study Group,1989).

Good health is an invaluable asset for better economic productivity, both at the individual and national level, but it is valued by those who own it as a prerequisite for a better quality of life and better standards of living. Those who are at the highest risk of poor health and its effects on longevity and morbidity are the poor, women and children, especially those in the lowest strata of society.

The inability to access healthcare and to spend on healthcare are the main reasons among these marginalized groups for their poor health status. Public healthcare systems do not have enough outreach to them; it is a known fact that rural India is facing an acute shortage of trained medical personnel. Across states, only 6.3 percent posts are vacant whereas 67 percent of doctors enrolled remain absent from duty.

Women undergoing Community Health Worker's Training

Women and Health

Community Health Cell's experience in Karnataka on empowering the poor rural women to be health activists/community health workers and its impact on primary health care is narrated here. The Ministry of Health and Family Welfare initiated a project towards empowering women for health with financial assistance from WHO-SEARO in 1998 to address the physical and emotional health problems of vulnerable groups of people in 15 states. Community Health Cell was identified as the lead NGO for the state of Karnataka to devise and conduct training programme 'Towards empowering women for health' along with other collaborators in Karnataka. This was in line with CHC's objective to render training to health workers from all levels in government and NGO sector.

Community Health Cell identified ten NGOs to be trained on health aspects. These organizations were engaged in empowering women through self-help groups (SHGs). The programme aimed at training 144 women

covering at least two women from each SHG, whereas the participating NGOs extended the programme covering more than 500 women from five districts viz., Bangalore Rural, Chamarajanagar, Bidar, Koppal and Bellary. Training was done in two phases of one week duration to strengthen an individual's knowledge on the understanding of health and women's empowerment, the various schemes available, social underpinnings of women's health and exploring strategies to take up at the village level. The training used participative methodology including exercises on self-reflection, personal growth, spiritual reflection, games, role-plays, songs, yoga and exercises.

Community Health Workers from Karnataka sharing their experiences on the 30th Anniversary of the Alma Ata Declaration

At the end, the women participants described simple and meaningful changes brought about by the training programme.

➢ *Participants' overall perception of the training*

- Individual's understanding on health issues increased
- Better understanding of superstitions
- Clear understanding of impact of nutrition on women's health
- Clearer understanding of the need for hygienic conditions and sterilisation
- Increased their confidence and women became more articulate

➢ *Many women described the following changes in their personal lives*

- They ate when hungry and did not wait for men
- Many of them ensure that some vegetables or greens are included in every meal
- Got the strength and confidence to bring in changes and to talk about health matters and alcoholism with others
- Increased their mobility
- Felt that they could influence the decisions regarding girls' marriage
- They spent at least 15 minutes for physical exercise and meditation when they meet for the sangha meeting. Some of them try to do it everyday to see the changes that would be brought on their health
- Personal hygiene was maintained during menstruation by having regular bath and washing clothes. Earlier they did not change their saris for three days. They started advising other women and especially the younger ones in their families

➢ *Community level action*

- Applications were submitted to the Panchayats to clean the drains and the areas around the source of drinking water and to build toilets in their villages.
- In Jagatgiri village of Kudligi taluk, Bellary district, the sangha women stopped the people from using the school compound for toilet purposes
- Seven Sangha women got together and stopped a child marriage (12 yrs old) in Rampur village, in Bellary after discussing the ill-effects of child marriage
- Role in ante/post natal care – Started maintaining records of pregnant women, births, herbal medicines used and list of women undergoing sterilisation
- Advised pregnant women to eat better food including papaya (as women do not take papaya during pregnancy for fear of miscarriage)
- Along with *dais*, advised pregnant women and their family a few days before the due date to clean the place where the delivery would take place
- Encouraged breast-feeding within half an hour of delivery instead of starting after three days
- Advised to give more vegetables and water after delivery and to break the belief that more water consumed would distend the stomach
- They discussed on HIV and sterlisation of needles among the people and with the ANMs. Women understood the causes for HIV and decided to hold village-level meetings to create awareness among the youth

(Continued on page 58)

Community Health Approaches in Environmental and Occupational Health
– *the CHESS experience*

Dr.R.Sukanya

Community Health Cell, along with a few other organizations, co-initiated a process of sharing and learning skills on performing simple epidemiological surveys for groups campaigning for environmental justice in India. This was in response to a specific need articulated by environmental groups fighting industrial pollution, hazards of mining, use of pesticides in agriculture and occupational hazards, towards understanding the health impact of pollution and toxins as well as gaining skills that will help communities to study the local health problems in a more systematic and scientific way. This is how the Community Health-Environment Survey Skillshare (CHESS) process started in 2001. Till date, there have been four CHESS workshops, two being on environmental issues, two (2004 and 2008) focussing on mining, occupational health and safety respectively.

What is CHESS?

Community members, environmental activists, scientists, and campaign organizations who are actively involved in the struggle against damage on land, water and livelihoods by industrial pollution (Kerala (Eloor), and Gujarat); toxins like pesticides (Endosulfan in Kasaragod, Kerala), mercury (ex-workers of a mercury thermometer factory in Kodaikanal) and mining (Andhra Pradesh, Orissa and Bihar) felt the urgent need to identify and document the health impact of environmental toxins and the pathways of environment exposure. **The main aim of the CHESS workshop was to build skills among various community groups in conducting community health surveys through tools that are relevant and usable by the people and to effectively use this information for their ongoing campaigns.**

CHESS 2008 – Prioritising worker's health – A strategy and resource-sharing workshop

CHESS process aims at

- Creating a multi-disciplinary resource base of medical practitioners, community activists and toxicologists capable of conducting community health surveys in communities subject to industrial and environmental pollution
- Promoting interaction between community activists and community health experts to facilitate a discussion aimed at understanding the strengths and limitations of community health surveys
- Understanding the role of community health surveys in campaigns against pollution.

CHESS workshops

Three workshops were held between 2001 and 2004 and one in 2008 specifically on worker's health. In each workshops, participants shared their experiences in their ongoing struggle against pollution, the perceived health impact on the people and their campaign efforts. The various aspects of community health surveys – design and implementation, resources and resource-sharing

opportunities, case-studies from various groups on how they used health surveys for campaigning — were shared. The sharing of different groups highlighted the **challenges in any kind of community health action** – vested interests of the company and the government; dichotomy between workers and other people living in the same community; lack of infrastructure and resources for health care and lack of a comprehensive understanding of the widespread and long-term impact of pollution.

The workshop also went beyond its narrower objective of capacity-building, with the coming-together of a larger network of people's groups, environmental activists, occupational health doctors or activists, lawyers, workers, union members, consumer groups, farmers and researchers. The coming-together created tremendous solidarity and positive energy with the sharing of stories, songs, movies and the networking of people's resources.

A lot of meaningful activity took place as a spin-off of the CHESS workshops- ***Community health surveys*** in industrially-polluted areas of Patancheru in Medak district of Andhra Pradesh, and Eloor in Ernakulam district of Kerala; ***Fact-finding mission*** of farmer deaths in Warangal district and health hazards of endosulfan spraying in Kasaragod, Kerala and *Health surveys* — development assessment of children in Punjab exposed to pesticides and neurological assessment of ex-workers exposed to mercury in Kodaikanal. In all these, CHC team members played a crucial role in supporting the groups, in refining the methodology of the study as well as reviewing the results of the study and highlighting the community health dimensions in each setting. In Kasaragod, a CHC team member helped in developing a short documentary, 'Sprays of misery in Kasaragod', on the health impact of aerial spraying of the pesticide endosulfan.

The Mercury Story

In Kodaikanal, Dr.Mohan Isaac, a SOCHARA member, led a preliminary situation-analysis of the health issues of the ex-workers of the erstwhile Hindustan Lever thermometer factory. His observations supported the people's campaign for a rigorous scientific study. Interestingly, doctors of Hindustan Lever presented the findings of the company-initiated study to the CHC team and other environmental and occupational health experts associated with CHC. The CHC team and associates found serious gaps in the study and called for 'more transparency and accountability' in divulging the full details of the study. They also stressed the need to 'look into evidence in an interactive, participatory and holistic way' focusing on the health of workers.

To this date, CHC team members have been supporting the court case of the workers against the Hindustan Lever Ltd (HLL) Company seeking justice and equitable compensation. The HLL worker's struggle as well as the other struggles highlighted in this article have brought about the various dimensions of the importance of the CHESS process:

- Ensuring that the "Polluter Pays"
- Mobilizing the community on the understanding of linkages of environment and health of communities.
- Preventing Future Harm – armed with the knowledge of pollution and wider health effects, communities can play a more active and informed role in deciding the course of their communities' development.
- Countering Government or the Industry – the major impediment is the baseless assertions of the industry and the government that a community's problems have nothing to do with the pollution they are subject to. Health surveys by the communities can help them to demand with governments or industries to establish beyond doubt that the polluting activities of industries or toxins are not related to the community's health problems and will not cause health problems among people.
- Health Care Needs — even after the BHOPAL gas disaster tragedy, the public health system in India is not geared to address the health care needs due to effects of recent or long-standing pollution and definitely not at all equipped to handle any emergency situation like an accident or gas leak.

Future role of CHESS

The CHESS process endeavours to highlight the impacts of pollution / toxins on the health of a community by building capacity among diverse groups in addressing environmental and worker's health issue. Community groups and activists learn skills of performing health surveys and professionals (medical, public health, toxicology) learn about health effects of toxins and other pollutants, adopt and develop indicators that are easy and simple to use. One of the activists describes the synergy, "*CHESS brought together two very important groups of people – those who know how to organize and fight, and those who can offer new tools and weapons (health surveys) for strengthening the fight*".■

(The author is Research and Training Associate, Community Health Cell, Bangalore 560 034)

Community Monitoring for Health for All

Dr Rakhal Gaitonde

Community-monitoring is one of the main pillars of the National Rural Health Mission (NRHM). Community-monitoring is a basic right of every community. As the public health care system, including both the salaries and the infrastructure, is paid for by tax payer's money, it is every citizen's right to be aware of how that money has been used. Apart from this, monitoring is the first step in raising awareness and collecting information that can be used in planning for health.

While we are very careful when we buy a bar of washing soap or a packet of salt or sugar, and we check the packet and the expiry date and return the packet even if there is a slight hint of damage, we seem to care very little about the type of health care that is provided to us in both the public and the private health care systems. This is partly because of the mystification of health and the feeling that as common persons we cannot question the practice of persons who have spent many years in studying the subject. However, it has been well established that unless health systems are accountable to the communities they serve, they cannot contribute to Health for All.

Some basic requirements for community-monitoring include the following:

- ***Awareness among people:*** Even though medical care is a complicated issue, it is possible for lay persons to understand enough to be able to engage with and demand accountability from the health care system. Towards this end, guarantees by the government and standards set are useful guides to what is to be expected (and that can thus be demanded) from the system. Therefore, people must be aware of the guarantees and standards themselves. Unless people know what is supposed to be offered at health centres at a particular level, they cannot monitor. Thus there is a lot of preparation required for communities before the monitoring and planning process.
- ***Structure / organization:*** It is obvious that monitoring has to be done by a group of people. Single individuals will find it very difficult to confront authority and question it. However, while it is true that a group of people is needed to monitor anything,the group has to be both representative and acceptable to the community in order to work for Health for All.
- ***Redressal mechanism:*** It is important to evolve proper redressal mechanisms to respond to the issues brought up by the monitoring groups. Unless there is a prompt response by the system, the monitoring group will get frustrated and disheartened. Of course, these redressal mechanisms need to be jointly evolved by both the people and the public health system.
- ***Sensitization of the public health staff:*** It is also important to sensitize the staff in the public health system about the issue of monitoring and that it is every community's right to monitor the health system. It is important to emphasize that monitoring should not be converted into individual blaming; it should attempt at *raising and understanding the underlying systemic issues*. The idea is not to confront staff but to improve the system together (the staff and the community).

Steps in the Community Monitoring process:

- ***Awareness-building:*** The first step is to get people enthusiastic about the whole process. To do this, it has to be something which people find important. There needs to be a concerted attempt at raising the awareness of the people both in terms of their rights as well as the guarantees to them. Ideally, this information should be made aware to them by the government itself. However, more practically, it is up to interested NGOs and CBOs to conduct

awareness programmes. Alternatively, interested citizens / community groups can collect information regarding their rights and the guarantees and standards from government websites *www.mohfw.nic.in/NRHM/iphs.htm* or through the Right to Information Act *(www.rti.gov.in).* Even simple information like the days the ANM is supposed to come to the village is very empowering and can galvanize people into action.

- ***Formation of committee:*** The committee must be representative of all the groups in the community and the process of its constitution should be transparent and acceptable to all. It is better to conduct awareness-building activities first before beginning the process of committee formation. Apart from the committee at the village level, it is important to form supportive committees at higher levels of administration like PHC, Block, District and State. These committees can gather information from committees below them and work with the government officials at their levels. While some problems can be sorted out at the village level itself, many issues need to be sorted out at higher levels and thus the presence of committees at various levels is very useful. The committees at higher levels can also play an important supportive role in training and capacity-building in committees at lower levels.
- ***Developing a monitoring checklist:*** It is important to create / evolve checklists that the monitoring committees can use while monitoring a particular service or institution. These checklists must be easily understandable, relevant and easily collectable at that level. Also the more tasks the committee is able to complete successfully as a group the more confident it gets. Thus, in the early stages, it is important to get the committee to perform simple and doable tasks to boost their confidence.
- ***Monitoring:*** Monitoring should be done at regular intervals and the results of each round of monitoring should be discussed at the level of the village itself. Only if the results are discussed at the village level it self can the people identify gaps, recognize trends (both positive and negative) and get information to discuss priorities. It is important that monitoring does not become a purely confrontational process. It should be seen as trying to uncover the systemic issues rather than blaming individual functionaries.

Other important issues:

- The role of the Panchayat: It is important to understand that however enthusiastic the NGO or CBO that is facilitating the project is, it is finally only structures like the Panchayat Raj institutions that can truly sustain such processes. It is thus important to get both the individuals as well as the institution involved.
- From monitoring to planning: Monitoring should not be seen as an end in itself. It is merely a means (albeit an important one) of gathering enough awareness and information so that communities can perform simple health planning exercises. This is a crucial aspect of community participation and crucial for the achievement of Health for All.

CHC has been facilitating the implementation of the Pilot phase of community monitoring project in Tamil Nadu and in Karnataka.CHC has been supporting all the activities mentioned in the monitoring process.

In Summary

- In this project, there is the formation of committees at various levels and training for these committees.
- There is an extensive checklist / questionnaire that the village health and sanitation committee members need to fill in once in three months.
- The information collected should be analysed at the village level itself.
- The information is then put together as a report card with colour-coded assessments – with *red* indicating poor performance, *orange* indicating fair performance and *green* indicating good performance.

At the end of the Pilot phase of the Community-Monitoring, the government is supposed to expand this to the whole state based on the recommendations emerging from the pilot phase. ■

(The author is Training and Research Associate, Community Health Cell, Tamil Nadu)

Key learnings from Community Monitoring

- There is tremendous enthusiasm among people to monitor and plan. They are very keen to get their rights. It is a great step towards the building of a people's movement for health.
- It is important to develop a strong district team to support the various stages of the programme and help in monitoring and analysis of data.
- It is important to plan in such a way that there are multiple engagements with the people – just one or two workshops are not enough for these concepts to sink in.
- Communities really like to understand the logic behind specific interventions. Explaining to them the logic of interventions / practices empowers them and they become more confident in questioning even doctors.

New Roots, Newer Generation

Naveen I Thomas

"Nature does nothing uselessly."
Aristotle (384 - 322 BC), Politics, Book 1.

Nature has been recognized as an ageless teacher from time immemorial. And the wise among us heed the lessons of nature. In nature, we find that propagation and nurture of young ones take on a special meaning. All species of animals and plants have their own unique ways of propagating their species and helping them to survive. Human beings too have devised their own methods to ensure that the young ones survive and thrive, even in the harshest of environmental and external conditions.

The People's Health Movement (PHM) globally, and Community Health Practitioners in India are two such groups that heed the lessons of nature and give importance to propagation and nurture of a younger generation of health activists and community health practitioners respectively. The PHM formed the International People's Health University (IPHU) to achieve this end. The Community Health Fellowship Scheme (CHFS), later called the Community Health Learning Programme or (CHLP) was one such initiative that has been playing this role in India, and continues to do so even today.

Fellows holding a medical camp during Tsunami relief in Tamil Nadu

Community Health Fellowship Scheme

The year was 2003. Three idealistic youngsters who were keen to explore community health work were selected to undergo the newly launched Community Health Fellowship Scheme by Community Health Cell (CHC), Bangalore. One of them was a dentist, another a doctor who had completed his postgraduation in Community Medicine and the third was a social worker. All three underwent a series of orientation sessions in community health which led them to explore their own motivations, aspirations and skills in community health. They were mentored in this process of reflection and skill-building. They were also given opportunities to share their experiences and learn from each other. People who had chosen the community health approach in different contexts were invited to share their experiences with the three young people. They also visited many community health projects across the country. Specific resources from the CHC Library and Information Centre were given as reading materials. All three of them were encouraged to present what they had read, following which there were discussions and debates in which the entire CHC team participated. After all these exercises, they were helped to choose their own paths in community health. One of them chose to work with a community health programme in Andhra Pradesh; the second person wanted to live in an urban slum in Bangalore, living, experiencing and learning from the people he wished to work with; while the third person chose research and action to support community health. They were mentored by senior members of CHC, and the partner organizations where they had been placed.

This was just the beginning. Over the next three years, forty young professionals were oriented and trained in community health by undergoing a similar rigorous experience. Around forty per cent of them were not provided any scholarships, leaving them to find

their own means of support during the training period. Twenty-three participants were provided fellowships, 44% of them were women. The fellows came from all over India, nearly half of them were from North India. The fellowship also attracted young professionals from different disciplines-about 60% were from the social science background, while the remaining were from the science and medical profession.

The fellowship offered different things to different people. It opened up a whole new world of community health, very different from the community medicine that some of them had studied in their medical courses. Dr. Vinay, a doctor from Bangalore, wrote at the end of his fellowship: *"The team at CHC provided me with one of the best learning opportunities in life. If not for the fellowship, I can imagine myself working my brains out there in the rat race for a seat in postgraduate medical education"*.

The fellowship helped some other participants to find their areas of interest within community health. The open-ended, participative, and person-centric approach adopted in the fellowship was designed to do just that. For some others the approach followed in the fellowship helped them to grow as individuals and professionals. Dr. Sandhya, a dentist from Karnataka, summed up her learning as follows: "*The fellowship experience allowed me to grow individually as a person especially in matters of creative thinking, positive thinking, the art of listening, reflecting, team work, and in becoming a good team member. Now since I know about the wider aspects of the world I live in, it just motivates me to continue learning more about life by being more with the people and working with them to build up a better community."*

Genesis of the Scheme

Community Health Cell (CHC), since its inception in 1984, had been providing short-term placements for young professionals who were in the process of reflecting about their personal interest in community health. When CHC conducted a review in 1998, it was found that over 95% of those supported through short-term placements continued to work in community health. The reviewers suggested that CHC "*should consider the evolution of a more structured training programme in community health, which explored and focused on Indian experience and stimulated participants to the 'social / community' paradigm"*. After a series of preparations and discussions with other community health organisations working in various parts of the country, the Community Health Fellowship Scheme was formally launched in April 2003.

The objective of the scheme was to promote life options in community health by offering a semi-structured, placement opportunity in CHC, in partnership with select community health projects by:

- Strengthening motivation, interest and commitment of persons for community health,
- Sharpening analytical skills, and
- Deepening the understanding of the societal paradigm of community health.

Revamped Programme

In 2006, the Community Health Fellowship

The first Fellow reminisces...

In the early 1980s, Medico Friends Circle (mfc) bulletin was edited by Kamala Jayarao and we found it on the shelves at the college library. A trip to Bangalore brought me face to face with a member, Dr Ravi Narayan. I was referred to him by Babu Beckers, my Chemistry teacher. A later trip to Bangalore with Dr Robin Mendanha from Physiology Department took me to a meeting of Dr. Zafarullah (Gono Swasthya, Bangladesh) on *Medical Education*. The meetings were organized by Ravi at St Johns and at IISc in Bangalore. In the third year, I decided to leave medical college and explore slums and villages in India.

My Principal was happy to hear that I was in touch with Ravi Narayan. Two others whom I met before my journey were Dr V Benjamin (who had taken classes for us before his retirement) and Dr CM Francis (who was in the Continuing Medical Education Cell at Vellore by then). I also met Dr Abel among others at RUHSA. Dr Benjamin and Dr CM Francis are remembered as the wise-old men of CHC.

My first stop in 1984 was at the Koramangala home of the Narayans. Ravi and Thelma were joint editors of MFC Bulletin and Ravi Narayan promised me a free subscription if I wrote about my travels. I went every day to Fr Claude for classes in Sociology. After about two weeks, I decided to move on. The next place I visited was CINI where I met Dr Samir Chowdhury. Ravi and Thelma also invited me to a CHAI Conference in Bangalore while I was in Nemur, studying Siddha medicine. The conference theme was *Traditional Remedies,* I guess. The year1984 ended eventfully with a trip to Bhopal after the gas tragedy. In January 1985 I was also able to attend a nMFC meet (on TB) at ISI Bangalore.

This trip of mine to explore, leaving the medical college, is what CHC has evolved as the "internship" programme. ■

Dr. Prabir Chaterjee is a Consultant on Routine Immunization based at Raiganj. He worked with UNICEF, West Bengal in 2004-08

Programme was evaluated by two external evaluators. The main drift of their recommendation was to "*consolidate the gains, strengthen the infrastructure and grow*". Keeping in view the recommendations and changing needs of the health movement, a revamped learning programme called the Community Health Learning Programme (CHLP) was launched in 2008. Currently, there are eight young professionals in the full-term 9 month programme and six young professionals who have completed flexible fellowships. As in the earlier programme, they include young men and women pursuing various vocations such as public health, nursing, medicine, engineering, social work and social sciences. Their backgrounds and experiences are also widely varied which greatly enhances the community health learning and thinking process.

New Roots, Newer Generation

The Community Health Fellowship Scheme was seen as the twentieth-year milestone project of the Community Health Cell (CHC), when it started in 2003. As CHC celebrates its silver jubilee in 2008, it can look back with satisfaction at the learning programme it had initiated. As the external reviewers of the scheme noted, an overwhelming majority of the participants of the programme are working in various community-health-oriented programmes across the country. It has also inspired a whole new generation of medical graduates to look at community health as a career option which fulfils their idealistic notions and visions of "Health for All".

A new generation of young professionals are rediscovering the meaning of Rudolf Virchow's statement made in 1849 "*For if medicine is really to accomplish its great task, it must intervene in political and social life. It must point out the hindrances that impede the normal social functioning of vital processes, and effect their removal*." (quoted in Pathologies of Power, Paul Farmer, p. 323).■

(The author is *Ph.D Scholar, Tata Institute of Social Sciences, and former fellow and staff member, CHC)*

(Continued from page 47)

declared their workplace as 'no smoking' and conducted "No Tobacco Day" programmes to encourage their workers to quit tobacco use. The team members of CHC have addressed the issue through news print, television and radio on many occasions. Awareness programmes conducted in railway stations, bus stations and many public places have covered thousands of people across all backgrounds. The students of an eminent city college had produced over 100 master-pieces of art through an awareness programme conducted for them. These posters are being used in awareness programmes. Celebrities from sports, film, social and environmental sectors supported the campaign.

Community Health Cell is part of a network that organizes the World No Tobacco Day (WNTD) every year in Bangalore . A reflection after a public awareness campaign led to the formation of a state level network known as 'the Consortium For Tobacco Free Karnataka (CFTFK)'. Considering the growing pandemic, many of the network members felt the need to engage both in advocacy and awareness programmes. CHC along with the CFTFK members have sent memorandum to the Members of Parliament as well as to central ministers for the passing of the National Tobacco Control Act in the Parliament.

While it easier for the individuals and organization to create awareness, it is easier for the networks to address advocacy issues. The Advocacy Forum For Tobacco Control (AFTC) is an example of a national-level network that has actively contributed towards development of many innovative programmes and policies.

Tobacco is a social problem! Therefore the solution has to be social. The Government of India is already making efforts to make desirable change through the recently launched National Tobacco Control Programme (NTCP). Every district is going to have a District Anti-Tobacco Cell. Let us strengthen the efforts of the government. It is community participation that will make a big difference. Community Participation is one of the four pillars of Comprehensive Primary Health Care — a potential approach to achieve 'Health For All'. The need for drastic social change is absolutely essential considering the huge loss of lives and economy due to tobacco consumption and cultivation. It is time that each one of us educates others and ourselves. Little drops make the mighty ocean! ■

(The author is Faculty, Institute of Public Health, Bangalore; and former CHC team member)

CELEBRATING Community Health Cell

Some Reflections

Prem C John

The seventies and eighties were, to borrow a phrase from an old song, a time of innocence. Following up on the concept of community health that evolved during the late sixties, several, though not too many, people were reaching out to communities in order to make health more accessible to those who needed it most. Doctors, as is well known, were not scholastically prepared to deal with communities, with social issues, in fact with ordinary people except in a clinical, four-walls-type of situation then. (Whether the situation is any different now, we don't know!). The fact is that those who went into communities went in wide-eyed and mostly devoid of skills to integrate and serve the communities of the poor. The fact is also that most of them were willing to de-learn, learn from the communities that they were serving and thus become more relevant to them. The fact is also that the early successes that they undoubtedly achieved (to name a few – Jamkhed, Deenabandu, Aurangabad, Hoshangabad etc.) were due mostly to chance than to a considered, informed, educated plan of action.

In this scenario came Community Health Cell (CHC). They dared to dream differently. They dared to follow up on their dream. Rather than depending on a throw of the dice, they came with an informed plan of action. This would not have been possible if CHC had a mere academic background. The people involved – Drs Ravi Narayan and Thelma Narayan, and their team of capable young people – were primarily activists in academic clothing but the time, then, was ripe for such interventions, such 'educated' inputs, such university type of organized thinking and action in the guise of activism. This brought a qualitative change to the practice of community health and gave a handle, as it were, to other practitioners striving to fill the needs of the poor.

CHC's influence, over the years, has been felt at different levels. Firstly, at the grassroots level, informed interventions brought about tangible changes. Their involvement with faith-based organisations, which had and still have a very significant role to play in health services, especially at the community level, brought about national-level change in thinking, planning and implementation of community level programmes.

Secondly, CHC then, intervened into mid- level activism by training a large number of trainers of health workers who continue to play a significant role in making health a reality to the poor.

Thirdly, CHC selected and trained enthusiastic, dynamic, committed community heath thinkers and activists with leadership potential who were then able to make an impact at the national level.

Fourthly CHC, consciously involved itself with the government and its systems and structures which many community health activists and practitioners had looked upon with suspicion. As one looks back, this fourth thrust was one of the outstanding strategies that have paid rich dividends since, ultimately, the state has the primary responsibility for providing health. Provoking the state with creative ideas of action and influencing state implementation of health delivery systems on a geographically and demographically significant scale has been one of the major achievements of CHC, of continuing significance.

Fifthly, by involving itself with national entities such as Jan Swasthya Abhiyan and Medico Friends Circle, CHC was able to draw upon their experiences at various levels to influence thinking and practice at local and national levels for non-governmental organizations and state and national health systems.

Sixthly, on an international level, CHC's achievements have been no less than outstanding. On the strength of their community level and national level achievements, they have been able to intrude into international health thinking and decision-making with special reference to the World Health Organisation where CHC's influence has been pervasive.

Along the way, CHC successfully demonstrated that it is possible to raise significant amounts of money from Indian sources instead of relying solely on foreign funds alone.

Having done all this, they involved themselves with the People's Health Movement (PHM) wholeheartedly and hosted the PHM Secretariat in Bangalore for three years. Three very significant years in the growth and outreach of PHM. In a sense, the philosophy, the values, norms and practices that CHC developed over the years are now part of the people's health movement worldwide.

Their record has been outstanding and achievements countless and of far reaching significance. Ravi, Thelma and their team have set an example that is hard to emulate. It is also hard to write laudatory notes about them since a lily does not need gilding!

On behalf of Asian Community Health Action Network (ACHAN), the Chairperson, Dr. Qasem Chowdhury and other trustees, it is my privilege to greet CHC on its Silver Jubilee and to hope that the next 25 years will prove quite successful for them.■

(The author is Honorary Coordinator , Asian Community Health Action Network, (ACHAN), and Co-Chair, Steering Council, People's Health Movement)

(Continued from page 49)

- They also discussed on common problems faced by women (white discharge) and got clearer understanding of identifying the symptoms to seek medical help in time.
- They learnt about components of herbal medicines for headache, pimples, cracked feet etc

The programme is still continuing through various efforts like advocacy, capacity-building and networking and all of these are linked to health action. Very recently, there was a meeting together of health workers from many parts of Karnataka to discuss their experiences and challenges in community health action.

Women in Primary Health Care

To commemorate the 30th Anniversary of the Alma Ata Declaration in a meaningful way, a two-day workshop for the community health workers of Karnataka was organized on 10th and 11th September 2008 by the Community Health Cell. Community health workers and health activists came together to share their experiences, challenges and hurdles faced by them in Primary Health Care.

Excerpts from the dialogue

- Women are playing a major role in addressing women's and children's health issues. They have developed skills in identifying diseases pertaining to women and giving herbal treatments. They have succeeded in conducting and assisting in normal deliveries and in identifying difficult cases and referring to the hospitals. In most cases they accompany women to hospitals during the time of delivery.
- Depending on the training received they have been able to identify malaria, T.B etc and in conducting the preliminary tests and referring to hospitals. They are also able to give medicines for common ailments.
- Those who were trained in herbal medicines have cured many cases of paralysis and skin-related problems.
- They help the poor and marginalized sections of the society in accessing the health systems, public distribution system, panchayats etc as well as tackling social issues (violence against women, alcoholism, superstitious beliefs etc) in the community.

It is evident from this experience that when women are empowered they are able to bring in changes in the community. Community Health Workers, mostly being local women, have tried to revitalize primary health care through the knowledge gained. There is a need to enhance their capacity with the updated knowledge to keep the community healthy and link them with the system to access their health rights. ■

(The author is Field Training Coordinator, Community Health Cell, Bangalore 560 034

CHC's Role in CHAI's Promotion of Community Health

Some Reflections

Fr. John Vattamattom

I came into the Catholic Health Association of India (CHAI) in August 1980, after heading a regional organization called Andhra Pradesh Social Service Society (APSSS), based in Hyderabad. I came on condition to promote rural health through Community Health programmes in what was primarily a 'professional organization, dominated by big hospitals'.

Fr. James S. Tong. SJ, the first Executive Director of CHAI (1957-74), had already sown the seed of community health.. He became my mentor, friend, philosopher and guide, with regard to the concept of Community Health. In addition, I also met Sr. Ann Cummins of Medical Mission Sisters, another champion of community health. This group of sisters had created history by moving away from big institutions and going to the communities.

Themes of our annual conventions soon included more and more of community health-related topics. During the exhibition held along with conventions, community health and alternative systems of health care found increasing space. Another step taken was the active collaboration and networking with VHAI, CMAI, AIDAN, MFC, ACHAN and other organizations with similar thinking.

After taking over as the Executive Director of CHAI in 1980, one of the first things I did was to go to St. John's and meet the then Dean, Dr. C.M. Francis. I told him about my mandate to promote community health in and through CHAI. Dr. Francis assured me of all help and introduced me to Drs Ravi Narayan and Thelma Narayan of Community Health Department of St. John's. I had already met Dr. Thelma when she came as a volunteer to the Andhra Cyclone Relief camp in Nagayalanka in 1977. A relationship, both personal and organizational, started that day with Dr Francis and the Narayans which continued throughout my sixteen years of leading CHAI; the relationship continues even today in all that I have been doing at the community level.

When Community Health Cell (CHC) was born in 1984 I was there. If I were a writer, I could have written at least a volume, if not more, narrating all that happened in and through CHAI during 1984-1996, with the support of the CHC team which included Drs Ravi and Thelma Narayan as co-initiators, and later Dr C.M. Francis, as consultant and advisor, and Dr. Shirdi Prasad as a trainer in alternative systems of medicine. If I could achieve anything in and through CHAI regarding community health, it was only because of this close link with CHC and these key resource-persons.

Reorientation of the CHAI team and its members to the new challenge of community health; the evolution of various training programmes in community health for members at various levels; the conversion of the in-house journal of 'Medical Service' to a more outward-looking journal for the voluntary sector *Health Action*; CHAI golden jubilee studies including the Delphi prediction on health situation in India and the role of the voluntary and mission sector; the development of interest in rational drug policy, and integration of traditional systems of medicine; and proactive networking efforts towards a health movement with other national networks by CHAI in those days — all these were possible through the catalytic support of CHC and its team of inspirational resource persons. This enthusiastic linkage continued long beyond my phase of directorship of CHAI. The Community Health Cell became a major technical and resource partner for CHAI in later years. Finally, it is because of the CHC's vision and persuasion that the CHAI network is now involved with people's health movement at different levels.

After leaving CHAI, I started *Sanghamitra*, the movement for social transformation working in Medak District of Andhra Pradesh. Community Health Cell continues to be a partner with our organization. We were also invited to be a mentor of CHC's Community Health Fellowship Scheme and Learning Programmes. As a honorary member of SOCHARA, I continue to be associated with CHC in all it does; as it celebrates its silver jubilee celebration, I am glad to share this short reflection and record my appreciation for this little cell and its continuing inspiration and motivation of so many people more towards community health action relevant to the Health for All movement.■

(Sanghamitra, Andhra Pradesh)

HEALTH ISSUES

Reappraisal of National Health Policy (10)

Need for comprehensive re-examination

Prof Ashok K Roy

PUBLIC HEALTH CONCERNS AND ANALYTICAL FRAMEWORK

Some of the Public Health Concerns and Conceptual (analytical) Framework discussed in details in late 1950s, 1960s and early 1970s are still valid to understand the health needs and health priorities of our country. A few are highlighted here.

- Agricultural production has declined, distribution is inadequate.
- Unemployment and Under-employment are still acute in rural, semi-rural and tribal areas, leading to disguised employment and under-utilization of manpower.
- Living condition: Water supply, sanitation, food and nutrition (related to distribution and health illiteracy), housing are still very poor, affecting the quality of life seriously. Ecological imbalances are adding on to this problem.
- Decreasing body resistance: prevalent more amongst, women and children, even in men in some tribal belts and remote villages with little or no employment opportunity.
- Poor yield: Prevailing at a much lesser extent; related to physical abilities of manpower,' work culture' and attitude is poor.
- Expenditure on curative medicine: expenditure is increasing at a much faster rate compared to increase in income which is also effecting the quality of life. Size of expenditure on 'family health' in a proportion to total family income is on the rise.
- Prophylactic medicine: emphasis is low which is more of an attitudinal factor rather than economic factor, more related to health illiteracy and low priority.
- Chronic invalid and handicapped: congenital deformities, physical and mental retardation, cancer, and kidney failure are on the rise and the largest threat is from HIV/AIDS positive cases.

One of the greatest public health proponents Prof. Stampr, on the eve of his death in 1958, came up with a few principles which are very valid in our situation:

- Health education of people is more important than any legal regulations.
- People should be constantly taught how to develop proper attitude towards public health affairs, life-style related diseases like diabetics and cardiovascular diseases. A large majority suffering from those disease are health illiterate
- Everybody, must take part in sorting out public health problems (country's leadership and media have a great role)
- The physician must always work on widest social basis because the results of an individual therapy do not reach all. It is only the group and social therapies which can lead to palpable results in promoting the health of people as a whole.
- Physicians must not be dependent on patients economically for such a dependence is a hindrance to the execution of his most essential task.
- Procedures and methods should constantly be sought which would enable, not prevent, the physician seeking and finding patients at early a stage as possible instead of having the patient looking for his physician when the disease is already far progressed.
- Public health problems, by their nature, are more economic than humanitarian

- A physician's primary place is where people live and work, not in laboratories.
- A good trained physician is the basic factor enabling good public health.

A much broader role of the physician in social change and development is neither properly understood nor discussed and debated in large social forums to create awareness.

Health problems of the country are more pronounced and precipitated it the following:

- Acute scarcity of resources
- Unhealthy and unhygienic living conditions – water supply, sanitation, housing etc
- Small proportion of the total population are capable enough to take care of their health
- Accumulation of health problems over a long period of time
- Shortage of health manpower both in terms of number and competence and skill.

Both national and state health planners and policy-makers are required to address the following continuously till such time an efficient and effective process is established:

- Which health problems to give priority to
- Which segment of the society to be accorded the priority in care
- Which optional methods (or combination of methods) to be used
- Which type of health care to be considered the most rational
- Which types of health personnel profiles are needed most and can offer most.
- Which kinds of institutions are the most appropriate.
- In what way to make the population itself active and participating as well as which political (administrative) authorities and professionals to include in solving of health problems.

Conclusion

Financial experts and economists are divided in their opinion whether expenditure on health is a consumption expenditure or investment. Health has three basic components (i) Prevention and promotion which include control programmes, environmental changes and developments (improvement of living condition), health education (ii) Health maintenance which includes immunization, periodical health check-up, lifestyle control programme, stress management, etc. (iii) Curative services including accident and emergency, critical care, investigation, diagnosis, treatment, care, therapy, etc.

The first two components could be easily considered as investment, the third one curative service is like a 'bottomless pit'; we may pour a lot in to it but it seldom contributes towards qualify of life, more particularly if it stands alone. Health economists have splitted their hair in respect of controlling cost of the third component without sacrificing basic human rights. But a lot of work has been done to minimize it, but 'unrestricted health insurance cover' is not an answer. It has only inflated the social cost as its emphasis is on 'curative service' at the break of health and or disease. Health plan which emphasizes on prevention, promotion and health maintenance is a much better model. Whether central and state government is capable of administering such a model needs experimentation with an open mind. Advocacy of health insurance is just a short-term solution. But it is possible to modify the principle as well as process of administering health insurance and developing a 'innovative, new generation scheme' within the basic framework of health insurance. I personally subscribe to a concept of that nature. Uncontrolled privatization of health is not an answer at all, as it is driven by 'super profit motive' of exploitation of human suffering when they are in distress. There is tremendous amount of wastages (mainly frills) which do not contribute to qualify of health services at all. A large group of senior physicians (specialists, consultants, and professors) strongly believe that their economic prosperity is directly dependent on magnitude of the illness, volume of patients, acuteness, prolongation, chronicity etc. Biomedical Science is advancing rapidly, if the fruits of such advancement could not be shared with the majority of the suffering population, the advancement could be considered futile from the view point of the society.

The country needs a lot of research, study, collection and analysis of authentic data and effective dissemination of observation and findings. A systematic process of consultation, both at the national as well as state levels involving experts from various fields is a must. The plans, programmes and policies are required to be reviewed from different viewpoints to evolve a dynamic process. The process of planning and implementation needs to be speeded up, knowing that a totally comprehensive and exhaustive solution to the highly complex health problems of a given society is an impossibility. Delay in planning and decision-making only contributes to further complication of such problems. A journey of a thousand miles begins with a single step and we should never try to withhold that step under any circumstances. *Concluded* ■

(Hospital and Health Management Consultant, Bishwatara, No.8, Lake Shore Homes, Kasavara Halli, Carmelaram PO, Bangalore 560 035)

HEALTH BITS

Young are at risk

How much you weigh and how old you are have a major effect on cancer risk, according to new studies. In adults under 45, tonsil and tongue cancers seem to be rising in many countries, due in part to the sexually transmitted human papillomavirus (HPV).

You can't change your age, but you can and should control your weight. What's worrying is that many recent surveys in India point to an increase in the incidence of obesity. And most people don't get screened for colon cancer until they're 60 (if at all), but the disease is on the rise in men younger than that. One likely reason: the new obesity epidemic.

Recently, authors of a major cancer report said that excess fat was linked to increased risk for six types, including colon cancer. Another study found that overweight and obese men with prostate cancer are nearly twice as likely to die as compared to thinner patients. You know the drill: diet and exercise to drop those deadly kilos.

Reader's Digest, October 2008

Whole body vibration does your bones and muscles good

Standing on a vibrating platform can be beneficial for muscles and bone, particularly in older or sedentary adults. Whole body vibration or WBV involves standing on a platform that sends mild vibratory impulses through the feet and into the rest of the body. It is claimed that the vibrations activate muscle fibres more efficiently than the conscious contraction of muscles during regular exercise. Some studies have found that WBV increases bone density in the hip, and inhibit bone loss in the spine and hip areas.

My Doctor, October 2008

Chocolate as medicine?

Here's even more evidence that chocolate can make us healthy:

It can lower blood pressure. Researchers at the University Hospital of Cologne, Germany, gave 44 people with borderline or mild hypertension 30 calories a day of dark or white chocolate. After about four months, the number of dark chocolate eaters diagnosed with hypertension dropped from 86 per cent to 68 per cent. Mostly likely the results were thanks to the antioxidant effect of dark chocolate, the researchers say.

It can help you burn fat. Chocolate-loving men who eat the sweet treat are in better health than those who don't like it, say docs at Imperial College London and Nestle. Over five days, a group of 22 healthy young men (half liked chocolate; half did not) ate the same food, plus either chocolate or bread. Blood and urine tests showed the chocolate lovers processed fatty foods better and hard lower LDL (bad) cholesterol.

Yes, indulging every once in a while may have long-term heart benefits – but only when paired with a healthy diet. "You can't just eat chocolate while you sit on the couch and watch TV," says researchers Sunil Kochhar, Ph.D

Reader's Digest, October 2008

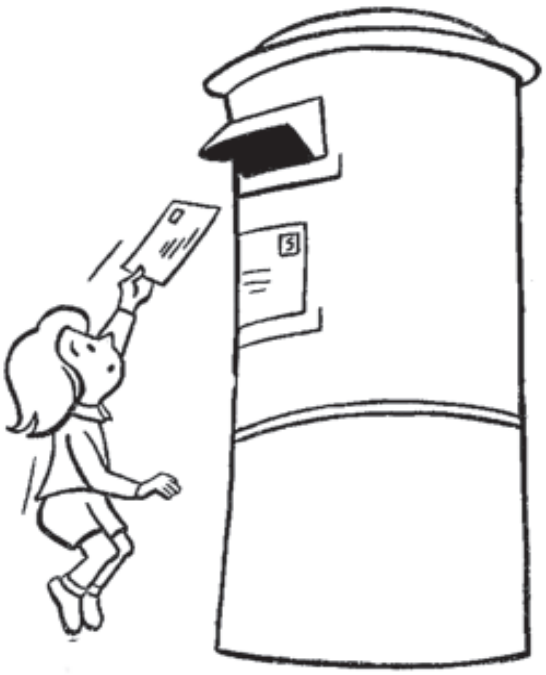
Aspirin only at night reduces the risk of heart attack

A small dose of aspirin may cut the risk of heart attack or stroke in patients with rising blood pressure but only if it is taken at night, says *dailymai.co.uk* quoting Spanish researchers. Doctors have found that aspirin lowers blood pressure to normal for up to 24 hours.

A 75 mg dose (one-fifth of the amount in a standard tablet) at bedtime is hoped to prevent pre-hypertension patients from having to take expensive long-term medication, say researchers at the *University of Vigo, Spain.*

Though it is unclear why aspirin works better at night, researchers believe it may slow down the production of hormones and other substances in the body that cause clotting. Many of these are produced while the body is at rest. Considering the side-effects, patients, however, should check with their physician whether they could safely take regular aspirin.

Insight—The Consumer Magazine, September-October 2008



One of the best issues so far

November 2008 issue on 'Adolescent Health' is superb and quite interesting. It is one of the best issues so far. S J Chander's well articulated article titled "It is time to talk human sexuality with adolescents" deserves a special mention. It is a must for all parents and teenagers. Keep up the high standards!

Elizabeth Shah
Secunderabad, Andhra Pradesh

Articles provide newer information

I am a regular reader of *Health Action*. I would like to congratulate the team for doing a wonderful job. The articles are found to be very useful for the medical people, nursing students and the staff. We have found that the articles provide newer information based on the needs of the society.

Mrs. Nahomi Clement
Thiruvalla, Pathanamthitta Dt, Kerala

Very informative

Health Action is very informative. It is helping us with lots of information while carrying out our daily activities at the field level, especially those of us who work in the health sector.

Vilhoumenuo Savi
Kohima, Nagaland

Forthcoming themes — 2008

(The order is subject to change)

- Information Technology and Health
- Urban Health Mission
- Leprosy

health action

HAFA

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Thought for the Month

"Action may not always bring happiness; but there is no happiness without action."

Benjamin Disraeli

Contents