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Health and Equity - Effecting Change

Editor: Shobha Raghuram

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Technical Report Series

This Technical Report Series is part of the Hivos-India Regional Office's effort to participate actively in the debate and dialogue in India on issues of human development and emancipatory interests. This series consists of monographs, working papers and Hivos conference proceedings. The publications reflect policy concerns of Hivos regarding development issues in India and address the problems faced by the marginalised in developing countries, such as in the areas of human governance, environment, gender, culture, the politics of development, human rights, information and communication technology, and economic activities.

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Introduction

The Community Health Cell (CHC), Bangalore, India, is the functional unit of the Society for Community Health Awareness, Research and Action, which was registered in 1991 under the Karnataka Societies Registration Act 17 of 1960, S. No. 44/91-92. Prior to that the CHC functioned for 7 years as a study-reflection-action-experiment, having been initiated in 1984. It has therefore already maintained its viability for 15 years.

The CHC is a professional resource group, rooted in the voluntary sector in India. It promotes and supports community health and public health action, training, research, policy evolution and advocacy, in partnership with non-governmental and governmental agencies and with people's organisations. The CHC attempts to relate local reality and local action to state, national and international health policy and action.

Its understanding of health issues while being inclusive of biomedical dimensions, is strongly based in the social paradigm, which recognises societal, political, economic, cultural and behavioural dimensions that historically influence the health status of people and health services. CHC explicitly stands for the interests of the poor and less powerful sections of society, basing on values of equity and social justice, in the quest towards better health status and improved access to care.

It supports the idea that health is integral to development and uses an empowerment approach in its strategies. It is also sensitive to gender and ecological perspectives and on the need for sustainability and self-reliance in an inter-dependant global and national environment.

CHC sees its primary role in community and public health to strengthen motivation; enhance conceptual clarity; evolve vision, mission and policy strategies; provide continuing education and peer support; undertake interactive participatory research, and develop an active information resource centre.

A small group of professionals and an office administrative team form the core of CHC, supported by an informal voluntary network of over 30 professionals with multi-disciplinary and multi-sectoral expertise. Support and networking with this group occurs at different levels – local, state, regional and national. CHC sees its work not as being project based in the area of public health and health services, but as being a facilitator, catalyst and participant in a process which may be termed an emerging health movement in the country. Much of its work has therefore been open-ended and issue based, generating a collective response.

WHY WE DO WHAT WE DO

A brief situation analysis of health status and health care in India – the context

- India has a population of approximately one billion (17% of the global population) spread over 26 states and 6 union territories, with wide disparities in health status and human development indices. Health care is provided by the government or public sector, voluntary agencies (not-for-profit NGOs), and the private sector (for -profit including general practitioners). Besides Allopathy, a variety of Indian and other systems of medicine are practiced. Folk health traditions, local knowledge systems and practitioners, comprise the people's sector.

- In spite of massive poverty alleviation and development efforts, there are still over 350 million persons below the poverty line, spread all over the country, but primarily in the BIMAROU region (Bihar, Madhya Pradesh, Assam, Rajasthan, Orissa, Uttar Pradesh), and in disadvantaged districts and pockets of other states. India has slipped further down in the Human Development Index from 134 to 139. Inequity is higher in areas with a concentration of indigenous people (scheduled tribes)

and marginalised social groups (dalits / scheduled castes). Women in general, particularly girl children, the urban poor including street children, child labourers and victims of communal and structural violence are important vulnerable groups. Persons suffering with leprosy, tuberculosis, AIDS, disabled persons and the elderly are also priority groups.

- Health service development in the public and private sector has been substantial, though uneven, ill distributed and poorly regulated since Independence in 1947. Excessive focus on bio-medicine and techno-managerial interventions, following international trends and policies, led to investment in costly, high tech, wasteful expenditure on secondary and tertiary care at the cost of primary health care. Due to insufficient political and financial support, the primary health care system initiated after 1947, and further evolved since 'Alma-Ata', is still inadequate, fragmented, of poor quality and inequitous, in terms of access and availability.

- In recent years, the new economic policy, has accentuated earlier trends of liberalisation, globalisation, and privatization. Of particular concern is the corporatisation, transnationalism and commercialisation of medicine and healing processes. This has increased costs of medical and health care, further strengthened market forces, increased corruption and profit-making and worsened the situation of inequity and inequalities in health care, with added burdens of debt and disease on the poor and disadvantaged.

- On the other hand, because of strong democratic traditions and an active 'civil society', voluntary agencies in health care (not-for-profit NGOs) are a large and increasing sector. Inspired by pioneering voluntary health action efforts that moved from institutional to community based approaches in the late 1960s and early 1970s, and further encouraged by the Alma-Ata declaration, to which India was an important contributor, the numbers of voluntary groups involved in community oriented and community based health action have increased substantially.

- Three membership based national coordinating agencies exist in the voluntary sector namely, the Voluntary Health Association of India – a national federation of state level organisations in health care; Catholic Health Association of India and the Christian Medical Association of India. These networks with their members organise annual

meetings, workshops, training and continuing education and provide information updates through regular journals / bulletins.

- Additionally, there are other issue-based networks and groups in the voluntary sector and people's social movements that raise broader issues for advocacy and policy change. Well known among them are the medico friend circle; the All India Drug Action Network, state drug action networks; the All India Peoples Health Tradition Network (LSPSS); All India and State level People's Science Networks and more recently the National Alliance of People's Movements. The latter are increasingly interested in health issues.

- Since the early 1980s, a small number of alternative, multidisciplinary, resource groups emerged in support of grass root groups and movements. They are primarily devoted to evolving community health approaches, participatory training methodologies, networking with field action initiators in the country, moving from micro level action to macro level situation analysis, policy research and advocacy. These groups include the Foundation for Research in Community Health (FRCH) - Mumbai and Pune; Centre for Enquiry into Health and Allied Themes (CEHAT) - Mumbai; Society for Education, Action and Research in Community Health (SEARCH) - Gadchiroli (Maharashtra); Child In Need Institute (CINI) - Calcutta; Action for Research in Community Health (ARCH) - Mangrol (Gujarat); Nucleus for Health Policies & Programmes (NHPP) - New Delhi. Studies done by them are beginning to address and inform health policy.

- Community Health Cell is also one such resource centre. It has established wide linkages with all the groups mentioned above through a strong commitment to interactive research and promoting collective action through networking. It has also worked with a large range of health action initiators. International linkages have included academic centres, such as the - London School of Hygiene and Tropical Medicine [LSHTM], Tropical Child Health Unit - Institute of Child Health, London, Centre for International Health, University of Bergen, International Child Health Unit, University of Uppsala, Sweden, WHO-ICO and Medicus Mundi International. Linkages range across ideological and religious affiliations and have established CHC's credibility as a known community health and health policy centre.

We are currently in the late 1990s working in a rapidly changing, uncertain and volatile global and national environment. Sudden events such as the nuclear explosion with its ethical and medical implications, sanctions, communal tensions, episodes of social violence, political instability and economic recession have health consequences and often require a response that may not have been planned earlier. This situation is also causing us to think seriously about re-defining the boundaries of public and community health in a context where strong forces are splintering communities apart. It is also our experience that major forces impacting on health are often deeply embedded in social relations. We need to rethink our vision, objectives and strategies in the context of this situation.

Problems of Health Care addressed by the CHC

The current problems of health care, as identified by the Society, are:

- Community health action initiatives of the voluntary sector in India are increasingly becoming top down, vertical packages of selective primary health care interventions, similar to the public sector, focussing on distribution of drugs, vaccines and contraceptives, with the community being involved as passive beneficiaries. With increasing funding for voluntary sector health work coming from governmental and bilateral programmes, NGOs are becoming subcontractors of top down health programmes and are conceptually viewed as alternative service providers. **The community empowerment - organisation - participation dimension crucial to sustained community health action is getting diluted and deemphasized.**

- Education of health personnel in the governmental and voluntary sector is too focussed on technical content with little attention to societal dimensions and educational processes. The emphasis is on 'what' but not adequately on 'how' and 'why'. **Doctors, nurses and health workers are not trained adequately to work 'with communities', but 'for individuals'.**

- The new economic policies with continued emphasis on high-tech bio-medical investigations and medicalised treatment focussed on secondary and tertiary care institutions in the private, corporate sector, is weakening and distorting primary health care system development, and is resulting in a neglect and dystrophy of public health expertise. This

has led to a continuing breakdown of the public health system in India leading to the re-emergence of old public health problems like malaria and kalazar, worsening of tuberculosis and an increasing inability to effectively handle newer problems like AIDS and other epidemics of communicable and non-communicable diseases.

- Unchecked growth of the pharmaceutical industry and increasing effects of market forces on drug policies in India, have continued a distortion in types of drugs manufactured and irrational prescription practices and use among medical professionals and health care providers. This increases costs of health care, besides subjecting patients to health hazards and economic stress. Amendments of the Indian Patents Act of 1970, under pressure from the WTO, will be a disincentive to and reduce indigenous drug production and pharmaceutical research, increase imports and escalate drug prices with adverse consequences on patients especially the poor.

- The dominance of the Allopathic/ Western system of medical / health care had led to the increasing marginalisation in planning and organisation of Indian and other systems of medicine and traditional practices and their continued neglect and lack of involvement in national health strategies.

- While a rich diversity of innovative approaches, alternative thinking and collective action in health care and health alternatives have developed in response to the above problems, these are still inadequately known, or communicated to others who could benefit from these experiences and ideas. They also do not adequately influence mainstream health policy, planning and practice.

- Finally, despite a growing networking of efforts and the evolution of independent, collective thinking and action in India, international public health packages together with globalisation and international capitalism are further distorting the health situation by topdown vertical selective health care programmes promoted by such partnerships. The preoccupation with project management rather than process facilitation in these efforts; and the increasing evolution of monitoring and evaluation systems are distracting and distorting action at the community / field level. There is increasing need for dialogue to counter these vertical programmes and convert them into integrated community health services. Horizontal partnerships of different actors

will be needed to evolve and support this, based on shared learning from local experience.

Strategies to tackle problems

CHC's strategy to counter each of these problems is:

- To promote community health action which enables and empowers communities to tackle health problems and evolve local solutions within a broader poverty eradication context.

- To promote and evolve educational strategies that enhances social and community orientation, process dimensions and approaches in training, especially for doctors and health workers.

- To increase awareness of the crisis and breakdown of the public health system and strengthen collective, multisectoral and multidimensional responses, especially in tackling priority disease problems at their roots.

- To promote rational drug use among health care providers and consumers and to enhance the understanding of rational and essential drug policy issues.

- To promote initiatives towards enhancing the dialogue and linkages between the plurality of Indian and other health systems / traditions and their increasing involvement in community health.

- To promote dissemination of information concerning deeper health situation analysis, problem identification, innovative ideas and approaches.

- To enhance dialogue with funding agencies to promote horizontal partnerships and collaborative efforts to counter distortions of the market economy on health care.

- As is evident, these strategies address underlying societal processes. Their impact can only occur later and be assessed by multi-disciplinary, including ethnographic methods.

What we do

Activities of CHC (refer pamphlet enclosed)

i) **Information and advisory service** through correspondence and personal interactions.

ii) **Training inputs** through five types of participatory programmes.

- Specific thematic sessions in formal training programmes of other voluntary and academic organisations.
- Specific inputs in informal workshops and short-term training programmes of voluntary sector coordinating agencies.
- Specific sessions in training programmes for governmental health personnel.
- Short training courses for community based health workers in collaboration with field based NGOs – on request, focussing on community health, herbal medicine, rational drug use, minor ailment treatment, etc. (in Kannada / Telugu / Tamil / Malayalam). (Requests for (a) to (d) vary annually).

Medical Education – Social Relevance / Community Orientation

iii) **Participatory reflections / review** with NGO teams to improve scope and quality of services, and with groups of NGOs through networking to pull in learning experiences and enhance sharing of ideas and expertise.

iv) **Participatory / Interactive Research and Evaluation** (an important contribution of CHC)

- In 1995 - 97 a Public Policy Analysis Study of the National TB Control Programme in India collected qualitative data from field interviews with TB patients, village leaders, grassroots health workers, and health care providers in government and NGO centres.
- An interactive process pulled in ideas and suggestions from over 50 participants involved in Malaria control issues or action for a VHAI facilitated Independent Assessment on Malaria programme in India.
- Prior to that participatory evaluations have been done of field NGOs e.g., (KSSS, RTU, etc.) training centres (e.g., ISI); and national agencies (e.g. CHAI).

v) **Peer group support** – A unique feature of CHC's activities is to provide time for reflection and dialogue with individuals searching for greater social relevance in their health work or in evolving and planning new ideas and approaches. These partners come from very diverse backgrounds and disciplines.

vi) **Networking** – CHC is an active member and/or a resource group to many networks in the country – national and state level. In solidarity, it is also actively involved with

governance of groups such as the Voluntary Health Association of Karnataka, International Services Association-Bangalore, Drug Action Forum -Karnataka, and Advisory Committees of FRCH-Mumbai and other resource groups supporting Health Action. Team members are resource persons for the Asian Community Health Action Network (ACHAN), founder members of WHO-ICO's new International Poverty and Health Network and Associate Members of the International Network of Community Oriented Health Sciences Institutions.

Partnerships and Collaboration

Historical ties with the Voluntary Sector

- CHC has worked closely with CHAI, CMAI and VHAI on various collaborative projects including facilitating workshops, interactive research and evaluation and supporting learning through networking around issues at a national level and regularly contributing to all the three journals – Health For the Millions, Health Action and Christian Medical Journal of India.

- It has linkages with CHAI-Karnataka unit, VHA-Karnataka, CMAI – Southern Region office in Bangalore and Drug Action Forum-Karnataka providing resource persons for their training programmes and workshops.

- It has been an active member of the mfc, a founder member of AIDAN and DAF-K and a resource group for LSPSS, AIPSN and other networks.

- CHC has been supported by European funding agencies like Misereor – Germany, Cebemo/ Bilance and Memisa – Netherlands; Oxfam – UK. It has been actively involved in horizontal dialogue and has been a resource group for partnership review and evaluation. It has worked with EZE, BFW, Action Aid and others as a resource group.

Newer Mainstream Linkages

- In Bangalore, with the National Institute of Advanced Studies, Institute for Social and Economic Change, National Law School of India, St. John's Medical College, Rajiv Gandhi University of Health Sciences, Community Medicine departments of medical colleges, etc.

- In India, with the Ministry of Health and Family Welfare, Indira Gandhi National Open University, Medical Council of India, Indian Council of Medical Research.

Strengths & Weaknesses Analysis of CHC - 1998 Review

(Refer to Review Proceedings for overall findings)

- The strengths of CHC identified by the 1998 Review included its values and work ethos, responsiveness to need, the social paradigm, networking, multi-disciplinary approach, non-hierarchical and participatory team functioning, flexibility, financial transparency, secular nature, perspectives deriving from Indian experience and a good library / information centre.

- Its weaknesses included shortage of professional personnel in respect to the demands of work, a resultant excessive work load, problem of time management because of open ended approach, conflicts between catalyst role and taking responsibility, inadequate efforts towards self reliance in financial and human resources, pressure on the team due to short notice, excessive freedom and flexibility.

Steps are being taken to address some of the weaknesses and threats.

Post Review Changes at CHC

The shifts that are occurring are:

a) An explicit commitment to equity and empowerment in its work.

b) Moving from open-ended catalyst interventions to more proactive, focussed, definitive and sustained work on areas in which it has developed experience and expertise. These include:

   i. promoting community health based on a social paradigm,

   ii. human resource development, particularly medical education of doctors and training of community level health workers,

   iii. rational therapeutics and rational drug policy, including the issue of patents,

   iv. Indian and other systems of medicine, particularly the integration of local health traditions and practitioners into community health,

   v. crisis in the public health system affecting infectious diseases such as malaria, TB, HIV/AIDS and other national programmes concerning priority health problems,

vi. health policy issues particularly those concerning implementation, and the influence of international agencies and policies on national health policy and practice,

vii. women's health and gender issues.

Emerging areas of interest and work are:

i. Poverty and health linkages,

ii. Medical and public health ethics.

A community health and public health approach will be utilised in tackling the above issues. Efforts will be made to strengthen and enhance public health policy action.

- Moving from voluntary sector focus to **mainstreaming**, that is being inclusive of the larger health care sector, such as strengthening of the public sector, universities / educational centres, challenging and engaging with the private sector and supporting movements that are pro-poor.

- Shifting from plural networking to developing **strategic links** with groups and individuals who are equity **and empowerment oriented** i.e., there will be an explicit focus on people and regions in poverty and need.

- **Developing appropriate organisational mechanisms, structures and linkages** required to make the above changes, including developing leadership and expanding the core team of professionals with persons who share values, vision, critical thinking and who function democratically. The ethos and values of CHC as identified by the Review will be retained and nurtured in this change process of evolution over the next few years into a Centre for Community Health and Health Policy, that will build on Indian experience.

Post Review Activities

Proactive measures have been taken to undertake follow-up work in areas of CHC's research studies and involvements and enhance their policy process dimensions.

1) Medical Education

- Interaction with the Parliamentary Sub-Committee on Medical Education included making submissions and participating in meetings.

- Interaction with (including giving reports to) the Medical Council of

India regarding internship, with the Indian Medical Association regarding postgraduate education, with the Indian Council of Medical Research regarding medical ethics concerning experimentation on human subjects.

- Work with the Rajiv Gandhi University of Health Sciences to which all-medical colleges and colleges of allied health professionals in Karnataka State are affiliated. A 2-day workshop on the Challenges of Management in Medical Education was organised for the Deans of all medical colleges. A note on the introduction of Rational Therapeutics and Rational Drug Policy was accepted. Another 2-day workshop on Medical Ethics is planned in March 1999. A few medical colleges have subsequently been in touch for inputs concerning medical education cells, research methodology workshops, drug policy etc.

2) *Follow-up of work with CHAI*

- Helped with planning and production of special issue of Health Action on WHO; joined Editorial Board; sent other material and suggestions.

- Was resource person for National Consultation of Regional Units and Stakeholders Meeting.

- Agreed to Review Comprehensive Plan, for which initial work has started.

- Participation and support to CHAI - Karnataka's {CHAIKA} activities - CHAI day meetings, AIDS action, District Health Action Forum.

- Helped to plan and participated in a South Bihar Health Policy Workshop with CHA - Bihar.

New Thrusts

i) Responding to local public health issues

⇨ Dengue Fever - organised meetings and catalysed small research studies concerning the problem in Bangalore through a local medical college and governmental agencies.

⇨ Hepatitis B vaccine - organised meetings, collection of reference material and a press conference (with Drug Action Forum - Karnataka (DAF-K) and Environment Support Group) regarding the irrational way in which Hepatitis B vaccination camps are being organised in the city and elsewhere. The State Health Minister has now constituted a Committee to go into this.

⇨ **Amendments to the Patents Act** (1970) - With DAF-K, organised a meeting, supporting further public debate on this issue as the long-term implications to the consumer/ patient, particularly the poor will be immense.

⇨ TB - This will be taken up in 1999-2000, but in the meantime, micro-inputs into 2 NGO's and discussions with CHAI, CMAI, VHAI and several people have been held. Also

1. Paper on "*Educational Approaches in Tuberculosis Control: Building on the 'Social' Paradigm*" written for a book titled "Tuberculosis – An Interdisciplinary Perspective", edited by Dr. John Grange and Dr. John Porter, published by Imperial College Press.
2. Paper entitled "*A Violation of Citizens Rights: The Role of the Health Sector, particularly of the State Health and Related Services, in regard to Tuberculosis in India*" presented at an International Conference in Mumbai, organised by CEHAT.
3. Meeting with European donor agencies on HIV & TB and the need for increased support.
4. Policy meeting at NTI with national and state policy managers, World Bank, WHO & DFID.
5. Karnataka State TB Association meeting

⇨ **Malaria** - Participated in facilitating a coalition of citizens groups and different levels of government (local / State / ICMR) to respond to problems in Mangalore City of Karnataka – gave professional inputs through a series of meetings and visits.

- Gave resource inputs at WHO-SEARO meeting on Roll-Back Malaria.
- Requested to help set up a National Task Force on Social Science Research in Malaria.

Continuation of 1997-98 initiatives

i) **WHO and International Poverty and Health Network (IPHN)**

Responded to Draft Policy Document of the new WHO-DG

- Conducted and collated responses to an email questionnaire from IHPN members on the Draft Document.
- SOCHARA Vice-President and three members suggested by us, including Catholic Health Association of India, participated in the IPHN meeting in Kisumu, Kenya.

- RN participated in a meeting on "Regenerating Public Health" organised by WHO and King's Fund in London.

- Planning for November 1999 dialogue in Bangalore hosted by CHC on South Asian Perspectives on Poverty and Health.

ii) Women and Health

- Attended meetings called by Ministry of Health, Government of India.

- Agreed to coordinate training of 2000 grassroot women leaders (mahila sangha and gram panchayat members) in 5 districts of Karnataka during 1999-2000 through State and District level resource groups, involving NGO's and Government. Preliminary discussions/ preparations are being held regarding this. Prepared two and part of a third module (on TB, malaria and rational health care) for Training cum Information Pack being produced by a national core group of which we are members.

Current Key Initiatives

◆ Working towards initiatives for a People's Health Parliament (Jana Swasthya Sabha) to be held at a national level in Calcutta and the People's Health Assembly at an international level, in Dhaka, in November/ December 2000 - as member of state, national and international coordinating group

◆ Participation in the Karnataka Task Force on Health - set up by Government of Karnataka to evolve a plan for promoting primary health care and public health with a focus on equity and quality.

◆ Collaboration with Government of Karnataka as a Technical Resource group to evolve an integrated and comprehensive health nutrition and population programme for the state.

How We Can Work Together —

☛ If you are planning Community Health action and would like to reflect on your plans with peers; undertake preliminary project visits, study tours or electives; do some background reading or prepare for action in any other way - please contact us.

☛ If you are involved in Community Health action, service, training, research and issue raising, and need information or advice, support with planning, training, review and evaluation - please contact us.

- If you are involved in Development, Education, Organization, Conscientization, Lobbying, Communications or Journalism, and are interested in exploring Community Health and/or Health Policy issues - please contact us.

- If you would like to participate in our activities and attend the Community Health Forum meetings or be kept on our mailing list - please contact us.

How you can Support us

- If you would like to support our work technically, please put us on your mailing list to receive papers / books / articles.

- If you would like to support our work financially, you could contribute

  i. By providing a regular annual contribution of Rs. 500/- ($50) or more and qualify to be a Friend of CHC.

  ii. By a donation of any amount to the Society's corpus fund.

[As a Friend, you will be kept on our regular mailing list and kept informed about all aspects of our work.]

NOTE: All donations by Cheque / draft / MO should be made in the name of The Society for Community Health Awareness, Research and Action or S.O.C.H..A.R.A or Community Health Cell.

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