Meeting of Fellows, Alumni, Mentors at the SOCHARA Silver Jubilee - April 2016

sochara
building community health

Capacity Building for Health Equity in India

A Reason to Hope...

SOCHARA – SOPHEA TEAM

2016

Objectives of SOCHARA

- To create awareness regarding the principles and practice of community health among all people involved and interested in health and related sectors.
- To promote and support community health action through voluntary as well as governmental initiatives.
- To undertake research in community health policy issues, particularly in areas of:
  - Community health care strategies
  - Health personnel training strategies
  - Integration of medical and health systems
- To evolve educational strategies that will enhance the knowledge, skill and attitudes of persons involved in community health and development.
- To dialogue and participate with health planners, decision-makers and implementers to enable the formulation and implementation of community oriented health policies.
- To establish a library, documentation and interactive information centre in community health.

The Constitution of India, 1950, followed by other national policy documents and five year plans, have made important social commitments to the citizens of the country. SOCHARA through the Community Health Learning Programme and other initiatives makes a contribution to enable citizens to realise these Constitutional rights.

Constitutional Pledge

"The State shall regard the raising of the level of nutrition, and the standard of living of its people and the improvement of public health as among its primary duties.

It shall ensure

that the health and strength of worker's, men and women, and the tender age of children are not abused, that children are given opportunities and facilities to develop in a healthy manner

It shall make

provision for securing just and humane conditions of work and for maternity relief, and for public assistance in cases of unemployment, old age, sickness, and disablement, and in other cases of undeserved want."

Constitution of India, 1950

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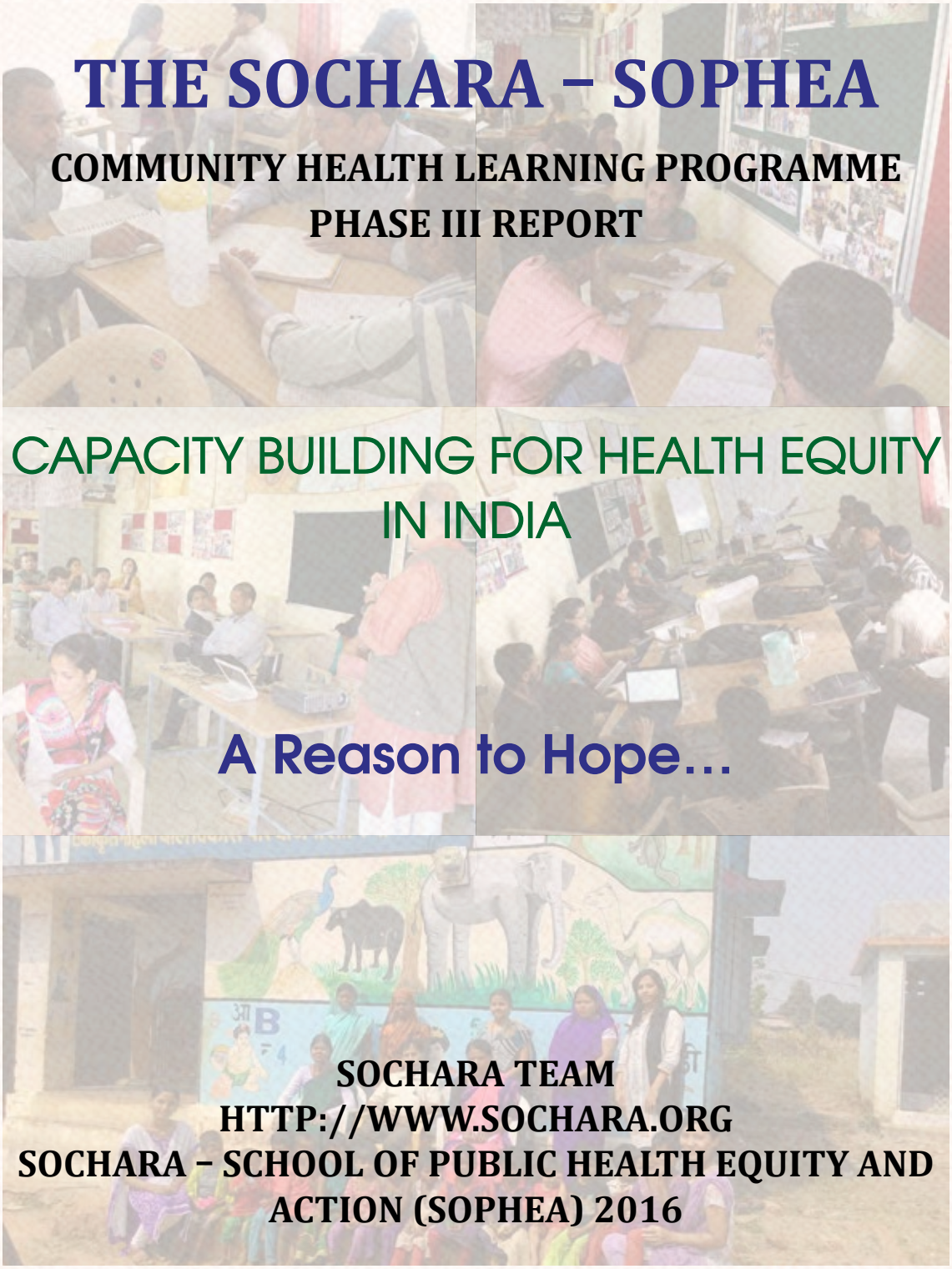

THE SOCHARA – SOPHEA

COMMUNITY HEALTH LEARNING PROGRAMME
PHASE III REPORT

CAPACITY BUILDING FOR HEALTH EQUITY IN INDIA

A Reason to Hope…

SOCHARA TEAM
HTTP://WWW.SOCHARA.ORG
SOCHARA – SCHOOL OF PUBLIC HEALTH EQUITY AND ACTION (SOPHEA) 2016

COMMUNITY HEALTH LEARNING PROGRAMME
PHASE III REPORT

CAPACITY BUILDING FOR HEALTH EQUITY IN INDIA

A Reason to Hope…

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SOCHARA TEAM
SOCHARA – SCHOOL OF PUBLIC HEALTH EQUITY AND ACTION (SOPHEA)

OCTOBER 2016

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EXECUTIVE SUMMARY

The community health learning programme (CHLP) during its third phase broke new ground. The general body and executive committee of the Society have taken keen interest in this initiative since its commencement in 2003, and during this phase mandated the Secretary and team to initiate the SOCHARA School of Public Health, Equity and Action (SOPHEA). This led to the formation and functioning of the Academic and Research Council (ARC) from April 2012 and the SOCHARA Institutional Scientific and Ethics Committee (SISEC) for review of research proposals from 2014. These groupings of resource persons with multi-disciplinary backgrounds functioned as an academic, scientific and ethical sounding board and were part of the governance mechanisms for the initiative. The Society also developed several operational policies and mechanisms during the period.

While team SOCHARA had a small group based in Bengaluru, taking prime responsibility for the day to day functioning of the CHLP, the entire group in all the three clusters contributed greatly to the initiative. Regular team meetings, annual team retreats, specialised workshops for the team, participation in other meetings were efforts at team development.

The CHLP over phase three nurtured 171 young persons in community health. These included 56 full time participants, 17 short term participants, 28 flexi interns and 70 postgraduate students on placement for varying periods of time. The team provided each of them personalised attention and mentorship. A well thought out semi-structured 52 week programme has been developed and implemented. Several mechanisms from selection to assessment have evolved further in the period. Very many partner NGOs supported the initiative by hosting participants for community placements and field work for the full time participants providing feedback during mentor's workshops. Alumni join a growing group of community health fellows as part of the collective journey towards Health for All. Annual alumni meetings and an active CH Friends What's App group provide occasion for the group to build solidarity and share experiences.

Proactive efforts at networking, dissemination, mainstreaming and website development enabled the work to be shared with a wider audience. Publication of newsletters, an e-newsletter, organisation of several workshops and participation in conferences supported this process.

The CHLP phase 3 was supported in a very collegial manner by the **Sir Ratan Tata Trust**, Mumbai, the **International Development Research Centre**, Canada and other donor partners of SOCHARA. A mid-term and end term participatory

review was conducted by teams of two professionals each. An external financial management system audit was added to the ongoing internal and statutory audits that take place regularly.

Alumni from the CHLP are followed up in a spirit of solidarity towards a common cause. They play increasingly important roles in several civil society organisation

Community Health Fellows and team from Phases One and Two

Fellows from the Community Health Fellowship (Phase One and Two) engage with communities using different platforms and methods

BACKGROUND

India has been home to several innovative community based initiatives for health since the early part of the last century. The equity dimension in health, and need for capacity building of a variety of stakeholders for health and equity, came into the discourse and into practice more explicitly later. These efforts built on the diverse health traditions and systems, evolved by communities over a period of time spanning centuries. Mechanisms for passing on knowledge varied. Some of the world's first written documents on health and disease were in Sanskrit (4) and were probably used for teaching. The older systems were however often embedded in societal structures and social relations with hierarchy and boundaries around gender, caste/ ethnicity, language, belief etc (1). While building caring communities at various levels is aspirational and constant 'work in progress', it is a basic building block for community health practice, requiring values, knowledge and skills (2). Capacity building for health and equity has been attempted and experimented with by several organisations, and there is a story to tell.

Trained and supervised community health workers and local village or ward health committees were an important component of the newer local initiatives for health (2,25). These new community oriented health initiatives were diverse and included experimentation in health financing and even in medical education towards making health services community centred and socially relevant (15,16,18).

" The physician of tomorrow, who will naturally be concerned, with the promotion of the new era of social medicine will be scientist and social worker, ready to cooperate in team work, in close touch with the people he disinterestedly serves, a friend and leader, he directs all his efforts towards the prevention of disease, and becomes a therapist where prevention has broken down, the social physician, protecting the people, and guiding them to a healthier and happier life". (54)

-BHORE COMMITTEE REPORT (1946)

" No permanent improvement of public health can be achieved unless the active participation of the people in the local health program can be secured. We have therefore suggested the establishment in each village, of a Health Committee consisting of five to seven individuals..... who will of course be voluntary workers, can, after suitable training help to promote specific lines of health activity... .... We consider that the development of local effort and the promotion of a spirit of self help in the community are as important to the success of the health programme as the specific services, which the health officials will be able to place at the disposal of the people." (54)

-BHORE COMMITTEE REPORT (1946)

Structural dimensions and justice issues were being introduced explicitly or implicitly through the WHO in its constitution and more specifically in the Alma Ata Declaration, the report of the Commission on the Social Determinants of Health and in the Rio Political Declaration (3,6,7). The role of civil society and social movements in negotiating this dimension is recognised among key stakeholders of the time (5), but perhaps insufficiently among the wider, mainstream policy, practice and academic communities. Efforts towards ensuring that communities and affected persons are primary stakeholders for health, met with resistance from professional bodies and certain interests, and are part of the struggle for health. The paucity of research and scholarship regarding the processes inherent in these shifts has been noted and is beginning to be redressed.

The Alma Ata Declaration in 1978 with its call towards Health for ALL (HFA) using comprehensive primary health care (CPHC) as a strategy, recognised and affirmed the work done in community health by NGOs and institutions over previous decades of working with communities in situations of poverty and vulnerability (3,5). Social justice was clearly mentioned as a value base, in support of the universal social goal of HFA (3). The World Health Organisation (WHO), for some years post 1978, facilitated a scale up of the CPHC strategy through global policy and governmental commitments (27).

This was a major shift from the disease control oriented, public health approach, promoted and used thus far (4). This dominant approach represented both the perception and understanding of health needs and also the social and political history within which the discipline of public health gets constructed, developed, and practised. This includes inherent power relations and contestations, and the manner in which the state, the market and professional elite shape public health philosophy, concepts, practice and public health education. Public health which is egalitarian in principle and practice, was seen and experienced by some as being heavy handed and top down. Personhood, community agency and the need for voice and participation in decision making and health action seemed subservient to larger goals, forces and interests representing the state and the market. Alienation of people and communities was apparent in low utilisation of public health facilities (4). The 1978 Alma Ata meeting, which had its own pre-history, was therefore an important point of inflection. New Public Health with efforts at democratisation of relationships between experts, the state and communities emerged. As in any paradigmatic social shift there was varied understanding at multiple levels, and resistance from several sectors, all of which adversely affected the implementation of comprehensive primary health care on the ground, with consequent inadequate political, financial and human resource commitments. **It seems that not enough attention was paid to the value base and qualitative aspects of education of**

the health human workforce to realise the "Health for All" goals, particularly in India within the mainstream. On the other hand, and not unsurprisingly, with a more dominant role played by international bodies and the state post Alma Ata, the role and voice of NGOs also diminished. The entry of the corporate sector into major health decision making since the mid 1990s has advanced considerably and also influences public health education. The sector has a large and growing presence and influence in education for health sciences, including in public health and community health.

An inadequacy in societal and political understanding by stakeholders, as well as lack of attention to implementation and financial allocation, led the CPHC approach being reduced to narrower selective, vertical technical strategies, with conflicting and competing interests, including commercial interests (4,8). The social majority were, and still are, left out of the Health for ALL vision and scope. Civil society together with some academic institutions however kept up a spirit of constructive critical analysis, with action on the ground, as well as pressure, for there to be serious efforts to implement the CPHC strategy as part of public health practice in order to realise the '*social goal of Health for All',* to which 134 countries, WHO and UNICEF had committed themselves (8,10). ***However, institutions and governance mechanisms for higher education in public health and medicine, for instance in India, were slower to respond.*** Issues mentioned above receive little or no attention in MPH and MD programmes in Community Medicine. The politics of health and critical analysis of health and equity are rarely discussed or studied. Debate and dialogue took place within smaller circles such as the Medico Friend Circle and other civil society groups. Social medicine and community health movements emerged in various countries. Scientific and technological growth continued at a rapid pace with strong links to public health education. Public health education including community medicine took multiple directions. ***A question that arises now, is the manner in which public health and community health education is structured and imparted, so that public health and community health human resources play a transformative role in society as part of the HFA quest, along with other societal partners, in the current and futuristic context.***

As part of a sustained commitment to community health and HFA, SOCHARA invested time, effort and human resources in developing and nurturing the Community Health Learning Programme (CHLP) since 2002-3 (12). This is an experimental initiative in the broad domain of creating critical human resources for health, with a social analysis and focus on a community health approach to public health issues and to action on underlying health determinants (12, 11). While a health systems approach was adopted in the Indian context, there was a conscious effort to address the underlying distal determinants of health. The learning framework is different

in that it builds on an understanding of community health that is underpinned by a range of social concepts, values and an approach that have been articulated and utilised in our work since 1986-7, referred to as the social or societal paradigm of health (2).

The SOCHARA objectives provide a mandate '*to evolve educational strategies for community health',* and this has been utilised in a variety of ways since 1991 (13,9) . **A social equity lens is core to the CHLP together with community participation and empowerment.** This cross cuts all dimensions of the CHLP from content, teaching learning methodology, selection of participants, selection of partner NGOs and donor partners (11). This led the programme to be context sensitive, for instance in terms of allocation of 50% of time to direct engagement with communities through community placements. This was for contextual community based learning, without frameworks and questionnaires. Debriefing reflections allow for unlearning and understanding societal structures that have a tendency to reproduce themselves (11). It is also reflected in the selection of participants who represent the social diversity of India. In phase three the 171 participants of the CHLP came from 20 states, with a large proportion of women and all social groups. Another instance is the choice of language used for teaching and reporting which includes Hindi, Kannada, Tamil, Telugu besides English. Building a community of learning, in a mindful manner, however imperfect, was a necessary environment for community health education

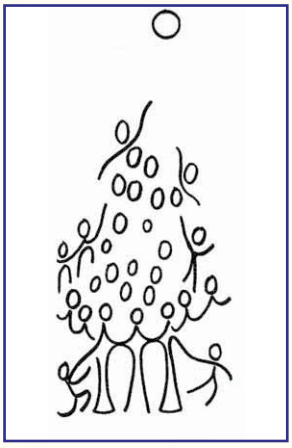
Significant changes have occurred in the broader social environment, as well as in the sphere of public health education over the past fifteen years in India. Within the health care sector, the role of the private sector has gained huge salience and support. Since 2000 the global People's Health Movement (PHM) and the *Jan Swasthya Abhiyan* (JSA or PHM India) have evolved as platforms with a strong voice that have proactively engaged with health policy process at national, state and local levels, as well as globally (8, 10). Enabling communities and individuals to move beyond victim positions to being protagonists for equitable and sustainable change for health was the call. Through advocacy with WHO and member countries, policy attention to HFA and CPHC was brought back on the agenda in 2003 during the silver jubilee of the Alma Ata Declaration. The need to address the underlying or distal determinants of health with a sense of urgency, based on principles of social justice and human rights became more widespread. The WHO Commission on Social Determinants of Health (2005-2008) in which the PHM, JSA and SOCHARA as a constituent in these collectives, played a role and participated in the process (6,7, 8). The development in 2005 of the National Rural Health Mission (NRHM) in India and its '*communitisation'* component was major milestone, and the engagers among the JSA were actively involved. The roll out of the national ASHA (Accredited Social Health

Activists) programme and the setting up of Village Health, Sanitation and Nutrition Committee were on an unprecedented scale. Social accountability mechanisms were introduced through the NRHM Framework of Implementation and continue through the Community Action for Health component of the National Health Mission in parts of 25 states. **The need for human resources trained in community health with values, perspectives and skills were acutely felt.** Social movements continue to hold all these global and national commitments and processes accountable. ***How much has this dynamic health policy process been reflected in mainstream public health education in India? While there are books and research studies on the politics of health, do these find a place in informing the teaching curriculum and learning methodology?***

In response to various epidemics including SARS, Avian Influenza, and HIV-AIDS earlier, the United Nations Secretary General in the early 2000's urged member countries to enhance their public health capacity through expanding public health education (22). There has been a large expansion in public health education in India, with a huge variety of programmes. The MD Community Medicine programmes have enhanced intake of postgraduates by almost double in many medical colleges. Competencies to be taught through this programme have been reworked. A large number of MPH programmes (46 at the last count in 2016) have been initiated based in medical colleges; social work colleges, universities and public health institutions, many of which were newly established. A fair number of students from multi-disciplinary backgrounds go abroad for postgraduate public health courses and return to India for jobs. Thus the field has become more populated and complex. The motivations and aspirations behind the institutions and individuals involved vary. Career pathways and 'salary packages' seem to be of higher priority, than being close to community or to address equity. Efforts at faculty development to steer and mentor programmes and students have been patchy. Public health has become a respectable and desirable career. Job opportunities have expanded in the public health system through the National Health Mission for both its rural and urban component and in urban local bodies; in research organisations; a range of academic institutions; CROs; NGOs; law firms/ institutions etc. ***The relevance, underlying philosophy, content, learning methodology and quality in these diverse programmes is an issue requiring further enquiry, debate and dialogue.*** The social justice principle and community based approach cannot be lost sight of.

The SOCHARA run CHLP has evolved since 2002. After a decade, in 2012, the School of Public Health, Equity and Action (SOPHEA) was formed through the third phase of the Community Health Learning Programme for Health Equity in India. This was preceded by organisational discussions in the team, the EC and AGBM during 2011, and was indicative of the thought and commitment at various levels for the initiative.

Through the development over the past five years, certain insights have been gained. These have been shared periodically in different public forums. The life and work journeys, experience and interaction, with the three hundred plus participants have been energising and motivating. This report shares the almost four year experience of the third phase of the CHLP from December 2012 which will be completed by October 2016.



We feel there is a reason to hope, more than ever.

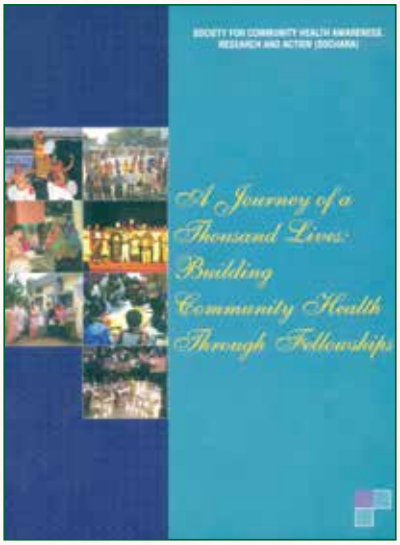
We express deep gratitude to all fellow travellers in the CHLP related journey.

We look forward to solidarity, cross learning and journeying together in the years ahead ■

Visit to Tamilnadu project by CHLP Fellows - Batch 9

INTRODUCTION

Five years of growth and evolution of the third phase of the Community Health Learning Programme (CHLP) by Team SOCHARA have gone by since 2011. The second phase of the CHLP which came to a close in 2011 was reported in '*A Journey of a Thousand Lives: Building Community Health through Fellowships"* (11).



After a preparatory phase during most of 2012, the Society for Community Health Awareness, Research and Action (SOCHARA) stepped up the pace during this third phase of an important initiative (33).

The School for Public Health Equity and Action (SOPHEA) was launched based on experience and early outcomes of the CHLP over two phases since 2002-3, on discussions during two national workshops in 2008 (12) and 2010, and after discussions with the advisory committee members, as well as within the SOCHARA executive committee and general body. An Academic and Research Council (ARC) was initiated, building on Advisory Committees of phase one and two, with a more specific and larger remit to strengthen the academic and research base of the CHLP and the team of learning facilitators. The ARC together with Society members and senior members of the team established the SOCHARA Institutional Scientific and Ethics Committee (SISEC) for review of research proposals conducted by team related projects and the community health fellows. A revamp of the website www.sochara.org was initiated in order to share our work more widely. The E-Sochara newsletter was launched. As an off shoot the SOCHARA Information Management System (SIMS) is evolving. A silver jubilee archival process, developing into a Health for All Learning Platform has also emerged. These operational mechanisms together with other policies regarding human resource, accounting procedures etc were developed as part of organisational strengthening during this phase. The CHLP is a complex and demanding process, as it also deals closely with the human condition. The SOCHARA Executive Committee members, senior team and other friends were always there to help respond to challenges that were faced.

The solidarity of two experienced development oriented donor partners of repute provided a solid support for this phase. The Sir Ratan Tata Trust (SRTT), of the Tata Trusts, Mumbai, India has been a consistent partner since inception of the learning programme in 2003. In fact they invited SOCHARA for a partnership in 2001 and through

a process of dialogue the programme was born and continued into the second phase. The two year Madhya Pradesh Community Health Fellowship Programme conducted in Hindi was also supported by the Sir Dorabji Tata Trust. With an increased intake of participants, both full time and flexi, during this third phase, a second donor partner was required, and the International Development Research Centre (IDRC), Canada joined as a co-donor partner bringing its own energy, perspectives and expertise. The three-way relationship between the two donor partners and SOCHARA was collegial and creative with active exchange of ideas.

Other donor partners of SOCHARA have also been partners of the initiative, as team members supported by them also facilitate the learning of CHLP participants. These partners include Misereor-Katholische-Zentralstelle furEntwicklungshilfe e.V (KZE) from Germany, the Sarathy Foundation from the USA, Association for India's Development (AID-Boston), USA and Friends of SOCHARA (39).

Two participatory reviews of the CHLP phase 3 during the short period from December 2012 till October 2016 provided an objective feedback loop (35,37). The reviews were undertaken by teams of two external reviewers each, working together with the SOCHARA team. Feedback from participants of the CHLP and mentors was reflected. Internal reflections and reviews helped the process.

The trust that participants of the CHLP had in us, together with the energy and hard work of every member of the team ensured that the goals and objectives of the CHLP were met to a more than satisfactory extent. Equally important has been the solidarity of partner NGOs, the trust and welcome by people and communities, and efforts and inputs by field mentors during the field placements of the CHLP participants. These factors, and the mechanisms that evolved, enabled us to address the requirements that came up during the implementation of this phase.

Phase three of the CHLP commenced in December 2012 supported by the SRTT (33). Recruitment and training of the team were the first steps. This was initiated by senior team members with experience, and supported by team members who had worked for several years. Ten full time participants were selected for the one-year programme and are referred to as CHLP Batch 9. The IDRC commenced financial support from May 2013. With this additional staff, and ten more full time participants were selected for CHLP Batch 10. During the second and third year of this phase efforts were made to select 20 participants at the same time as a group (Batch 11 and 12) to enable the group teaching learning process and to reduce the workload on the team who took extra sessions for all those who joined after commencement of the batch. Short term (stipendiary) and flexi interns, and student placements added to the group at different points in time. All participants are given attention and time by team mentors, and teaching learning sessions are through planned schedule

(developed in a participatory manner) for however short or long a time they spend with us.

A total of 171 young persons have been through the third phase of the CHLP. These include the full time participants of the one year programme, together with short term participants of 1-4 months, flexi-interns and postgraduate students on placement as part of their programmes. They come from twenty states of India, with a few from five countries. The breakup is given in the body of the report. The reach of the initiative was wider through proactive networking, dissemination and mainstreaming strategies, as well as through the website.

This effort at capacity building for health equity is a small, and we think significant, contribution to the Health for ALL journey in India. ***It is a reason to hope!***

The CHLP has been a source of community joy with song, dance, and fun along with the learning.

A CHLP Phase III alumnus has this to share about his experience.....

Rajeev Basapathy (CHLP Batch 12)

I am Rajeev B R, a Community Dentist and a CHLP fellow of the 12th batch. I was told about SOCHARA by Dr Eugenio Villare when I was interning at WHO, Geneva, in the Global Oral Health Programme. I joined CHLP as a full-time fellow in February 2015. I did my Masters in Community Dentistry earlier and I always felt a lacuna in my training.

I could feel that strongly when I was interning at WHO. I strongly felt I lacked skills and was incompetent in understanding the social determinants of health and the resulting health inequity and inequalities among societies. Thus, I decided to join CHLP to strengthen my understanding of health equity and social justice.

SOCHARA with its vast network of organisations in India and abroad and also with the government has demonstrated a way to solve health issues governed primarily by social problems. It gives the required strength and belief in the system and reinforces the fact that, it is possible to get things worked. During the course, we met inspiring people and had a chance to know their work. They were all engaging the public in the political process. Most of them were 'Scholar-activists' who have an excellent combination of skills, competencies and activism.

CHLP helps to unlearn oneself, in the process of being introduced to the concepts of community health. The various pedagogy methods used are based on immersion, discussion, debate, reflection, and critical thinking. The programme emphasised on not just community health but also on building essential skills such as communication strategies, learning by doing, community health in action, etc. The life skills required to manage intra and interpersonal skills, which in turn are important aspects of community health, are taught with simulation exercises. CHLP is a unique learning experience where there is an equal stress on field work. The field exposure spaced between the learning collectives gave the much needed pragmatic experience to reflect upon the teaching and facilitating sessions. The field work helps one to understand community health through the lens of multiple fields such as political sociology, epidemiology and biostatistics, anthropology, environmental sciences, globalisation, health economics, health systems and social policies, etc.

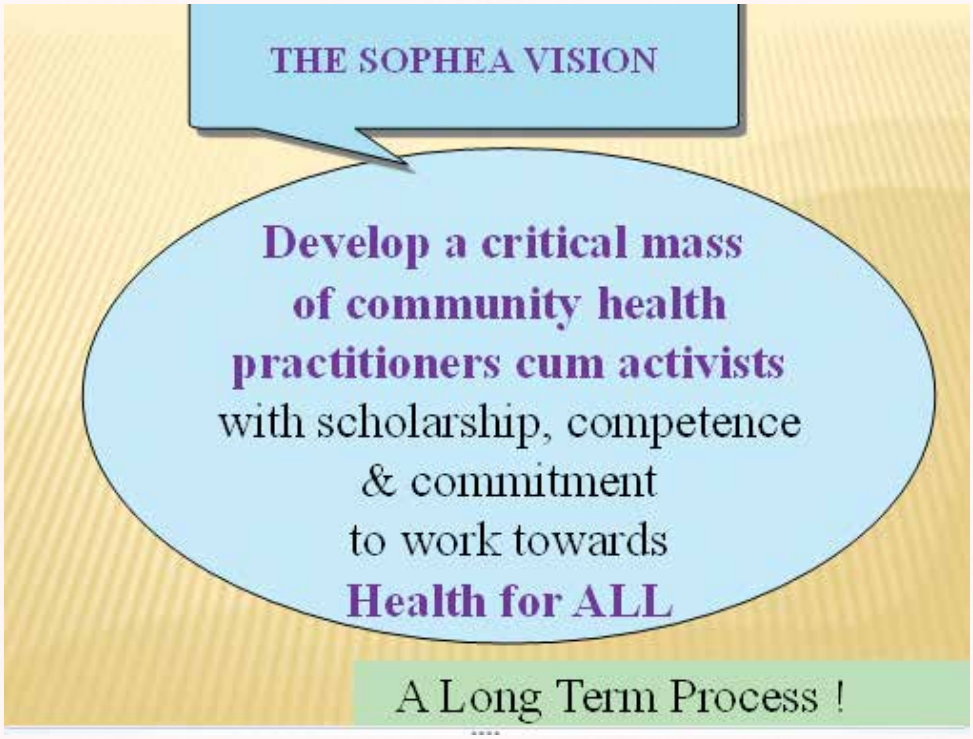
During my fellowship, I did my field studies at ACCORD in Gudalur. ACCORD (Association for Action and Rehabilitation and Development) has been working with the indigenous communities in the Nilgiris. It gave me an opportunity to understand the role of development in the indigenous people's lives. The alienation of the Adivasis (indigenous people) from the forests and subsequent exploitation because of the inadvertent policies have caused health inequalities. I was able to appreciate community health in action, community empowerment and other axioms of community health. The community

Dr. Rajeev in ACCORD in Gudalur, Tamilnadu

experience at Gudalur was powerful and had a tremendous influence on me. Learning from the community, their lifestyle, attitudes, worldview left a mark on me. An important and crucial habit that, I am still developing is 'value based judgement'. I learnt this as part of the ethnographic understanding of Adivasis, which later, I started implementing in my life too. To remain neutral in understanding a process or culture or an individual reflects on how we perceive things. It is the most difficult exercise. Getting into others shoes and to see the world through their eyes makes one see the entire situation so differently to that of one's former understanding.

After the fellowship I am now working at ACCORD. I realised the need to work at grassroots level more closely to understand the ecology of the issues, particularly the social determinants of health of the Adivasis and hence I decided to join ACCORD. I am primarily working on Local Health Traditions of the Adivasis. The work involves understanding the legitimacy and social relevance of the Local Health Traditions and to translate this to actionable outcomes. I am also involved in fundraising, media and communications for the organisation. The work gives me a chance to interact with people and interact more closely. This will comprehensively help me in understanding the social determinants of well-being

SOCHARA is a wonderful place with really nice people. Friendly smiling faces always welcome people here. This had a tremendous impact on the learning and made the entire learning experience a memorable one." ■



CHAPTER 1

What is the community health learning programme?

1.1 History of the community Health Learning Programme (CHLP)

SOCHARA is a registered Society and a civil society based professional resource group in community health and public health (13). It has worked for over two decades in community health action; innovative training and teaching; networking; research and policy engagement in community health and public health since its registration on 16th April 1991 (9). It has two functional units – the Community Health Cell (CHC) in Bengaluru and Chennai (Community Health Extension Unit) and Centre for Public Health and Equity (CPHE), based in Bengaluru and Bhopal. The Community Health Library and Information Centre (CLIC) and Administration and Accounts service all units, sub-units, programs and initiatives. From the beginning, the Community Health Cell (CHC) and SOCHARA team have consciously adopted a catalyst role, and engaged with many individuals to explore dimensions of community health and development (9). An approach to community health in the Indian context based on a social paradigm was articulated and disseminated by the CHC team in 1987 based on a situation analysis (2).

The shift to a Social Paradigm in Community Health and Public Health involves a broadening of understanding and action from:
• **The biomedical model to an inclusive socio-community approach,**
• **Individual to community focus,**
• **People as patients or beneficiaries, to persons as equal participants,**
• **Providing to enabling and empowering,**
• **Drugs and technology to interactive educational and social processes,**
• **Professional control to demystification, and social control.**

This approach has been used by team members in training and educational initiatives, research, movement building and health policy action over the past three decades. This was republished by SOCHARA in 2011. The axioms of Community Health have been a framework used in the community health learning programme across the three phases, and particularly in phase three with the published document available (2).

One of SOCHARA's objectives in its Memorandum of Association (MoA) of 16th April 1991 is to *"evolve educational strategies that will enhance the knowledge, skills and attitudes of persons involved in community health and development (13)."* This was introduced as many founding members worked in academic settings in a medical college department of community health earlier. Inspired by the 1978 WHO-UNICEF Alma Ata declaration, the 1976 Cor Unum document, the 1975 Shrivastava Committee report of the Government of India and a host of other documents, and particularly through active community engagements and reflection, they experienced the need for alternate approaches to community health and community health education. Towards realising this objective, various initiatives have been undertaken through the Community Health Cell (CHC) and SOCHARA which are ongoing (9). The range includes conducting short training programmes for communities and NGO partners, to involvement in longer term community health education. These have been detailed in previous reports (9,10,11,12) presented in meetings and conferences, and in a recent background paper written for the First All Indian People's Medical and Health Science Convention. (36)

Such engagements led to the realisation that the many existing academic programmes in the country use a predominantly bio-medical model or framework, with limited questioning or discourse on the approach being applied. Community-based learning is also limited. Conventional teaching methods are adopted. Though professionals graduating from these institutions contribute to the public good, there remains a dearth of trained health human resource persons engaging and working with communities. Many professionals passing out of the mushrooming public health institutes that have developed since 1996 look for career opportunities with international agencies, donor organisations or as 'consultants' in the public sector. **A perceived critical gap was the paucity of trained and committed community health professionals to work with communities and strengthen civil society.** This programme was therefore positioned to strengthen civil society capacity for community health with an equity perspective. This would also enable the communitisation component of the public health system to be realised better.

In this context, based on earlier experiences of mentoring and providing space to different individuals at various points in their career in exploring community health, and in response to an invitation from the **Sir Ratan Tata Trust (SRTT),** the **Community Health Internship cum Fellowship Scheme (CHFS)** was initiated in 2003 in Bengaluru to fill critical gaps in developing and sustaining civil society human resource capacity and leadership for community health with an equity perspective. The word "Fellow" was used for participants, even though most were young and fresh, for a variety of reasons. An important rationale was

that we are all fellow travellers in the journey towards Health for ALL. It was also an alternate approach to the concept of senior fellowships, with no disrespect, but with an invitation that everyone is a learner and equally respected. Suggestions of using the word '*felli*' were dropped as the majority felt it did not sound good in an introduction of oneself and it was not a word! We used the word 'fellow' with gender neutrality.

Being a new initiative in 2003 it had a concurrent external review and an end review built into the proposal. These were conducted by Dr. Rajani Ved and by Dr. MK Vasundhra with Dr. Narendra Gupta respectively. The CHFS is now referred to as **Phase One (2003 - 2007)** of the learning programme.

Building on the learning's and experiences of Phase One, and following the reviews of CFHS done by the agency and external reviewers, the SOCHARA executive committee and general body and the donor partner, together with the team, decided that this initiative should continue and grow. Considerable thought and discussion went into making this decision. A **Phase Two (2008 – 2010),** renamed the **Community Health Learning Programme (CHLP)** was initiated in 2008, and conducted over a three-year period till 2010 with support from SRTT. Following a workshop on "**Learning Programmes in Community Health and Public Health**" conducted in 2008, a two-year programme for Madhya Pradesh was discussed and the **MP Community Health Fellowship Programme** was launched by SOCHARA in 2009 with the support of Sir Dorabji Tata Trust through MP CPHE, Bhopal (12). The Centre for Public Health and Equity (CPHE) was initiated by SOCHARA in 2008 during the silver jubilee of the Community Health Cell. CPHE established the MP CPHE in the same year, with an alumnus of the CHLP as its first team member. Details of the second phase of the CHLP conducted in Bangalore was published through a reflective report, mentioned earlier (11).

1.2 Establishment of SOPHEA and Phase Three of the CHLP

During its twentieth year in 2011, SOCHARA began a new journey by reorganising itself and all its resources, linkages and experience into a new framework called the **SOCHARA School of Public Health, Equity and Action. SOPHEA** is dedicated to the education of a diverse group of researchers, activists, community builders, community health and development practitioners and public health professionals through a process inseparably linked to justice, equity, culture, community health interventions, and development, through teaching learning programs, research, and advocacy. Through SOPHEA it is envisaged to create a network of dedicated community health and public health scholar practitioners who work with communities, address health determinants, initiate community health action towards 'Health for All', with sound theoretical grounding and ability for critical, constructive, creative thinking

and action. SOPHEA is strengthening the SOCHARA efforts at mainstreaming the community health approach with institutions involved with public health education as well as with civil society. This builds on the SOCHARA team process of engaging with health policy process and the public health system through engagement with the '*communitisation*' component of the National Rural Health Mission (NRHM) and the National Health Mission (NHM), and various other inter-related processes.

Based on the end term review of CHLP phase two conducted by Dr. Abraham Joseph former Professor and Head of Community Medicine, at Christian Medical College (CMC), Vellore, and the mid-term review of the Madhya Pradesh Community Health Fellowship Programme by Dr. Shanti Minj from CMC Vellore and Dr. Sunil Kaul from the Action for Northeast Trust (ANT Bongaigaon), Phase Three (2012-2016) of the CHLP was initiated in 2012, under the aegis of SOPHEA**.**

Overall, the Community Health Learning Programme for Health Equity in India is a space created by SOCHARA and partners for exploration and mentored-learning about community health, while playing a catalyst role, to increase the reach of the ideas concerning community health, 'Health for All,' social justice and a social determinants of health paradigm. This we believe is in the public interest and for the public good. An external general organisational review of SOCHARA in 2004 recommended that the team utilise its professional expertise more broadly. "*I have a feeling that the list of what is to be catalysed and facilitated has expanded considerably and within that .... socially relevant research, policy advocacy, monitoring implementation of policies, and impacting the mainstream, have emerged as newer areas having direct connection to the development process"* (49). The senior team takes suggestions and recommendations from review processes seriously and works on them over time. This review undertaken when the first phase, the CHFS, was already underway helped the process. The CHLP has enabled the nurturing and development of a critical mass of persons who came to us with a social commitment, and who participated in a collective learning process about community health and its determinants.

Important **steps in organisational strengthening** were undertaken as part of this phase from 2011 with the evolution of the *School of Public Health, Equity and Action (SOPHEA).* New policies were developed building on older policies and staff rules. A *new SOCHARA logo* with a *tag line 'Building Community Health'* was developed with professional help in 2011, the twentieth anniversary. The significance of the logo is given in the latter part of this document (Annexure IX). This logo replaced the earlier CHC logo which was also well loved. The *organogram* was re-done and discussed at the first ARC meeting. A *SOCHARA and CLIC brochure* were developed, printed and placed on the website to share an overview of the work of the organisation

over time. *Standard operating procedures (SOP) for accounting practices* and a *procurement policy* were developed and adopted. These were discussed with the team. *Annual five day team retreats* were initiated in Bengaluru with participation of team members from all three clusters. This is in addition to the regular team meetings that are a practice in the Bengaluru team since inception. Daily admin team meetings were also introduced. Skype meetings were held with teams in Chennai and Bhopal for coordination. An *anti-sexual harassment at the workplace policy*, and a *human resource policy* were adopted. *The general body and executive committee of the Society* have always played an important role and regular meetings are held as per the requirements and beyond. All major policies and changes are discussed and approved by them. A *finance and management committee (FMC)* and *project management unit (PMU)* were established as mechanisms during the period to enable smooth functioning within time frames of different initiatives. The CHLP team maintained a *process documentation*, which helped review and *reporting* which was done on a quarterly and six monthly basis to the two donor partners respectively. *Annual statutory audits*, a *mid term six monthly audit,* and an *internal audit* support the financial management system. Two *external financial management system audits* were undertaken in 2016.

1.3 Vision, Mission, Goals and Objectives of Phase Three of CHLP

While the goals and objectives of the three phases of CHLP (2003-2011) and two batches of CHFP in Madhya Pradesh (2009-2013), have evolved, the underlying vision has been consistent, namely, to create and develop a critical mass of community health practitioners and scholar activists who would work in diverse and creative ways, and in a collective manner whenever needed, towards 'Health for All.' The vision, mission, objectives and values that guided **Phase Three** of CHLP are given below.

Vision of SOPHEA

" *To develop a critical mass of community health practitioners cum activists with scholarship, competence and commitment to work towards 'Health for All' through developing a civil society School of Public Health, Equity and Action (33).*"

Mission Statement

"*Our Mission is to evolve into a civil society based School of Public Health, Equity and Action over the next three years, with a specific focus on strengthening the Academic and Research Framework; Mentoring Processes and Systems and Organisational Mechanisms, based on principles of social justice, humanitarianism, quality and integrity that underpin all work (ibid).*"

Goal

"To establish a civil society School of Public Health, Equity and Action through clusters of professionals based in Bengaluru, Chennai and Bhopal, facilitating the development of a critical mass of scholar activists in Community Health towards achieving 'Health for All *(ibid)*."

Objectives

"1. *To* ***build the capacity*** *of sixty professionals in community and public health in India (intake of 20 per year over a three-year period) for the 'Health for All' goal and movement.*

2. To ***conduct a postgraduate level teaching programme*** *of one-year duration in public health and community health with learning modules, resource materials, web based learning strategies, and field placements for experiential learning through community action.*

3. To ***foster and develop the core competencies for community health and public health*** *among the faculty team of learning facilitators, and the interns / fellows, through theoretical and experiential learning.*

4. To ***build a community health resource network of practitioner scholar activists*** *(a community of learning and practice) committed to an alternative Public Health paradigm based on a community health approach that has equity, rights, social determinants, and 'communitization' of the health system at the core.*

5. To ***strengthen the community health learning and information centre*** *(CLIC) which links and draws upon the rich resources of the community action, training, research, and policy advocacy facilitated by the alternative sector of community health and public health practitioners committed to Health for All (ibid)."*

To realise the vision, mission, goals and objectives, a series of steps were taken through the implementation phase. Many of these took place concurrently and were part of organisational strengthening required to manage an ambitious and complex programme of this nature. One stream of work related to the participants – their selection, training, mentoring, inner learning, accompaniment, assessment, till completion of report writing, and then follow up. The second stream was with the team of teaching learning facilitators. New team members had to be selected and inducted to the SOCHARA ethos and to the CHLP. Older team members needed to join in as part of the learning environment. Team work and team thinking across three clusters required close communication. The third stream was linking with partner NGOs building on older relationships and developing new ones through

linkages with newer team members. The fourth stream was system building with development of newer policies and mechanisms internally within the organisation. All this was embedded within the ongoing work of team members which was part of the substrate of the learning programme.

A brief capsule about the outcomes of the initiative with regard to CHLP participants and other aspects at this stage may be useful. Over the period of CHLP Phase Three (a preparatory phase from April 2012 and commencement from December 2012 to August/October 2016), fifty-six participants completed the one year full time fellowship (of which eight persons did nine to eleven months). There have been 17 short term stipendiary fellows, 28 flexi-interns (non-stipendiary) and 70 post graduate students/interns on placement. Thus 171 post-graduate students have been through the CHLP related process during phase three. This was beyond the numbers planned (60 full time and 30 flexi ie 90 in total) and beyond the numbers reached in phase one (40 inclusive of full time and flexi) and two (44 inclusive of full time and flexi) together. The entire SOCHARA team and the network of field mentors and others have put in a large effort, and this is the fruit of collective endeavours. **The increased number indicates the need that exists in the country for such programmes, and for organisations that can manage fellowships/internships for community health.** Interaction with alumni and field mentors continued with proactive team initiative. Other postgraduate and undergraduate students come for short orientation sessions of a day or less and these are not included in the lists. Team members teach/ facilitate learning sessions in other academic and NGO programmes. Systematic efforts for team development included workshops, annual team retreats, regular meetings, encouragement to undertake independent community based work, to write, mentor, participate in conferences etc. A transition process in the final year 2015-16 was open and democratic, with the taking of increased organisational responsibility. Together with mainstreaming and dissemination efforts, the CHLP outreach is more than the numbers indicate. Further details of the community health fellows are provided in Chapter 3 and in an Annexure. Different components of the third phase of the CHLP are outlined over the next few sections.

1.4 Selection processes of participants for the CHLP

The selection criteria and processes for CHLP participants, developed by the team and advisors, and tested in phase one (the CHFS 2003-7) were found to be robust and sound. **Selection of participants is a very crucial component of the learning programme**, and is conducted through a careful multi-stage process, using due diligence. The entire process is time consuming for both the professional and administrative team, and staff time needs to be factored in and even budgeted. Applications were received after advertisements were published in health journals,

e-groups, and the SOCHARA website. Brochures about the CHLP were printed in phase two and distributed widely. During phase three, soft copies of redesigned brochures were circulated to educational institutions, NGOs and others. In one instance a partner institution placed the advert in a local newspaper, the Shillong Times. This resulted in many applications. Another medium used to disseminate information about the CHLP was through correspondence and personal contact with NGOs, educational institutions and referrals by alumni. Spread through word of mouth through former participants also takes place. The entire process has involved very minimal expenditure. There is a feedback that the reach could be wider, and efforts need to be made towards this.

The application process involves applicants being requested to submit their detailed curriculum vitae, contact details of two referees and a statement of purpose explaining why they would like to join the programme. Candidates were then short-listed after screening the applications and contacting referees. Referee checks are done based on a checklist with points. Detailed interviews were conducted by a panel/selection committee of three members. Applicants are scored based on criteria that encompass several dimensions, including a commitment to working with communities and to learning about community health. There are built in methods to ensure social inclusion and social sensitivity, together with learning ability. Previous academic performance accounts for only a small component. Interviewers on the selection panel are briefed about the objectives, expectations and process of the CHLP prior to the interviews. Local Indian languages are often used during the interview, so that applicants can speak their mind and heart more comfortably, and express themselves more freely about what they want to do in their life. Emphasis was given to selecting women, *Adivasis*, *Dalits*, and those from minority groups, disadvantaged populations, and regions. Across the programmes in Bengaluru and Bhopal we have had participants living with HIV, with mental illness and with disability. Confidentiality is maintained with regard to non-obvious conditions. Applicants and CHLP participants have given a feedback that the interviews in themselves are motivational. The process has been re-visited by different interviewers on the selection panels. Based on feedback this has continued to remain almost the same across the various phases of CHLP and CHFP.

The selection process and image of the CHLP, often spread through word of mouth by participants, resulted in selection of Community Health Fellows generally with commitment, passion, enthusiasm and willingness to learn the principles and practice of community health. There were some who were unclear about the programme despite details being on the webiste, but became more informed over the course of the year. Since this is not a university recognised programme (this has consciously been kept that way so far, and is in the public domain) participants join or stay only if they

really want to. The full time fellowship programme accepts postgraduates in social sciences or graduates in medical science preferably with at least two years of work experience. Candidates from other disciplines with relevant motivation, community experience, and clear long-term goals of working in community health, were also considered.

1.5 The selection of team members is equally, if not more important. Criteria that differ somewhat different from those for selection of CHLP participants, and processes that are similar (with application announcements on the website, application processes, referee checks, interviews with a selection panel and scoring) were adopted. Team members are confirmed after six months of probation. The first month was a period of induction. With a tight time frame for the initiative, they had to jump into teaching learning roles very early. The team was multidisciplinary, and came with a range of experience spanning a few years to decades in a variety of settings and with diverse responsibilities held in the past. This diversity brought in various strengths which added to the CHLP.

1.6 Team work and management took place through daily meetings of the CHLP team for review and planning. These occurred most often, though there were periods when they did not. Full team meetings took place on a fortnightly or monthly basis. There was a division of responsibilities according to knowledge and skill sets among team members. Development of the teaching learning schedules for the collective teaching sessions went through iterations. Team members were encouraged to develop lesson plans with learning objectives for sessions. Sessions on teaching learning methods and on participant assessment were held with development of a set of background papers. Discussions on the learning curve of individual CHLP participants were held regularly. Leadership capacity to handle a multi-faceted programme that required multi-tasking was slowly built up. Conflict resolution was needed as many held strong views, and there was a space to express them. Challenges that arose in team work and team management, for instance when boundaries were crossed, were addressed in a fair manner, with the support and engagement of the executive committee, based on norms, principles and procedures. Challenges faced by the team in programme implementation were regularly discussed. Certain challenges such as multi-lingual teaching facilitation were inherent in the programme design. Others are discussed later.

The human condition is experienced both among the team as well as among the participants of the learning programme, particularly the full time 'fellows'. The process of sharing stories and life journeys, and the encouragement of inner learning, helped open up spaces for personal and inter-personal sharing and growth that

enabled the build up of a degree of trust and friendship between people. This was a very important component of the initiative, enabling challenges inherent in a diverse group to be addressed. This was part of a conscious, mindful, gradual building up of a shared community of learning in the initial period after commencement of each batch. Later efforts in expanding the community of practice continue, despite many other differences in background. However despite all this effort there were moments of concern, given the complexity and scale of the initiative, with participants placed across the country. Decisions needed to be made within fairly short time spans regarding placements in partner NGOs which allowed participants to move beyond their zones of comfort. Team members visited participants in the field where possible, and kept in touch with them and the field mentors. Planning, mentoring and accompanying participant exposure to vulnerable communities required sensitivity and insight. That this needs to be undertaken with respect and recognition of the strength, resilience and sense of agency of people in the community, required time and support from a variety of sources to internalise.

Two national workshops for mainstreaming the CHLP in 2016, where there was sharing by staff from other educational institutions and organisations, pointed out that rapid expansion of public health postgraduate programmes in the country created a challenge. Institutions faced a difficulty in not having adequately qualified and experienced staff, especially those who can work with communities in a democratic manner. The SOCHARA team had a core group of experienced team members, balanced by a younger group with enthusiasm and new ideas. Thus through a reciprocal relationship the third objective of team development for community health was addressed, with a conscious effort made to avoid being patronising or paternalistic (within human limitations).

1.7 The Programme Design, Structure and Learning Methods of the CHLP

The design and structure of the CHLP has evolved over the two phases, and relates to the objectives of the programme. Changes have been made based on team reflections, participant feedback, and recommendations by reviewers and Advisory Committees. During the first phase, internships and fellowships were offered for six months and one year, as per the learning need of the participant. The programme was more unstructured in keeping with the purpose of that phase, which offered a space for young professionals to decide if they would like to make a life-long option for community health. The objectives in phase one were *"to promote life options in community health by offering a semi-structured placement opportunity in CHC in partnership with selected community health projects; strengthen motivation, commitment and interest in community health, sharpen analytical skills and deepen*

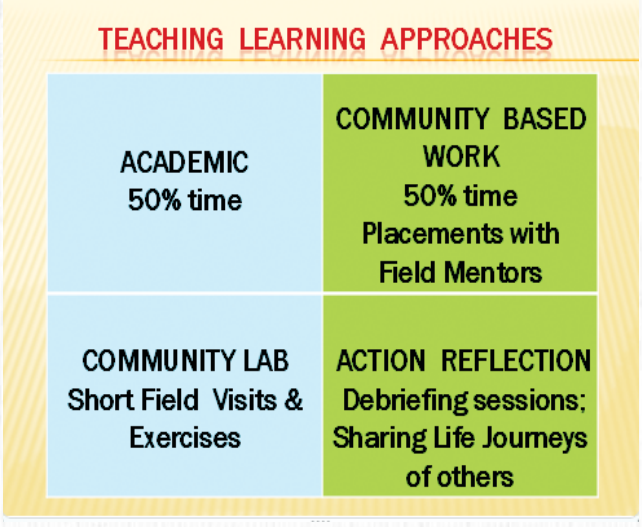
the understanding of the societal understanding of community health and public health(40)". In the second phase the duration was extended to nine months. The objectives were similar "*to develop a community health perspective by offering a....., strengthen motivation, commitment and interest in community health, sharpen analytical skills and deepen the understanding of the societal understanding of community health and public health (11)".* The additional three month period was to undertake a small research project or enquiry, or a community health initiative. In the third phase the full time CHLP became a year-long programme. It can be seen that phase three objectives built further on the previous phases. This phase required more careful attention to the objectives and teaching learning processes from all facilitators in order to realise its potential.

The one-year programme structure in phase three, based on objectives mentioned earlier, was divided into six months of collective teaching based in Bengaluru, interspersed with three phases of experiential learning through two month long community based placements in field areas of network partners, that include the three Sochara team clusters (Figure 1).

Figure 1: Structure of the Community Health Learning Programme during Phase Three

Orientation Sessions	Field Work I	Collective Teaching I	Field Work II	Collective Teaching-II	Field Work III	Final Sessions
Two Months	Two Months	One Month	Two Months	One Month	Two Months	Two Months

PROGRAMME DESIGN AND EDUCATIONAL PHILOSOPHY



The **programme design** with a mix of collective teaching learning sessions, and community based placements with partner NGOs or with our own teams in three locations, enabled both textual and contextual learning among participants and facilitators. Immersion with raw reality through the lives of people living in challenging circumstances, and the community health and development initiatives being undertaken by

NGOs and the Government, resulted in an understanding of underlying health determinants in a direct manner. Organising this constant shift has been demanding for both the team and participants. But it has been worthwhile

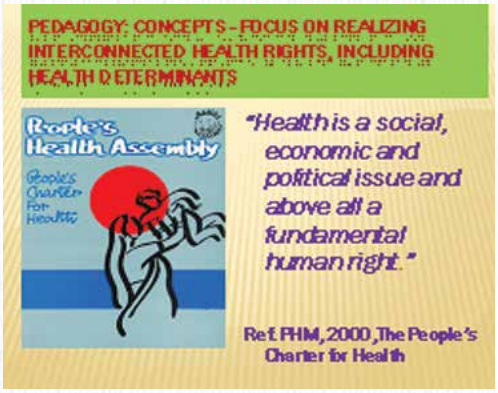
The CHLP uses the Paulo Freire **philosophy and approach to education**, which is social justice based, work towards liberation of the oppressed and egalitarianism. Learning's from the SEARCH experiment in Bangalore of running a development apprenticeship in the 1970s provided useful insights about methodology. Participation with a network of development, justice and health partners in Bangalore also informed the educational approach.

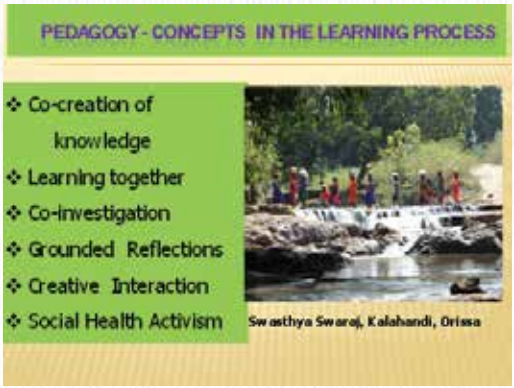
FROM TEACHING & TRAINING TO FACILITATING LEARNING: A PARADIGM SHIFT

TEACHING	LEARNING
❑ Student →	❑ Learner
❑ Teacher →	❑ Facilitator
❑ Banking facts →	❑ Problem Solving
❑ Memorise →	❑ Think/ Participate actively
❑ Listening to lectures →	❑ Contributing to sessions
❑ Disconnected & compartmentalized →	❑ Integrated & interconnected
❑ Submergence of consciousness →	❑ Emergence of consciousness
❑ Domination →	❑ Freedom

Source: Adapted from Paulo Freire, Pedagogy of the Oppressed

In the first week of joining as part of person-centred learning, participants were asked to individually *write their personal learning objectives at the beginning* of their fellowship. This enables taking of responsibility for learning and also helped in further review and planning by the fellow and the mentor. These learning objectives were most often modified over time by the '*dyads' of participant with mentor.*





The **teaching-learning approach** also used principles of flexibility, adult teaching learning methods and multiple learning processes, facilitated in a multilingual environment. This was often challenging, sometimes threatening and time consuming for the facilitators, mentors, and participants. This became a community building process. Learning facilitators in the team came from different backgrounds. While initially not everyone was familiar with the skills required to facilitate learning in a democratic, interactive, participative manner, while sharing their own special knowledge base, the learning by the team was quick. It made the teaching learning process more alive, enjoyable and less burdensome. Regular team meetings, annual team retreats and mentors workshops were held to meet the objective of team development for the CHLP. This is work in progress and requires inner learning and openness to feedback by all concerned.

New paradigms in community health and Public health were introduced. There was a focus on understanding and addressing the underlined societal determinants of health using analytical methods. The Communitisation of Public Health system was discussed as a process of scaling up community health approaches across a large population.

A 52 week curriculum was developed by the team following a curriculum development workshop and this is discussed in a later section. Each collective session and week had a broad theme for discussion and exploration (**see Annexure I**).

The alternative **teaching learning methods** used enabled the curriculum to be covered in a meaningful manner. This has been crucial in realising the objectives of the initiative. Classroom based sessions were facilitated by team members and sometimes by external resource persons. Given the multi-disciplinary intake of participants, efforts were made to respond to the diverse learning needs of participants from different educational backgrounds, some of whom are first generation learners at a post graduate level. Hence SOCHARA members, extended team members and partners sensitive to people, and not those who are primarily knowledge or task oriented were invited as resources persons.

Facilitators were encouraged to develop and share the learning objectives and session plans in advance with the team for feedback. Sessions were conducted using participatory methods of pedagogy with simulation exercises, role-play with discussion, case studies, lecture-discussions, written assignments, video documentaries with discussions and other creative activities.

Exposure visits to organisations such as partner NGOs where community interaction was encouraged, as well as to Government run primary health centres, urban health centres, *anganwadi's (*child care centres) were planned every week during the collective teaching sessions **(see Annexure II**). These were planned according to the topics being discussed during the week. Space was made to accommodate participation in events that were taking place in Bengaluru which would be of value to the learning for participants. For instance this included film viewing, thematic festivals around environment etc, protests, community events, or panel discussions.

Additional learning material included use of reading and audio resources available at CLIC (**see Annexure III).** Individual reflections with encouragement of inner learning, and individual fieldwork were part of the mentoring process discussed later. Participants were also encouraged to maintain a daily diary for the purpose of writing their reflections, which they then shared with other fellows during recap sessions the next morning. The recap sessions held as the first session every morning are reflective, open, relaxed, and learner driven though facilitated by a team member, have received very positive feedback. Learning was facilitated through participation in workshops, seminars and conferences, and taking part in protests and solidarity events. The staggered nature of collective learning sessions enabled fellows to share experiences and also link the conceptual and experiential components, learning from both text (theories) and context (raw reality).

During the field placements in partner NGOs, fellows focused in an in-depth manner on understanding communities, community health approaches to public health problems, local health traditions and also conducted community based

PROJECT SELECTION CRITERIA FOR PARTNER NGOs

- ✓ Community Oriented
- ✓ Community Based
- ✓ Community Action
- ✓ Multi-Sectoral
- ✓ Empowerment Oriented
- ✓ Reflective Action

studies. Checklists developed for the first and second field placement were guides to learning (**see Annexure IV**). The third field placement was oriented to conducting a small research enquiry or undertaking a community health initiative. Field organisations for placement were predominantly those working on community health, development and in realising the basic health and development rights of communities. Partnership with NGOs by the SOCHARA team has developed in an organic manner over the decades as groups worked for a common cause and joined forces for the community health movement. A profile of 44 partner NGOs is indicative of the rich experience that fellows have in learning about community health and development **(Annexure V).**

ROLE OF A MENTOR

- ✓ Guidance
- ✓ Nurture
- ✓ Development
- ✓ Partnership
- ✓ Mutual respect
- ✓ Shared learning

Mentorship has been identified by CHLP participants and team members as being a core process associated with the community health learning programme since inception. This is probably because effort and thought has been invested in discussing the mentorship process for community health learning. A meeting organised with fellow travellers of the pre-2003 phase identified qualities and roles that mentors could play. There is a specific team mentor for each participant identified in the first couple of weeks based on areas of interest, language skills etc. A field mentor is identified once the field placement area is mutually finalised. This triad of fellow/participant, team and field mentor was identified in the first concurrent review as a very important relationship that requires effort to maintain.

PHILOSOPHY OF MENTORSHIP

- ✓ Mutual Learning
- ✓ Stimulate interest
- ✓ Promote enquiry
- ✓ Promote self reflection
- ✓ Values – Equity
- ✓ Values – Gender sensitivity
- ✓ Values – Solidarity

A note on mentorship written during CHLP phase one, and further developed in phase two (50,51), was built upon by the CHLP phase 3 team and through annual mentors workshops (52). This note is shared with all team mentors and field mentors in the partner NGOs. The role envisaged for mentors

was to be a friend, philosopher and guide and a fellow traveller in the community health journey, during the CHLP and beyond. There are frequent discussions about mentorship in the team and during annual mentors' workshops, with feedback from the CHLP participants and alumni as well. Mentoring is person centred, supportive of learning and professional development, as well as of personal growth with a focus on capacity development to undertake responsibilities in community health and in public health systems. Reviewers of the first phase in 2007 noted that "*Mentorship was the 'masterstroke methodology'. All the fellows unanimously agreed that it was the most valuable component of the CHFS. Constant guidance, patient hearing, the informal environment, and the personal care by committed mentors brought out the best in the fellows*" (51).

FIELD MENTORING PROCESS

- ✓ Accompaniment,
- ✓ A companion in the HFA journey
- ✓ Exploring, reflecting
- ✓ Developing work plans
- ✓ Weekly meetings
- ✓ Encourage documentation
- ✓ Debriefing
- ✓ 360 degree feedback

MENTORSHIP FUNCTIONS DURING COMMUNITY POSTING

- ✓ Plan directions (consultative)
- ✓ Plan structure (consultative)
- ✓ Field Placement
- ✓ Assignments
- ✓ Simple research/enquiry
- ✓ Negotiate linkages
- ✓ Review/Reflection
- ✓ Regular Communication
- ✓ Ongoing and final assessment

EXPECTATIONS FROM A MENTOR (by a fellow)

- ✓ Share the history of issues
- ✓ Coordinate interactive sessions
- ✓ Develop a framework of expectations
- ✓ Critically evaluate
- ✓ Consolidate learning
- ✓ Identify strengths/challenges
- ✓ Network with mentors/others
- ✓ Learn from fellows too!
- ✓ Encourage documentation
- ✓ 'Not a drill master'
- ✓ 'Senior experienced colleague & guide'

1.8 Perspectives, Content and Curriculum of the CHLP Phase Three

The content of the CHLP developed in an iterative manner over time across the three phases. It is focused on strengthening civil society in community health and draws on the rich resources available from the experience of civil society organisations and NGOs working on diverse dimensions of community health and development over the years. A national workshop in Bangalore in 2008 on "*Learning Programmes for Community Health and Public Health"*, informed the content of the CHLP and subsequently the two-year Madhya Pradesh Community Health Fellowship Programme, which commenced in end 2009. A second national workshop was held in Bhopal in 2010. A Curriculum Development Workshop organised as preparation for phase three from 27th to 29th December 2011, provided the team with expert and experienced inputs regarding the process. The course content evolved further through the Academic and Research Council (ARC), established in 2012 with its first formal meeting in April 2012.

The **AXIOMS OF COMMUNITY HEALTH** are used as a framework for the teaching learning programme (2), Key values and elements of a community health approach are:

- **Rights and responsibilities:** Community health is a process enabling people to collectively exercise their responsibility to their own health and to demand health as a right.
- **Autonomy:** increasing individual, family and community autonomy over health, and over the organizations, means, opportunities, knowledge and supportive structures that make health possible.
- **Integrates health and development** activities including education, agriculture, income generation/ livelihood.
- **Builds decentralized democracy at community and team level** through decentralized participatory, people-building and people empowering activity. It enhances a team empowering' ethos in relationships.
- **Builds equity and empowers community beyond social conflicts,** recognizing that in the present inequitous and stratified social system there is no 'community' in the real sense. Hence it enhances increasing organisation, involvement and participation of the large sections of the community in decision making.
- **Promotes and enhances a sense of community** in concept and spirit, to improve group dynamics and group inter-relationships that are preliminary to evolving community actions of any sort among the large majority who are poor and marginalized.
- **Confronts the biomedical model with new attitudes skills and approaches** challenging the present over medicalized health care system dominated by doctors with hierarchy, compartments and divisions; with over-emphasis on drugs and technology leading to a complete disregard for non-drug therapy and skills.
- **Confronts the existing super structure of medical/ health care services to be more people and community oriented** at primary health centres, dispensaries, hospitals, teaching and research institutions, and become sensitive to the realities of the life of the large majority of people - the poor and the underprivileged.
- **A new vision of health and health care and not a professional package of actions is** encouraged with new attitudes, ' value orientation' in health action, and perspectives for the future linked to a new vision of society as against the professional discipline, a 'technological fix' or a package of actions.
- **An effort to build a system in which Health For All can become a reality** closely intertwined with efforts to build an alternative socio-political-economic-cultural system in which health can become a reality for all people. It recognizes that the components of actions are means and not ends (2).

These issues become a reference point for discussion: throughout the programme

CURRICULUM CONTENT

The **curriculum contents** covered are organised under the following categories / broad themes (**see Annexure I** for more detailed information about the 52 week curriculum).

i. Building blocks for the fellowship - learning together
ii. Understanding community, society, development and health
iii. Understanding community health and public health - principles and axioms and primary health care
iv. Situation analysis of health and health care in India
v. Social determinants of health and social action
vi. Globalization and health
vii. Research- i – measuring health and disease
viii. Health systems and health policy – (3 days)
ix. Consolidating fellowship plan – (3 days)
x. Nutrition, and women and children's health
xi. Communicable diseases– community health responses
xii. Research-ii
xiii. Non-communicable diseases - community health responses
xiv. Health technology and innovation
xv. Equity in health
xvi. Research- iii
xvii. Occupational health and urban health
xviii. Health policy
xix. Health research project – planning basic steps
xx. Public health management
xxi. Research iv
xxii. Health movements, social movements and social change
xxiii. Special challenges
xxiv. Right to health
xxv. Health economics
xxvi. Special competencies – i
xxvii. Special competencies – ii

Given below are the overall perspectives and principles around which the content of the CHLP is centred. The translation of perspectives and principles into behaviour and action depends very much on the internalisation or resonance that team members feel for the thoughts expressed, which depend on personal vision and motivations,

that can be strengthened, discussed in a democratic manner and challenged within a team ethos.

OVERALL PERSPECTIVES

- Community based and led approaches – community dynamics, perceptions, community mobilisation, community capacity building and societal analysis
- People's perspectives of health systems
- Social, economic, political and cultural analysis
- Gender perspectives
- Political economy of health and the forces of liberalisation, privatisation, globalisation; and their impact on health and equity
- Secularism
- Epidemiological perspectives - understand data, analyse data/situation and respond
- Perspectives on self-transformation while engaging in social action

PRINCIPLES

- Health equity (understand the differences based on factors such as caste, class, urban/rural location, region, language, culture, gender and religion),
- Health rights/entitlements (health as a fundamental human right, universal access to health care and comparison with other country models)
- Governance
- State responsibility and role for health, including universal access to health care
- Leadership and activism in health that is enabling.

The course participants were encouraged to develop a mix of an adequate knowledge base, perspectives, skills (networking, advocacy, communication, community health skills) and attitudes that are sensitive to diverse communities and to field implementers. At the end of the course, it is intended that the fellows be familiar with the public health system, and also be able to collect data, present and interpret data.

NEW PUBLIC HEALTH/EPIDEMIOLOGY-I
THE PARADIGM SHIFT

Approach	Biomedical and technomangerial (Old Public Health)	Social and community health oriented public health (New Public Health)
Focus	Individual diseases / disabilities	Community challenges and systems orientation
Dimensions	Physical / Pathological	Psycho- social, cultural, economic, political, ecological
Technology	Drugs / vaccines / Diagnostics	Systems, 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 Research and Health Policy Research

Participants make **presentations** throughout the programme during and after which they receive feedback. **Debriefing discussions** take place after field visits during the collective sessions to get deeper insights about different issues and to discuss the community health approach. Detailed presentations by each fellow after the field placements results in a lot of shared learning from diverse contexts. Batch 12 needed to go through the scientific and ethical review process, for which presentations were also made.

The process of the fellowship allows for team feedback to be given to the participants in formal and informal ways. **Each fellow writes a detailed report** during the fellowship. Part A of the report is based on all aspects of the programme and their reflections, while Part B reports on the research study undertaken by them. The team mentor is responsible for finalisation of the report. A second peer reviewer from the team also provides inputs. Criteria have been developed to assess the report. There is no ranking given as all are part of the community with contributions based on the strengths of each one. Some of the fellows write in the local language. Three copies of the report are made with one for the fellow, a copy for CLIC and the archival section.

Participants are given a **certificate** by SOCHARA on completion of the programme.

1.9 THE ACADEMIC AND RESEARCH COUNCIL (ARC)

The Academic and Research Council (ARC) established in 2012 for the period of CHLP phase three, had a specific focus to strengthen the academic and research ethos within the CHLP programme, and among team members, within the organisational ethos and values.

Members of the Academic Research Council (ARC) were:

1. Dr. Mohan Isaac – Chairperson (He was elected President SOCHARA in the final year of the ARC)
2. Dr. Thelma Narayan – Member Secretary
3. Dr. John Porter – Member
4. Dr. Shantidani Minz – Member
5. Dr. Mario Vaz – Member
6. Dr. Aditi Iyer – Member
7. Dr. Kaaren Mathias – Member
8. Dr. Magimai Pragasam – Member
9. Dr. Kabir Sheikh – Member

This newly constituted multidisciplinary council representing academics and researchers from different disciplines, together with experience and linkages with different dimensions of public health, health policy, health systems and action on social determinants of health was to provide direction and support to the academic and research vision, content and process of the School of Public Health, Equity and Action (SOPHEA) (47).

Members of the Academic Research Council Meet, December 2014.

The Terms of Reference for the group were outlined under broad headings:

"Values, Vision and Framework

1. *Evolve and endorse the values, vision and framework of a community health oriented public health with a focus on equity, ethics, rights, and on the underlying health determinants including gender, and community processes that will form the core of all the training and research endeavours of SOPHEA.*

Curriculum, Content and Process

2. *Evolve and endorse the ongoing curriculum development, content and teaching learning processes of all the courses offered by SOPHEA – short courses, long courses and community health fellowship programmes.*

Assessment, Monitoring and Evaluation

3. *Evolve and endorse the mechanisms of concurrent and terminal assessment of the students on the courses, and the monitoring and evaluation of the programs.*

Research and Enquiry

4. *Evolve and endorse the guidelines for all research and enquiry undertaken by SOPHEA developing thematic areas if necessary for instance environmental health and eco-justice; urban health; health policy process; health related social movements.*

Continuing Education and Communications

5. *Evolve and endorse the technical content of all continuing educational progammes and communications which are offered by SOPHEA and the mechanisms for linkages with all its fellows and alumni (46)".*

The '*ARC community*' was a forum that functioned with free and frank discussion, which included differences of opinion, which allowed greater clarity to emerge and were part of a feedback loop. Documents for discussion were shared with members who were a sounding board, as well as a part of the governance mechanism for the initiative. Though three annual meetings of the ARC were planned, five were held, besides additional informal visits and discussions during SISEC and internal review meetings. Team members (Mr. Mohammad, Mr. Venkatesan and Mr. Prasanna Saligrama) joined some of the meetings. Meetings were often organised around other events (such as the annual alumni and mentors meetings, national bioethics conference, the dissemination meeting), so that there was opportunity for ARC members to interact with the wider community that SOCHARA is part of. Formal meetings were held as follows:

i. The **first meeting** was held during the preparatory phase on 23rd-24th April 2012 with funding from another partner the Ford Foundation. Detailed discussions took place based on extensive documentation provided by the team through a background note on the scope, curriculum and process of phase three. Several team members participated in this meeting.The Chair noted from a 20th anniversary SOCHARA brochure that "*Dreams are the foundations on which we build (9)*." Efforts to streamline CHLP content made in this phase received approval from the ARC.

ii. The **second meeting** was on 15-16th April 2013 when Batch 9 the first in this phase had commenced the programme. ARC members interacted with participants around poster presentations of their plan of work, and also with the team.

iii. The **third meeting** on 9th September 2013 worked through the proposal for SISEC. The ARC supported the establishment of the SOCHARA Institutional Scientific and Ethics Committee (SISEC) for review of research proposals. Members also met with the team and CHLP participants.

iv. The **fourth meeting** on 10th December 2014 was held just before the 5th National Bioethics Conference (NBC) co-organised by SOCHARA, and relooked at the curriculum and also discussed ongoing collaborative research

v. The **fifth and final meeting** was on 7th December 2015 which further reviewed the phase and received analytic feedback from one alumnus from batch 11 and a present participant from Batch12. ARC members made a presentation the following day at the Dissemination Meeting to a large audience of the key aspects of the ARC work. It was an opportunity for community health fellows, members of the ARC and SISEC and participants from diverse backgrounds to meet each other and build community. Members had also earlier been sent the report of the mid-term review of the CHLP Phase Three. Members reviewed the changes in the flow of topics suggested in the last meeting. Experiences of recent collaborative research programmes were reviewed. The research component of the CHLP needs further attention. Based on the internal review process within the team in July 2015 it was felt that governance systems within SOPHEA can be further strengthened to ensure accountability and adequate good quality work performance by all team members. ARC members were thanked for their contribution to the development of SOPHEA and SISEC and the evolution and conduct of the third phase of the CHLP. They too appreciated and thanked SOCHARA for being part of this journey.

The ARC together with the SISEC contributed to the building of scientific and academic rigor within the learning and research activities undertaken by SOCHARA-SOPHEA during Phase Three of the CHLP. Their professional services and input as been offered in a spirit of Solidarity as part of the wider SOCHARA Community.

1.10 The SOCHARA Institutional Scientific and Ethics Committee (SISEC)

The SISEC was set up under SOPHEA during the middle of the third phase of the CHLP to strengthen the research initiatives of SOCHARA both by the faculty and fellows, with regard to scientific rigor and ethical considerations. ARC members responded to the draft foundational document developed by the team and draft Terms of Reference for the establishment of SISEC helping to develop it further. A ten-member committee was formed by drawing experts from various disciplines required such as; Community Health, Ethics, Law, Social Sciences etc. from the SOCHARA network.

Review of a Research proposal by members of the SISEC

Review of a Research Proposal by Members of the SISEC

The Purpose and Role of SISEC

"The purpose of constituting an institutional scientific and ethics committee is to ensure a competent review of all scientific and ethical aspects in the research proposals submitted in an objective manner. The SISEC reviews and approves all research proposals involving individual participants and communities with a view to safeguard the dignity, rights, safety and well-being of all actual and potential research participants. The goal of the SISEC is to protect the health and well-being of each one of the research participants.

The SISEC takes into consideration the scientific and social science basis and the cardinal principles of research while reviewing proposals. For the ethics review, principles of Autonomy, Beneficence, and Non-malfeasance (do no harm) and Justice will be reflected upon. For this purpose, it looks into aspects of the voluntary informed consent process, getting approval from statutory bodies where needed, provision of adequate information to relevant stakeholders, risk benefit ratio, distribution of burden and benefit and provisions for appropriate compensation to all groups and classes in society, taking into account age, gender, economic status, culture, and ethnic considerations wherever required. The committee reviews the proposals before start of the study, as well as ensure that there is a monitoring mechanism for the research throughout the study until and after completion of the study, through appropriate well documented procedures for example regular reports, final reports and site visits (where possible) etc. The committee also examines compliance with all statutory and

regulatory requirements, applicable guidelines and laws. In summary, the mandate of the SISEC is to review all research projects involving human persons and communities conducted at SOCHARA-SOPHEA, irrespective of the donor agency or the University affiliation. The role of SISEC can be modified according to the evolving requirements of SOCHARA-SOPHEA (48)."

A sub committee was formed to review the field studies of the fellows. The subcommittee reviewed 18 proposals of the fellows of CHLP-batch 12. For the fellows this was a new experience as they did not have similar process in their previous Master's Degree programmes in University settings. The team mentors supported the fellows in preparing them to adhere to the scientific and ethical rigor required for their field studies. Besides this, in 2014 the SISEC reviewed the research proposals of two PhD studies by its associates, two are research studies carried out in collaboration with other partner organisations, and one proposal by a student from Nepal who was recommended to seek the help of other committees due to nationality and other legal issues. In 2015, the SISEC also reviewed the research proposal of Ms. Rebecca D Son, a Nehru Fulbright Fellow from DePaul University, Chicago, Illinois, USA from the Bachelor of Arts programme in International Studies and Certificate in Geographic Information Systems.

Table 1: List of SISEC members

S. No	Name	Designation	Discipline Represented
01	Mr. Abhijit Sengupta	Chairperson	Administrative Services
02	Mr. S.J. Chander	Member Secretary	Community Health and Social Science
03	Dr. D.K. Srinivasa	Member	Public Health, Research
04	Dr. Arvind Kasturi	Member	Community Health- Academic
05	Dr. Maya Mascarenhas	Member	Community Health – Practice
06	Ms. Manjulika Vaz	Member	Social Science
07	Ms. Kathyayini Chamaraj	Member	Civil Society
08	Rev. Fr. Clement Campos	Member	Ethicist, Theologian
09	Ms. Aparna Ravi	Member	Law
10	Mr. As. Mohammad	Member	Social Demography and Statistics

1.11 The Community Health Library and Information Centre (CLIC)

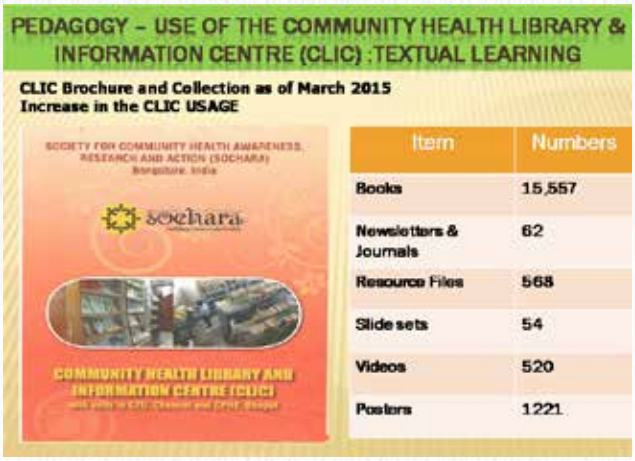
SOCHARA's Community Health Library and Information Centre (CLIC) has evolved to provide students, staff, and the general public, access to a substantial collection of resource material that would support and promote discussions, debates on current

and relevant issues in community and public health; and wider efforts in building community health. The CLIC evolved gradually in response to the priorities and emerging issues. CLIC today functions through our website, CLIC units in all our centres, and also provides regular updates through Health Digest and Health Round-up. CHLP phase three aimed to further energise CLIC and redesign the website, so that a dynamic learning platform for community health develops.

CLIC has a rich collection of resources on community health and development, as well as on a range of related classified thematic areas listed below, which are available to team members, CHLP fellows, other institutions and the public. A variety of registers (including a Utilisation Register) and files are maintained as part of the CLIC management system. Stock checks are undertaken once in two years. The *CLIC committee* consisting of a few team members guides its work. The committee has met regularly and discussed ways to improve its functioning. Issues discussed include replacing missing books, digitisation of in-house articles, annotated bibliographies being developed for certain themes and updated for others. The Librarian Mr. Mahadevaswamy also supports the documentation work of SJMAP (SOCHARA Silver Jubilee Museum and Archival Project). He has provided specific inputs, based on areas of interest, to fellows and flexi-interns. CLIC has also helped in collecting the required background materials for the fellows, based on their requests.

The Community Health Library and Information Centre (CLIC).

CLIC- Bangalore: An Overview of the Collection as of 2016



Training materials on community health, public health and health are available for distribution and sale with publications in English, Tamil, Kannada and Hindi. We have official reports, news releases, research papers, presentations, media and cartoons.

A CLIC Brochure helps disseminate information about the resources available. A monthly **'Health Round-up'** is produced and sent to around 1100 registered subscribers. This publication is an index of health related books and journal articles identified and acquired during the previous month. Subscribers can request for these articles by email. They can also request CLIC to acquire and provide other articles of interest. Twelve issues were produced during the year.

CLIC also regularly produces **'Health Digest'**, a summary of newspaper and magazine articles on issues of Health, Vulnerability, Environment and Social Development, which is sent to a similar number of registered members. CLIC has continued to collect paper clippings from 2 newspapers (one English and one regional language "Kannada") on health, environmental, marginalised communities' issues etc. and organises it in a subject wise manner.

CLIC in the SOCHARA Community Health Cell Extension Unit (CEU) - Chennai

During the year 2015-16 CEU further developed its unit of CLIC. Many magazines, journals and books were added and sorted for easy access. This year this library unit witnessed an increased number of user's accessing the material, including outside members.

CEU- Chennai Collection details

939 Books on various categories (638 +301 added this year)
18 Journals, newsletters and periodicals (16 + 2 added this year)
20 Resource folders on various themes
38 Videos & Documentaries (CD & DVD format)
10 Posters

A CEU team member contributed to the SOCHARA Information Management System (SIMS) in the following way: As a preparatory activity a brief policy note on SIMS and a project note on SJMAP was prepared and circulated to Society members and staff members. The policy note describes the concept of information management that evolved with the growth of the organisation, and the present context of contribution towards SOCHARA's objectives. It includes all the sectors like CLIC, Website (www.sochara.org), Publications, Documentation, Newsletters, SJMAP and online learning Media of SOCHARA under one roof. It also discusses the vision and strategies, with an implementation plan linking different components.

CLIC in the SOCHARA – CPHE Madhya Pradesh (MP)

The Resource Centre for Public Health at Bhopal has also initiated a process to further develop a library and information unit focusing on health and health system issues relevant to central India with materials in Hindi. The evolving library and information unit is a part of the overall Community Health Library and Information Centre (CLIC) in Bangalore.

> The library at MP CPHE has a total of 1024 books which have been indexed as per the library catalogue. The language allocations of the Publications are in English (550) and Hindi (474). The collection of books covers thematic issues related to: agriculture, child health, community health, de-addiction, decentralization and governance, demography, development, disability, disaster, drug, Economics, globalization, management, nutrition, political science, public health, policy, reports, rights, sociology, women's health, women's rights etc. Apart from this the library has issues of Health action, Reproductive health Matters,

Website – www.sochara.org: SOCHARA's website was updated and given a new look through this period. While the website redesigning process started in 2014 it became operational on 1st January, 2015. The website in relation to CLIC contains newsletters, resource material, publications, presentations, and a gallery with cartoons, photos, videos and posters. All our publications are available on the website, making the objective of developing a web repository of resource material for community health a reality. There is a regular tracking of the hits/viewership of the website which has shown an increasing trend with users from India and other countries. The website will serve in the future as a platform for web based learning. The changes extend to the content produced for the CHLP documentation.

From March 2016 responsibility for management of SIMS, including the website, was taken by a team member Mr. Suresh D from Mr. P. Chandran who was a part-time consultant during the previous two years. In the later part of the year, a series of meetings were held with Mr. Prasad, KGLN, service provider and the SOCHARA team to discuss and understand about the website development, requirements, constraints, alternatives etc. A detailed review was done with Dr. Ravi & Mr. Mahadevaswamy to find the grey areas and block holes in the website content and these were listed for updates.

1.12 Video-documentation of the CHLP was undertaken for the first time in Phase Three with two productions. This was conceived as part of the dissemination strategy being planned for the CHLP. The first video was initiated and completed in 2014 through a fairly long and interactive process with calling for Expressions of Interest, a selection process to identify a suitable agency, development of a script based on the content outline given by the team, viewing draft versions and receiving feedback from the team. The production process required the contracted party which undertook the production to understand community health and the CHLP.The final version was launched at a meeting with Mr. Alan Leather, President-NGO Forum, Geneva, and formerly with the ILO, who visited us in Bengaluru. It has been shared on several occasions at meetings and with fellows and other visitors with a positive feedback. The second video was developed in 2015. The Bangalore Media Centre (BMC), produced the first video after successfully going through the due processes of procurement, and won the contract again. Development of the script took time for both video's, with inputs by the senior team members and feedback from all CHLP team members. Various CHLP team members accompanied the video-documentation team during visits to alumni, mentors and fellows in three field mentoring organisations to facilitate the process of filming. The pre-final version of the video titled "*Campus without Walls*" was screened during the Dissemination Meeting held in December 2015. Small changes were made based on feedback and the video was finalised. It is used for all visiting groups of students.

1.13 Publications - E-SOCHARA Newsletters carry articles by team members, community health fellows and alumni. They have been brought out regularly by Mr. Chandran and recently by Mr. Suresh D on a bi-monthly basis.

- Vol. 1 (1) was launched on 8th March, 2015, on International Women's day;
- Vol. 1 (2) was released on 1st May 2015, Labour Day/International Worker's Day.
- Vol. 1 (3) was released in July 2015 on World Population Day;
- Vol. 1 (4) in September 2015 prior to World Mental Health Day of 10th October;
- Vol. 1 (5) in November 2015 on World Toilet Day;

- Vol. 2 (1) January 2016 on Climate Change;
- Vol. 2 (2) March 2016 on the SOCHARA Silver Jubilee
- Vol. 2 (3) May 2016 on World No Tobacco Day
- Vol. 2 (4) July 2016 on Sustainable Development Goals and other issues;
- Vol. 2 (5) October 2016 covers several themes, including an update on the transition process and leadership change in SOCHARA.

SOCHARA Website www.sochara.org & E-SOCHARA Newsletter

•Redesigned in 2014 and Statistics as on September 2015

Month	Unique visitors	Number of Visits	Pages	Hits
Jan	1,150	2,396	13,848	103,323
Feb	1,112	1,656	7,555	56,137
Mar	1,394	1,950	9,484	76,841
Apr	1,101	1,671	6,059	52,456
May	1,078	1822	10,353	78,826
Jun	1,160	1,716	8,234	66,692
July	1,459	2140	8819	73445
Aug	1,094	1,597	9,377	78,053
Sept	1,023	1,322	6,417	61,121

The E-SOCHARA Newsletters are circulated to 1079 subscribers on the CLIC g-mail group, and uploaded on the www.sochara.org website as part of a dissemination strategy about community health work. Mr. Suresh D has taken over the responsibility for the Newsletter after March 2016.The website receives a fair number of hits every month and the newsletter does receive feedback.

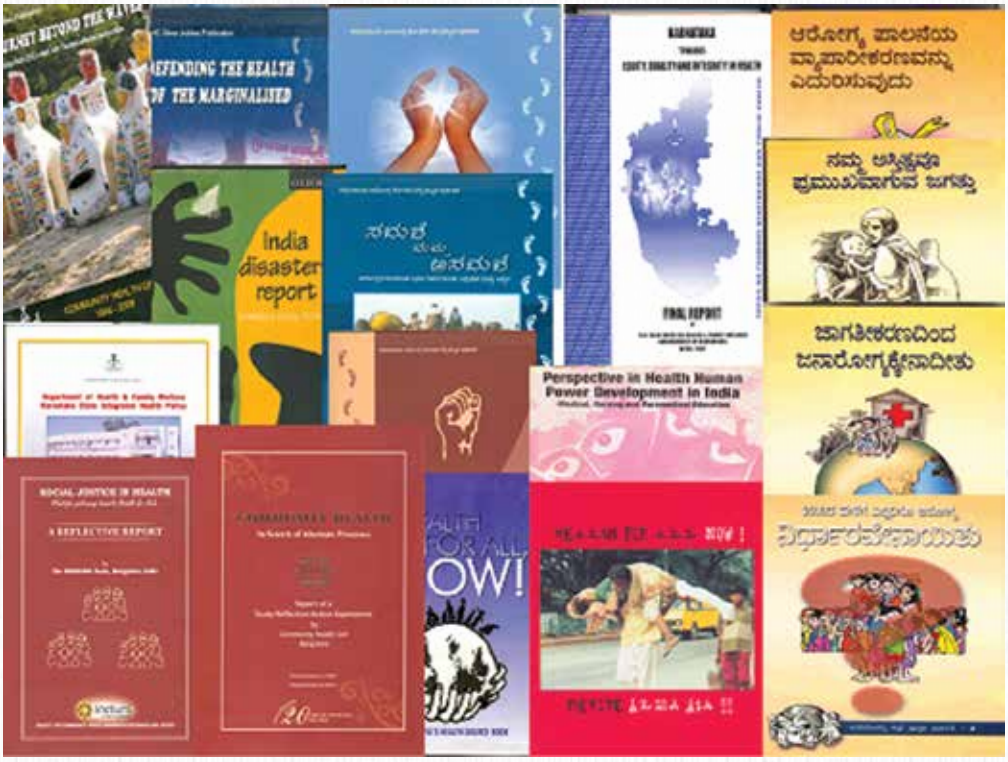
'DIMENTIONS' is another newsletter available in print form and electronically on the website. Introduced during an earlier project on Social Justice and Health, it continued during phase three of the CHLP. An earlier version during CHLP phase 2 was called Building Blocks (with two issues in 2008 and 2010 respectively). The newsletter in this phase covers research initiatives, workshop reports, recent activities and write-ups contributed by team members, fellows, flexi-interns and associates of SOCHARA. Issues published during Phase Three were in November 2013, March 2014, September 2014. Issue No. 4. which was released in June 2016

was quite substantive and led to the newsletter being renamed **'COMMUNITY HEALTH DIMENTIONS'.** These newsletters are widely distributed.

Team members are encouraged to write and a list of publications is available in the SOCHARA Annual Reports which are uploaded onto the website.

A very recent report titled 'Surviving Burns with Care' published jointly by SOCHARA and VIMOCHANA (a partner organisation) was launched at a public event at the Victoria Hospital of the government run Bangalore Medical College (53). While there was an audience of about 100 people, the event received very good media coverage in the Kannada and English newspapers. This drew attention to the issue of violence against women, and particularly on the issue of burns and the challenges faced by the health system in responding to this situation. This report was written by an alumnus from CHLP phase two.

Through increasing its publications over the past five years, adding to earlier reports and articles, the SOCHARA-SOPHEA team has contributed in a small way to the growing body of knowledge in the field of the community health and equity ■



SOCHARA Publications

CHAPTER 2

What is the need for the Community Health Learning Programme?

2.1 Human Resources for Health

Health human resources are crucial for health, health care and development, yet this remains a neglected and distorted component in public policy and in health system development in India in terms of quality, distribution and direction of work. Too often human resources for health are seen as a budgetary expenditure and a burden, rather than as a vital investment for society in a repository with knowledge and skills. Postgraduate level education in community health and public health in particular is in need of revitalisation and expansion with a clear focus on cultural competence and social relevance. Sound investment in human resources for community health and public health with the right orientation, knowledge and skill mix facilitate the achievement of health, development and equity goals. At the same time education of health professionals is increasingly becoming commercialised with graduates/ postgraduates seeking careers in the private sector, or migrating abroad.

2.2 Human resources – neglected and maldistributed

Given the critical importance of trained human resources for health to population health, as well as the intimate link between the evolution of health care services (including health human resource policies) to the dominant paradigm of development of a society, it is not difficult to see the link between the growing inequity and marginalisation of populations on one hand and the neglect and maldistribution of human resources on the other.

2.3 Changing dynamics in development of Health Human Resources

The current scenario in the field of education for public health reveals significant initiatives over the past decade by the private sector. Several of these are commercially driven and fill the needs in clinical research organisations, international organisations, while some function as 'consultants' in the public sector which has expanded positions recently.

There is also a growth in the 'alternative community health and development sector' with internship and fellowship programmes attracting committed young people taking up the challenge of working innovatively in resource poor settings, building social and human capital for health and development.

SOCHARA has been a resource group and participant in several community health and public health initiatives in the country and region, and has emphasised the need for creating and enhancing the cadre of public health professionals and managers with a strong community health orientation. These initiatives have included the Medical Education and allied human resource Task Force of the National Rural Health Mission; the Independent Commission on Health in India; the National Knowledge Commission (sub-group on Community Health); the health policy initiatives for public health education of UNESCAP; the recent initiatives of WHO SEARO on epidemiology; and the Indian Public Health association (IPHA) on public health competencies.

In all the above, SOCHARA has consistently focused on the educational needs for practical, community based public health professionals. This approach has been supported recently by the final National Knowledge Commission report recommending – '*appropriate community health education programs that respond to people's needs in order to improve public health in India'.*

2.4 Building a critical mass of 'Scholar Activists'

There is an urgent need for a much larger cadre of dedicated community health and public health scholar activists and practitioners who work with communities, initiating community health action towards 'Health for All' and 'All for Equity', with an understanding of social reality in India, with sound theoretical grounding and an ability for critical, constructive and creative thinking and action.

There is a need for scale-up along with greater use of technology to ensure an adequate density of such persons in all 688 districts (+ 30 recently created districts in Telangana) in the country. Participants in one of our workshops felt that at least ten such committed and trained community health practitioners across every district could be an immediate goal. However such persons are needed in every *taluk,* village and urban ward. This has been attempted through the communitisation component of the National Rural Health Mission (2005-12) and continued through the National Health Mission (till 2017). The scale up of ASHAs (accredited social health activists), village health, nutrition, and sanitation committees (*Swasthya Gram Samiti's*), Community Action for Health (CAH), Patient Welfare Societies has been large and fairly unprecedented. However the quality has varied a great deal and the presence of NGOs and trained sensitive persons has played a crucial role. SOCHARA's unique experience over the last 25 years, where it has engaged with communities, NGOs, public sector groups and policy making bodies as well as being deeply involved in the People's Health movement is a very good base, on which a series of learning programmes in community health have already been initiated since 2002 during which year we had pre-fellows and many persons on placement.

The values, knowledge, attitudes and skills-set required for community based public health action (now also referred to as communitization in the NRHM) requires a very different type of teaching learning methodology (pedagogy) to be used. It calls for greater experiential and group / community based learning, self-directed learning and learning through study-reflection-action cycles. These pedagogical opportunities based on praxis are often not available in the mainstream. This teaching learning method focuses on values, attitudinal change and skills required in community settings, skills in critical thinking and analysis; and in advocacy at different levels.

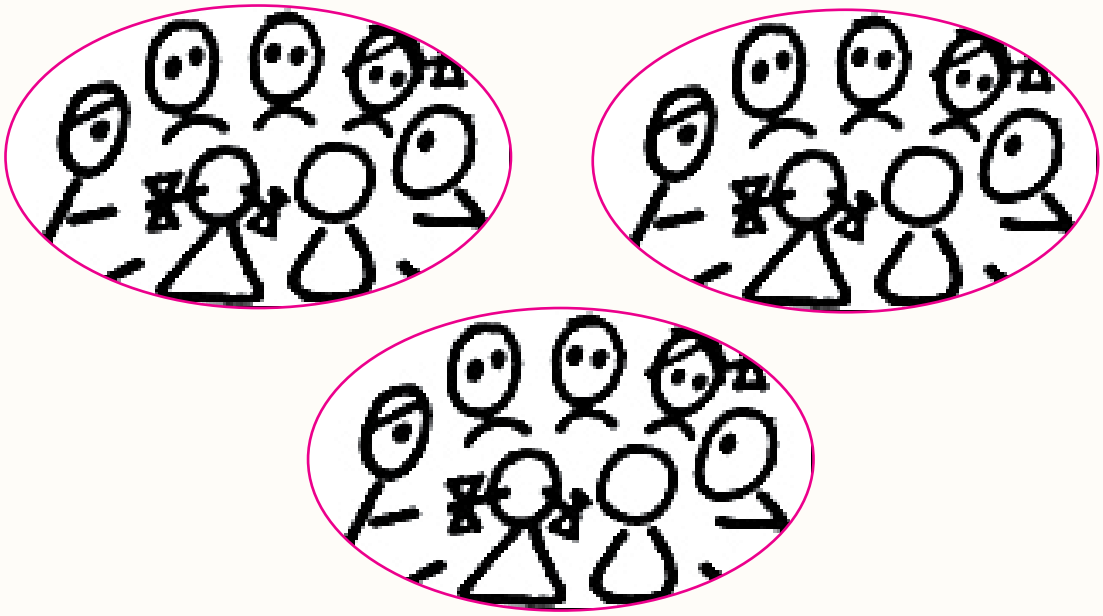
Fellows of CHLP Phase Three - Batch 12

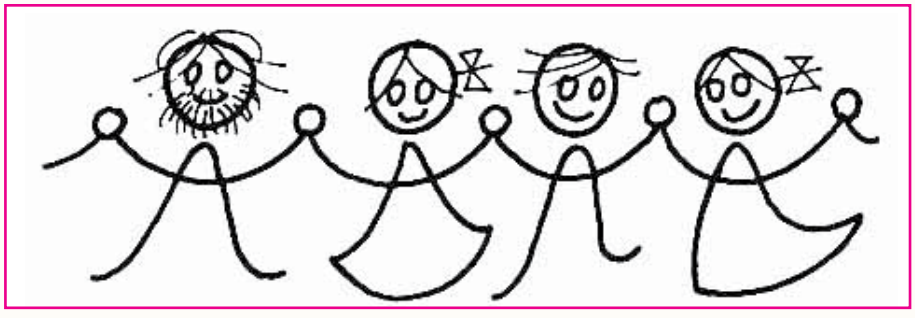
2.5 Community Health Fellowship Project Experience (2003- 2011)

The Community Health Fellowship innovated and experimented by SOCHARA with the support of partners that include the Sir Ratan Tata Trust (SRTT), IDRC in Bangalore, and the Sir Dorabji Tata Trust (SDTT) in Bhopal and the Sarathy Foundation supporting both, have led to an increasing appreciation of the need for sustained and scaled up effort which focuses on imparting values and a theoretical framework along with field exposure to the different dimensions of community and public health. This exposure will strengthen grounded perspectives in social justice and equity. It is also the belief of SOCHARA that through research and community

engagement by scholar activists, we will be able to increase documentation based on evidence gained from ground realities which will inform and influence perspectives for activists and organisations involved in the politics and processes of engagement for health to influence policies that are pro people. It will enable public policy processes for health to make people central through adoption of participatory methods; make space for greater voice in decision making and universalise access to health care.

Over the years SOCAHRA team clusters have developed rich experience in community action for health; in engagement with health policy processes that promotes equity and community health principles; in evolving community health approaches to tackle alcoholism, tobacco control, sanitation and waste management environmental health. It was felt that this rich experience could be part of the learning environment for a younger generation of community health practitioners and scholar activities. There is a mutual growth and learning in each others presence ■





CHAPTER 3

The CHLP Fellows and Who They Are

3.1 Since the Community Health Fellowship Scheme, 2003, across the three phase Community Health Learning Programme (CHLP), 300 participants largely from India, with a few from other countries, with varied educational backgrounds completed fellowships, internships and placements with us. The small team engaged with this intensive process for capacity building for health equity in India, while concurrently working together with many others in supporting health policy process through the National Rural Health Mission/ National Health Mission (NRHM/NHM) to scale up community action for health through communitisation in the country, in an extensive manner. There have been gains in improving health and to some extent equity through the NRHM/NHM. Gaps are present, with concerns about continuity of the effort. The team worked with the People's Health Movement moving the health agenda forwards. The intensive effort through the fellowship programme has long lasting effect through nurture of individuals who address different important issues related to public health that they are deeply interested in. To recap, in phase three, 60 community health practitioners were to be trained over three years (20 annually) with an additional 10 flexi-fellows per year. After institutionalising the School of Public Health Equity Action (SOPHEA) in December 2012, until end October 2016 when the donor support closed, 171 young professionals have spent varying lengths of time with us, either as full-time fellows, short-term paid fellows, flexi-fellows or on placements as a part of post-graduate academic courses they were pursuing.

Changes of plans were necessitated during implementation of phase 3, due to challenges met such as selected fellows discontinuing the programme. SOCHARA made every effort to maximise the reach and potential benefit to young professionals with 56 full-time fellows, 15 short-term paid fellows, 28 flexi fellows, and 70 students on placements associated with SOPHEA (total 171). An analysis of the background of these individuals will help understand the wide reach of CHLP especially in light of SOPHEA deciding to focus on fellows from Central, Northern and North-eastern parts of the country in the subsequent phases.

Table 2: Number of full time community health fellows in each phase of the CHLP

CHLP Phases	Number of full time Fellows
CHLP Phase One (2003-7)	18
CHLP Phase Two (2008-11/12)	30
CHLP Phase Three (2012-16)	56

3.1 Full-Time Fellows

During phase-3 the full-time fellows of the community health learning programme, ie. those with a year-long stipendiary support, were selected in four batches (Batch 9, 10, 11 and 12). Batches 9 and 10 had ten fellows each, and the latter two batches had 18 fellows each. Due to reasons which have been detailed later, primarily fellows discontinuing, fewer numbers 56 than the planned 60 fellows completed their full-time one year fellowship. With efforts to redistribute the remaining months of the stipendiary fellowship of the 12 fellows who discontinued, 56 fellows were able to complete the full-time fellowship (**Table 3**). The batched 9 and 10 did not have any dropt but the batches 11 and 12 had two dropouts in each. A combined total of 655 months of full-time stipendiary fellowship was offered over the three and half years of phase three. The budgetary balance from the total of 720 months available was utilised by selecting persons for short term stipendiary fellowships.

Table 3: Number of full-time fellows who completed the fellowship in each batch

Batch	No of seats available	No of seats filled	No of drop outs	Percent completed
9	10	10	0	100%
10	10	10	0	100%
11	20	18	2	90%
12	20	18	2	90%
Total	60	56	4	93%

The gender distribution of full-time fellows has changed. More women than men enrolled for the fellowship in this phase, while in the earlier two phases more men than women enrolled. The positive gender distribution towards women is unique feature of CHLP since it is one of the few non-formal academic programmes in India which sees such enrolment. The selection process with inbuilt social inclusion is partly the reason for this. The majority of those who completed the full-time fellowship belonged to the age group of 20 to 29 years. The majority of participants were those who had completed their Masters in Social Work degree and had none or less than five-year' experience. This distribution was seen even during the earlier phases which illustrate the role SOCHARA/SOPHEA has been offering a learning opportunity to young persons interested in exploring community health (**Table 4**).

Table 4. Gender and age distribution of full-time fellows of phase three

Demographics	No of fellows	Percent
Gender		
Female	29	52%
Male	27	48%
Age group (years)		
20-29	43	77%
30-39	13	23%

SOPHEA through its fellows has a footprint in 20 states across Central, Eastern, Northern, Southern, and Western regions of the country. There were 12 interns from other countries oriented to community health. Building on earlier phases of the programme in Bangalore and Bhopal, there was greater geographical diversity in this phase, regarding both numbers of fellows from each state, as well as number of states represented. This provided opportunity for cross cultural interaction and learning, including development of communication skills (listening, singing, speaking) in different languages. The learning about community health was enhanced among the fellows and team through sharing of grounded experiences from diverse geographies, since conditions determining health are specific to a particular state or a particular part of a state. Linguistic diversity also proved to be a challenge while facilitating teaching learning sessions with the need for facilitators to speak in more than one language whenever possible. A conscious decision was taken to select fellows from states where the health situation is poorer as compared to the national level and other states. This is reflected in the large number of fellows who were selected from central India as part of efforts since 2009 towards creating a critical mass of community health practitioners working towards 'Health for All'. These fellows along with those of the two batches of Community Health Fellowship Programme conducted by CPHE, Bhopal have formed a fellow's collective which has taken up an initiative towards tackling undernutrition in Madhya Pradesh. The Martin Luther Christian University, Shillong, provided the initial linkage to the Northeast which has since developed with the fellows from the North-eastern states planning to start a collective of their own **(Table 5)**.

Table 5: Geographical distribution of full-time fellows of phase three

	States	No of fellows	Percent
1	Kerala	6	11
2	Tamil Nadu	3	5
3	Karnataka	17	30
4	Andhra Pradesh	1	2
5	Orissa	2	4
6	Chhattisgarh	1	2
7	Rajasthan	2	4
8	Madhya Pradesh	13	23
9	Uttar Pradesh	2	4
10	Meghalaya	9	16
	Total	**56**	
	Regions	**-**	
1	North	2	4
2	South	27	48
3	East	11	20
4	Central	14	25
5	West	2	4
	Total	**56**	

Phase one had more equal distribution of participants from various educational backgrounds (there were more with a medical training). In phases two and three, more than half the participants had social science backgrounds (through the report the postgraduate qualification has been considered, except for those with public health training for whom undergraduate qualification has also been used for analysis). This is more pronounced in phase three where more than two-thirds of the participants come with a social science background, in particular those who completed their postgraduate studies in social work. This flowed from an organisational understanding of the need to address the underlying social determinants of health, for which a social science background provides better preparation. Fellows included undergraduates and postgraduates, including those who completed an M.Phil. programme. Graduates mainly belonged to the medical and allied

health fields for whom under graduation is the selection criteria, whereas other graduates were selected based on work experience and interest expressed. (**Table 6**)

While SOPHEA strived to select fellows with varied academic backgrounds, the number of applicants with an MA in Social Work was much higher than any other field resulting in full-time fellows predominantly having a social science background. Since many applicants were referred by previous fellows or through network partners of SOCHARA the uniformity of the educational backgrounds prevailed. That those with post-graduate degrees in public health/public health dentistry have joined and completed the year long fellowship to enhance their understanding of community health vis-à-vis public health is indicative of the value fellows associate with CHLP. Every batch during this phase had participants with diverse educational backgrounds. This ensured that varied perspectives were brought in during discussions.

Table 6: Educational background of full-time fellows of phase three

	Educational Background	**No of fellows**	**Percent**
	Educational Stream		
1	Social Sciences including social work, sociology, economics, politics	42	75
2	Science including physics, engineering, management and environmental science	10	18
3	Medical including AYUSH and dentistry	3	5
4	Allied health professionals including nursing	1	2
	Educational Level		
1	Under-Graduation	6	11
2	Post-Graduation	50	89

An earlier document with profiles of participants over three phases of fellowship showed that almost fifty percent had less than five years of work experience prior to joining the fellowship. In this phase, exactly half have less than five years of experience which does not include the one-third who joined CHLP immediately following their graduation or post-graduation. Most of those who joined immediately after their academic courses have a social work background (**Table 7**).

Table 7: Prior work-experience of full-time fellows of phase three

	Work Experience	No of fellows	Percent
1	No Experience	19	34
2	Up to 5 years	29	52
3	More than 5 years	8	14

Fellows usually start their community health journeys with CHLP and most have continued their journeys with NGO's working on community health and development following their fellowship. Others have taken up jobs as researchers, are pursuing further education, have started their own NGO's or are working with various programmes under NRHM. Those starting their NGO's, such as Ms. Ranu Sharma and Mr. Pravesh Varma, are a minority, and did so while working for other organisations in order to pursue their areas of interest and to empower communities in the places where they belong (**Table 8**).

Table 8: Post CHLP journey of full-time fellows of phase three

Post CHLP Journey	Frequency	Percent
Joined NGO's doing Community Health and Development	41	73
Teaching in academic institutions	4	7
Work with Project of state, UNICEF, Public Health Institutes and CSR project	4	7
Work for private firms	3	5
Married recently and not working presently	4	7
	56	

While women participants take time off work following marriage or child bearing, the experience (not fully documented) is that all of them return to work. Women should continue to be encouraged to join the learning programme.

3.2 Short-Term Stipendiary Fellows

At various points of the programme 10 full-time fellows could not continue their yearlong fellowship due to reasons including personal issues, further education and job opportunities. These fellows were then considered as short term paid fellows. It was decided to take additional suitable applicants who go through the selection process, for shorter durations but with stipendiary support. Additional crash training was provided to the new

participants on key areas for them to join the ongoing group. Short term participants are different from flexi-fellows, who are non-stipendiary, who join on a voluntary basis to learn. A total of 71.5 months of short-term paid fellowship was offered to 17 individuals. As explained earlier the remaining duration of stipendiary fellowship available from those who discontinued was utilised in supporting other full-time fellows and short-term paid fellows. The gender and age distribution is given below (**Table 9**).

Table 9: Gender and age distribution of short-term paid fellows of phase three

Demographics	No of fellows	Percent
Gender		
Female	8	47
Male	9	53
Age group (in years)		
20-29	10	59
30-39	5	29
40-49	2	12

Short-term paid fellows were from eight states across the central, eastern, northern and southern regions of the country. Those discontinuing their fellowship were from batches 10, 11 and 12, with a majority from batch 12. Through a reflective process we realised that among other reasons, fellows not disclosing their plans for further studies during the selection process was a reason for them dropping out. (**Table 10**)

Table 10: Geographic distribution of short term paid fellows of phase three

	State	No of fellows	Percent
1	Arunachal Pradesh	1	6
2	Karnataka	4	24
3	Kerala	1	6
4	Madhya Pradesh	4	24
5	Manipur	1	6
6	Odisha	1	6
7	Tamil Nadu	2	12
8	Uttar Pradesh	1	6
9	Jammu and Kashmir	2	12

Similar to full-time fellows, two-thirds of short term paid fellows had social science backgrounds; however, individuals qualified in law, textile engineering, family studies and medicine brought diversity to the learning (**Table 11**).

Table 11: Educational background of short-term paid fellows of phase three

	Educational Background	No of fellows	Percent
	Education Stream		
1	Social Sciences including social work, sociology, economics, politics	12	71
2	Medical including AYUSH and Dentistry	2	12
3	Science including physics, engineering management and environmental science	1	6
4	Humanities, languages and others	1	6
5	Law	1	6
	Educational Level		
1	Graduate	3	18
2	Post-Graduate	14	82

Majority short term paid fellows had work experience, with one-fourth having more five years of experience. Those with work experience and in age groups of more than 29 years were more likely to discontinue their fellowship (**Table 12**).

Table 12: Prior work-experience of full-time fellows of phase three

	Work Experience	No of fellows	Percent
1	No experience	3	18
2	Less than five years	10	59
3	More than five years	4	24

3.3 Flexi Fellows

Since the initiation of the fellowship programme in 2003 along with the full-time fellowships SOCHARA has been offering individuals, both national and international, the chance to have a mentored space for learning community health through internships of varying durations based on the needs expressed. During the present phase, 28 flexi-fellows completed internships of varying duration from under a month to up to a whole year joining at various points of time in all three units of SOCHARA – SOPHEA, CEU and CPHE. Similar to the full-time fellows there were more

women flexi-fellows as compared to men and more than two-thirds were between 20-29 years of age (**Table 13**).

Table 13 Gender and age distribution of flexi-time fellows of phase three

No	Demographics	No of fellows	Percent
	Gender		
1	Female	20	71
2	Male	8	29
	Age Group (in years)		
1	<20	5	18
2	20-29	19	68
3	30-39	3	11
4	≥40	1	4

Twelve of the flexi-fellows belonged to five countries with a majority from the USA. Sixteen came from five Indian states with majority from Tamil Nadu and Karnataka. The ability of SOPHEA of attract interns from other countries is indicative of its reach; these interns themselves approached to pursue their internships and many came to know about SOCHARA through the website and those who had earlier completed their fellowships (**Table 14**).

Table 14: Geographic distribution of flexi fellows of phase three

No	Geographic distribution	No of fellows	Percent
	Country		
1	Canada	2	7
2	England	3	11
3	India	16	57
4	Nepal	1	4
5	USA	6	21
	State within India (n=16)		
1	Karnataka	5	31
2	Madhya Pradesh	1	6
3	Maharashtra	3	19
4	Tamil Nadu	6	38
5	Uttar Pradesh	1	6

Flexi-fellows have more varied educational backgrounds compared to full-time fellows. The range is from high school to MPH postgraduates, which is even more diverse in case of student placements as seen in subsequent section. This is partly explained by there being no educational criteria for selection; however, they undergo the selection process and not everyone who applies is selected. We hosted students who did their internship as a part of their Master of Public Health course and those with public health training interested in expanding their understanding of community health. Those in high school at the time of their internships were from the USA which reflects the nature of learning programmes there. Four-tenths of the flexi-fellows were medical or allied health professionals. They were trying to fill gaps in the existing curriculum of their courses in understanding community health (**Table 15**).

Table 15: Educational background of flexi-fellows of phase three

	Educational Background*	**No of fellows**	**Percent**
	Education Stream		
1	Medical including AYUSH and Dentistry	7	25
2	Science including physics, engineering management and environmental science	4	14
3	Public Health	6	21
4	Social Sciences including social work, sociology, economics, politics	5	18
5	High School	4	14
6	Allied health professionals including Nursing	1	4
7	Law	1	4
	Educational Level		
	High School	4	14
	Graduate	10	36
	Post-Graduate	14	50

3.4 Post graduates and Students on Placements:

As part of reaching out to and to orient students to the tenets of community health, the three team clusters of SOCHARA hosted and mentored students from various universities and colleges across seven states of India, and other countries pursuing undergraduate and postgraduate courses. Seventy students from 15 universities /colleges pursuing undergraduate /postgraduate courses in social work, law, sociology, public health, family studies and development spent time learning with us. Student placements offer a chance to network with academic institutions and build two way partnerships. Some universities invite team members to facilitate sessions in their courses as detailed in the chapter on mainstreaming. Other than hosting students for longer placements, we conducted orientation sessions for students from four institutions located in Bengaluru and elsewhere.

The journey with 171 fellow travellers on the CHLP path has been meaningful for the team and all concerned with two-way and multi-dimensional learning. A brief profile of some of the participants and their first persons reflections are given in the next section ■

Staff and Fellows of CHLP Phase Three - Batch 12

A SNAPSHOT OF SOME CHLP ALUMNI FELLOW'S PROFILES

CHLP Batch 9

Ms. Ranu Sharma from Khargone, Madhya Pradesh a post-graduate in Social Work, who has completed a Post Graduate Diploma in Computer Applications. Prior to joining the CHLP she had three years experience with an organisation 'Towards Action and Learning (TAAL)' in Dhar district, Madhya Pradesh working on Child Rights. During the fellowship she was placed with NGOs Muskaan, Bhopal and Synergy, Harda where her activities included conducting training on nutrition for adolescent girls and participatory rural appraisal (PRA). Currently she works as the Cluster Coordinator, MARAF Sanjhi Sehat Project, Barwani district where her responsibilities include coordinating Participatory Learning and Action (PLA) activities, and conducting training for CRP & PLA facilitators. She is also the President of Swar Sankalp Sansthan a registered NGO which she started along with another CHLP alumnus, Pravesh Varma, working on child rights, health and sanitation.

Ms. Shashirekha P from Kolar district, Karnataka is a post-graduate in Social Work with specialisation in Community Development. She was placed with Association for Promoting Social Action (APSA), Bangalore and Rural Women Social Education Centre (RUWSEC), Chengalpattu during her fellowship. She also conducted studies on the knowledge, awareness and experience of women on maternal health in a slum in urban Bangalore, factors responsible for anaemia in women 18-45 years of age in five villages located in Chengalpattu District, Tamil Nadu and reasons for not following medical advice given by women at screening camps held at five villages in Chengalpattu District, Tamil Nadu. She says that the experience and studies during the fellowship helped her to understand different communities and their needs. Following her fellowship, she worked with the AYUSHGRAM project of the Foundation for Revitalization of Local Health Traditions (FRLHT). Presently she is working as a Counsellor and Advisor with the District Special Women's Protection Cell and MYRADA at Chikkaballapur for a Targeted Intervention programme for Female Sex Workers under the Karnataka

State AIDS Prevention Society (KSAPS) focusing on women who face crisis in their lives and are most at risk.

Mr. Bhimraj Surpur is from Yadgir, Karnataka is a post-graduate in Environment Science, with a Bachelor's degree in Education (B Ed). During his fellowship he worked on environmental health issues and was placed with M S Ramaiah Medical College, Bengaluru and Gurukul Botanical Sanctuary, Wayanad, Kerala. He presented and published a study on the status of health care waste management and infection control practices in health care settings of Anekal Taluk, Bangalore Urban district, and conducted a health care waste management awareness programme for healthcare workers in Anekal taluk. Following his fellowship, he was a part of a research project on 'Access to Essential Drugs' and later worked as an Executive (Recruitment/Training) with the Association of People with Disability (APD) Bangalore. He then worked with the Karnataka Health System Development and Reform Project (KHSDRP), overseeing their bio-medical waste management section for Koppal district. After closure of the project in mid 2016 he is working as guest lecturer on environmental science in two colleges in Gulbarga, North Karnataka.

Ms. Shanthi D'Souza is from Mangalore, Karnataka, and has completed her Bachelor degree in Social Work and is currently pursuing her post-graduation in Social Work. From childhood, she was interested in the social work. This dream came true when she started to work with working children in Bidar where she saw the condition of the children, who due to poverty and other reasons, were forced to work at a young age. She says they did not have a childhood as she had. After graduation she joined the CHLP where she got an opportunity to learn both from classes and the field. She learnt about social determinants of health and to analyse problems. She says she got a chance to enhance her capacity and knowledge of research. Inner learning sessions helped her to learn more about herself. Later she joined an organisation working on anti-human trafficking wherein she uses her capacity to save lives, and connect persons back to their families. She has learnt more about the Immoral Traffic (Prevention) Act and Protection of Children from Sexual Offences Act (POCSO) at her current place of work. She works closely with Child Welfare Committees and other stakeholders.

CHLP Batch 10

Mr. Ganesh CK from Chickaballapura, Karnataka is a post-graduate in Social Work. He says, "The year 2013, I will never forget because it was a turning point in my life with surge of events that took place in both my personal as well as professional life. While looking I see many differences that have happened. My thinking capacity has improved, now while seeing people who are suffering I try to understand the situation, think and discuss with others what can be done. I have realized and relate that every issue is related to health.

My observation skills have improved and I am able to understand the situation much better. If I see any problem in the village I will go to the people and talk with them. Even though I don't know anything about the medicine, I have the confidence that at least I can tell them to go where they have to go; otherwise I will find out about it and pass on the information. I also visited the PHC and sub-centre to understand about the health system and the challenges.

SOCHARA as an organisation itself is to be thanked, for wherever I go I feel welcomed when I mention that I am from SOCHARA. I learnt about the importance of being connected with organisations to make movements successful."

As a very good singer and composer of songs he enlivened many sessions during the fellowship. He worked as the Livelihood Coordinator at the Centre for Social Action, Christ University Bengaluru through which he was placed in Kolar district. He now works in a CSR project called BUZZ India in Bengaluru training community based organisations on financial literacy and leadership qualities.

Dr. Samantha Lobbo is a budding dental public health graduate from the University of New South Wales, Australia whose area of interest is community health education and promotion. During her study period, she had been enthusiastically involved with promotional activities related to anti-tobacco and awareness campaigns with organisations like Oxfam Australia, Cancer Council Australia etc. To gain a better perspective of community health, she pursued the Community Health Learning Program Fellowship at SOCHARA. Post fellowship, she went onto work with tribal communities in Kalahandi district, Odisha mainly focusing on health promotion and awareness activities.

She presently works as a Training Officer at the Institute of Public Health, Bengaluru, with responsibility for content development, design, coordination and management

of the online e-learning course on Public Health Management for 150 Block Programme Managers across the state of Karnataka (in collaboration with the Department of Health, Karnataka). She also works as internship coordinator and face-to-face workshop coordinator. Apart from health promotion, she has a keen interest in tobacco control, women's rights and the social determinants of health.

CHLP Batch 11

Ms. Asma S from Bellary, Karnataka is a post-graduate in Social Work. She had two years experience as a Counsellor in St. Marys Hospital, Bellary in an HIV/AIDS project. Her area of interest is on malnutrition. She joined the CHLP to learn about community health and more about the living conditions experienced by people. Her hobbies include reading books and listening to songs. Asma currently works with FEDINA in Bengaluru as Project Coordinator, with workers along with their Union called Pragatipara Beedi Karmikara Union and she also works with retired unorganised sector workers.

Dr. Bharti Shekhar Sahu from Raipur, Chhattisgarh is a dentist, with two years experience as Medical Officer at Medi Assist India Pvt. Ltd, and as Medical Consultant at HealthcareMagic.com. prior to joining the CHLP. Her area of interest is women and child health. She joined CHLP to work at grass root level for needy people. She intends to further her career in Public Health in the future. Her hobbies include photography and music. Bharti is currently working with EKAM Foundation, Raipur as State Programme Manager for the State of Chhattisgarh.

CHLP Batch 12

Ms. Anu Maria Jacob from Chennai, Tamil Nadu has completed the Master of Public Health programme. She has one year of work experience with the Spices Board of India prior to joining CHLP. She has joined CHLP to learn more and develop skills in community health. She hopes that the experience she gets at SOCHARA will help her to work on community health issues. Her areas of interest include health issues of workers, nutrition of women and health promotion among adolescents. After the CHLP, Anu joined the Sree Chitra Tirunal Institute of Medical Sciences and Technology Trivandrum, as a District Project Manager for a project on Prevention and Control of Non Communicable Diseases (NCDs) in Kerala.

Her responsibility is to implement the NCD risk reduction strategies in selected schools and panchayats in Ernakulam district. For this she provides educational interventions for school teachers, students, health workers and ASHA workers. She also coordinates all the district level training and the NCD survey in the district.

Ms. Uma Chaitanya Vipparthi from West Godavari, Andhra Pradesh has completed the Master of Pharmacy programme. Her area of interest is on rational drugs and therapeutics and related issues. She joined the CHLP to understand and learn about community health, and to develop skills to sensitise, enable and motivate the community on rational drug use. Her future plans are to work on promoting rational use of drugs, manufacture of essential drugs to meet the needs of the country, rational prescription by doctors and rational dispensing. Reading is her hobby. Uma has been awarded a scholarship based on which she is currently pursuing studies prior to taking the national Civil Services Examination ■

FELLOW'S REFLECT ON THEIR CHLP EXPERIENCE……

Saraswathi. S (CHLP Batch 11)

Background: " I was born in an orthodox and traditional family living in a rural village of Madurai District in Tamil Nadu. Children & youth should obey parents or elder's words without asking questions, is custom of the community. My studies have been decided by my family members without any consultation or identifying the skills within me. I followed the same as they wish. When I completed 10th standard, my family members told to take science group without my opinion, at that same time I didn't like to continue my studies because I felt bad on others interference. Hence, I have completed my Higher Secondary education with science group. Then, my parents asked me to go for higher studies, but, I did not expect that, my parents are interested in my future career. I was sent for higher education in College where I took B.Sc - Rehabilitation Science. As soon as I completed my degree course I asked my professor for advice, she suggested me to go for MSW and I did the same.

Association with CHLP: When I just completed my MSW, my father passed away by heart attack and I was upset and could not do anything. At that time, I met my relative who is working in DEEPS and asked me to come to DEEPS to get relaxed for some time and get experience. I joined in DEEPS organization and I worked there for five months. When I was working, we had done a study on women at work place in 10 districts of Tamil Nadu which was facilitated by SOCHARA - Chennai. During the study period I happened to discuss with Mr. Suresh in SOCHARA, Chennai and who suggested I go for CHLP fellowship programme for a year in Bangalore. Then this opportunity was shared with DEEPS Director Mr. M. Shankar who encouraged me to join Community Health Fellowship Programme to equip my capacity on various aspects such as community health, experience with community, reporting and documentation etc.

My Learning:

- During my MSW course had very limited exposure could not gained much experience on the real term "Social". In fact, my intention was not blaming the institution but the system. With this background I joined CHLP and learnt many new things. I learnt what do we mean by Community and Health and also Medical services.

- During my placement, I gained skills in interacting with community on values, culture and practices. And also learnt interactive methods in communicating with community.
- Gained knowledge and learnt reporting and documentation by assignment and field experiences.
- Commune life at CHLP with different people from different parts of the country.

Changes:

Changes during CHLP period, it can be divided in three aspects which I felt within me.

Changes within myself: Related to Perspective, Behaviours and Practices.

My perspective on community health earlier was hospital and treatment, but the internship changed me and I learnt that Community Health is different from Hospital and Treatment.

During my academic period I felt like a professional, but have realised that professionalism cannot resolve community issues. I have begun to observe problems when they occur.

I found many changes in personal practice where I now take care of my own health, and have regularized my diary writing.

Changes in my work situation: I try to understand the values and attitudes of the people and this helps me associate with them.

Changes in my skills: My communication skills improved and this was proven when I was able to conduct a training programme for Women Workers in the unorganised sector.

I believe that I have been equipped with co-ordination skills, and these are reflected in the project that I am responsible for where I am required to coordinate an entire project with NGO partners in 10 Districts of Tamil Nadu.

I should say thanks to SOCHARA for giving me the opportunity to learn."

Anusha Purushotham (CHLP Batch 11-12)

Through my CHLP journey, my attitude towards the concept of 'development' completely changed. I began to understand how the larger socio-political global forces influence 'developmental' activities, including those related to health. My perspective of health, now became wider, to encompass SEPCE determinants in addition to biological determinants. CHLP also taught me the practice of action-reflection and inner learning;

learning by doing and reflecting has become a powerful tool that I continue to use in my professional life. CHLP equipped me with the confidence of engaging in both scholarly as well as advocacy based approaches and guided me towards research and action for social change.

The experiences at CHLP fortified my commitment to work in the field of community-public health and provided me with a network and platform to enable this work.

CHLP was unique in that the primary emphasis was on inquiry and critical thinking unlike many other post-graduate programmes. The sharing of reflections on various topics was encouraged and valued.

The drawbacks of the programme were that both theory and field practice had to be structured a bit better - theoretical concepts had to soon be followed by practical field exposure. Although this was done for a few topics, field exposure was neglected in many other topics. The field placement of 6 months should be a continuous process instead of being divided into 3 placements of 2 months each.

Despite these few logistical drawbacks, the CHLP is a wonderful, one-of-a kind learning programme that deserves a space of its own in the present and the future."

Sabeena Lyngdoh (CHLP Batch 10)

I am from Shillong, Meghalaya and have a post-graduate degree in Social Work. I am a person who loves to learn and explore new ideas and thoughts, and always strives to achieve high standards in whatever I undertake. SOCHARA was the platform where I got to know my strength and weakness. It was a beautiful journey surrounded by enthusiastic people who work towards community health for improving the lives of the people. My entire world changed and I must say that I feel blessed to have come to Bangalore and be a part of Community Health Learning Programme (CHLP). Before joining CHLP I had limited knowledge about public health, my only interaction with the health care field was through interning at hospitals, shadowing doctors, and conversing with family friends who were involved in the field. I always had passion to work with the people in distress and help them in whatever possible way. The experience which I received from my institution was not enough for the better understanding of the community, it was only after I joined SOCHARA I got to explore different fields of community health and understand better the real world of the people in our country. At present I am working at Rajiv Gandhi Indian Institute of Management (RGIIM), Shillong as a Research Assistant."

Ankit Vashishtha (CHLP Batch 9)

"I am from Gwalior, Madhya Pradesh, and have completed my post-graduation in Social Work, and am currently pursuing my doctoral studies in Sociology. Prior to joining CHLP I had three years of work experience with Centre for Integrated Development (CID), Gwalior, working on child rights in health, freedom from hunger and fear campaign, and nutrition and health awareness programme among the Sahariya Adivasi community. The CHLP is a platform through which fellows understand health along with its social, political, economic and other determinants; policy level initiatives; and community based approaches of Primary Health Care. Currently I am working as Project Coordinator of the Vitamin A and other micronutrients promotional programme in Gwalior-Chambal Division, Centre for Integrated Development, Gwalior. I was able to gain practical exposure to the existing health system during my CHLP field placement which is now helping me to improve grassroots service delivery and increase demand from the Panchayati Raj system which is an essential part of 'decentralised' and 'Bottom-Up' approach in the rural health system. We motivate Panchayats to raise demand of health facilities and utilise the funds to improve the Gram Arogya Kendra (village health centre). On the whole, on one hand we are ensuring better health facilities and on the other hand, we are encouraging people to use these facilities and raise demands."

There is presently in October 2016 a cluster of five CHLP alumni working in the Centre for Integrated Development (CID). This is a reflection of the value the organisation gives to the CHLP and to the contribution that fellow travellers are making in an area of need.

In concluding this section, we feel that each person who participates in the CHLP is a unique person with whom we try and spend time establishing a friendship based on which learning of community health takes place and is built. The learning environment is crucial. The participants of the CHLP have taught us a lot and have been a motivation. The CHLP is demanding and those who join are courageous. We hope that many such fellows and their journeys can be facilitated in the future through the combined efforts of team SOCHARA-SOPHEA supported by the wider community of network partners ■

CHAPTER 4

The SOCHARA-SOPHEA CHLP Mentoring Network

Mentorship for community health learning is a dynamic, complex, sensitive and crucial component. The CHLP was possible because of the network of friends and mentors involved and working in community health and development related initiatives across the country (2). Over the years and much before the CHLP commenced, the CHC team and later SOCHARA developed close links and friendship with like-minded individuals and organisations interested and working in community health, development and the broader societal issues that determine health (10). Networking was a core principle for our work (2). Linkages developed in the late 1970s and early 1980s continue to be alive with a spirit of solidarity in working towards a common cause. Ability in critical thinking and dialectical discussions with a capacity to weather differences of opinion and approach grew with time. This loosely networked group spread across the country, and beyond, can be called an epistemic community. People, organisations and institutions who have engaged with each other over this long journey, are willing, capable and able to mentor and support community health fellows in their own search and journey. A list of over eighty partners across India has been developed over the different phases of the community health learning programmes. These organisations have hosted, and can host community health fellows and mentor them in their journey of learning (33). While there are many more such organisations, these are groups with whom working relationships have been established. They have been referred to as the 'Who's Who' of community health in India. During CHLP phase three, 44 partner NGOs hosted fellows. A brief sketch of the work undertaken by these partner NGOs is listed in an Annexure.

Networks such as the Medico-Friends Circle (mfc) which celebrated its fortieth anniversary in 2014, the *Jan Swasthya Abhiyan* (JSA) since 2000 and its state units, the all India Drug Action Network (AIDAN) since the early 1980s, the Catholic Health Association of India (CHAI) which is preparing for its 75th anniversary, the Christian Medical Association of India (CMAI) which is older, the Voluntary Health Association of India (VHAI) since the 1970s, the environmental, right to food, children and women's movement groups together embrace several thousand groups in the country (10). They are a force for change. They are also an important resource for community health education, being a repository of grounded knowledge and experience with community based work. Social movements and communities linked to the networks mentioned above comprise an even larger group. Team members have been engaged with most of these networks, groups and movements over time,

having played a proactive, as well as supportive role in many. The CHLP with a focus on learning from, and strengthening the civil society sector for health, felt that rich learning for the CHLP interns and fellows was possible if they spent time with these organisations and with field mentors. The contextual learning would balance textual learning making

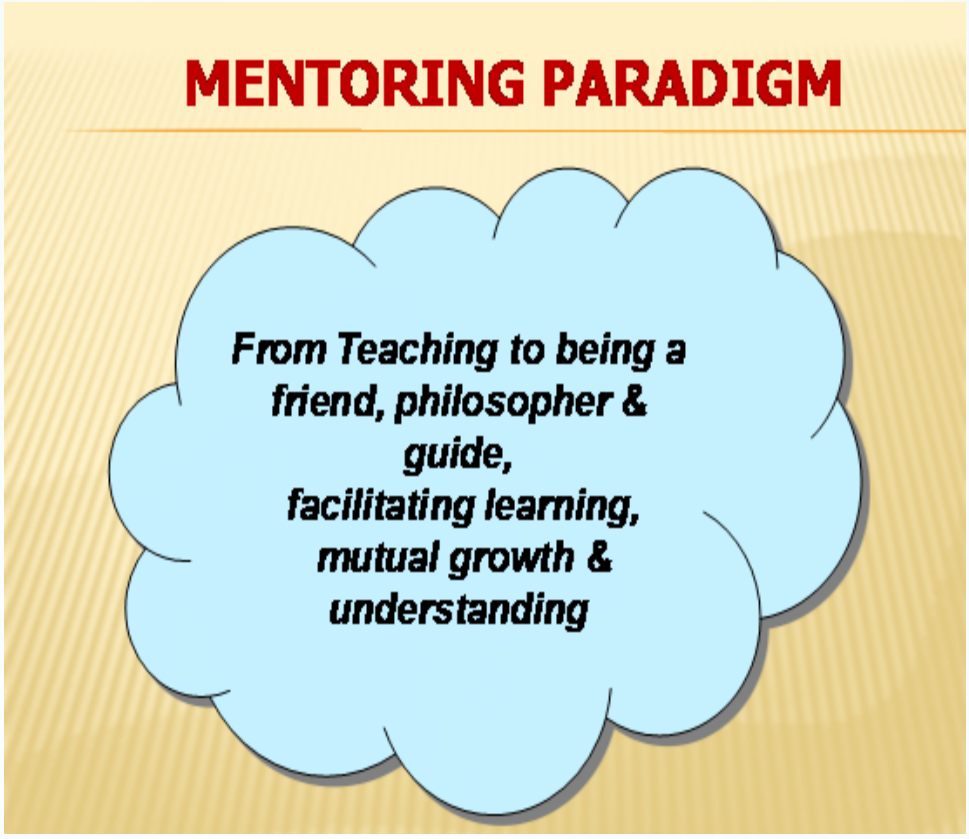
The mentorship role was undertaken by senior as well as all team members from the partner organisations, though one person was functionally responsible as the 'field mentor'. CHLP participants learnt from interactions with the community, who are a part of the mentoring and learning environment. Community activities and public participation play a major role in addressing the social determinants of health with an overarching aim of achieving health for all. As such, the CHLP phase three incorporates six months of field-based learning with the support of SOCHARA's networking partners spread across India. These organisations serve as field-based 'mentoring partners' to provide the CHLP fellows with guidance, knowledge and field experience in diverse areas of health, research, advocacy and action, in relation to their own areas of experience and expertise. The diversity of culture, skills and areas of focus the fellows are exposed to, enables them to build their own professional networks and also incorporates and encourages elements of multi-sectoral action that is essential for achieving health for all.

A 'Note for Mentors' developed in phase one was modified in phase two (50,51). This is shared with the field mentor by the team mentor. An informal agreement is reached between the team mentor, field mentor and fellow who form a 'learning triad' during the fieldwork period. Fellows have checklists for learning during the first and second fieldwork placements (see Annexure I). While the community health fellows are encouraged to integrate their work and learning with their mentoring organisation's areas of work; they are also encouraged to use the Axioms of Community Health in their learning approach with the communities they encounter.

Following is a representation of the values, themes, expertise and practical aspects that our mentoring partners bring to community health education and the CHLP in particular.

Identifying mentoring organisations not only serves as a significant component of the CHLP, providing the CHLP fellows with a rich range of exposure and support in working to address the wider social determinants of health during their field placements and exposure visits; but has also played an important part in expanding our network across multiple areas of work that impact health and influence our efforts towards achieving health for all. The third phase of the CHLP has seen an expansion of our mentoring network across organisations and states in India. We

have revived strengthened existing relationships, renewed some and or established new relationships with organisations across India. A brief outline of the rich diversity of work undertaken by some of the partner NGOs where fellows have been placed during phase threeTheir relevance and contribution to health has been summarised belowin an Annexure. This is a smaller subset of the over 80 partner NGOs/ organisations working in community health and development with whom SOCHARA (CHC, CPHE) have interacted closely over the years. Their social relevance and contribution to health of the communities they work with, and to the CHLP is immense.



The lived values, wide ranging thematic areas of work, expertise and practical experience that mentoring partner organisations offer to community health education, and the CHLP in particular are invaluable. Fellows make detailed individual presentations after each field placement followed by discussion. Thus the learning of each person from each mentor and mentoring organisation also is shared in a planned manner among the group. The informal sharing is even greater. This social capital is being increasingly realised and appreciated.

CHAPTER 5

NETWORKING AND DISSEMINATION

NETWORK- NETWORKING
"A group of people who exchange information, contacts and experience for professional or social purpose" The Concise Oxford Dictionary

Networking for better health in India has been a conscious and systematic effort undertaken by CHC and SOCHARA since its inception in 1984 and 1991 respectively (2, 9) and by many other organisations. This strategy is integrated into the Community Health Learning Programme as well (33). This draws from the need for there to be a groundswell of community action for health, across deeply embedded structural barriers social constructs of gender, caste/ ethnicity, class, geography, language, age (10).

The recognition of one's common humanity is the basis, with adoption of a strength based approach helping to cross difficult terrain. Linking with networks, organisations, social movements and with individuals has been attempted by integrating the component of networking, into the curriculum as well as in the methodology of learning community health, where participants interact with a variety of groups for praxis based experience. The development and nurturing of communities with common cause, and the ability to participate in a democratic and constructive manner in such groups, is one of the skills that evolves through participation in the CHLP.

Skills needed for Networking

- Keep a strong focus on the purpose of the network
- Assess progress in reaching its objectives
- Identify external and internal factors that may be a barrier or enabler to achieving objectives
- Ensure collective, democratic, participatory functioning
- Listen to all voices, especially the vulnerable
- Link with like minded groups and networks
- Communicate in a transparent manner
- Develop cultural competence as we work in a diverse situation

Annual Alumni Meeting 2016

Role play by batch 12 fellows 2016

For instance, participants of all CHLP batches, including of Phase Three have participated in annual meetings of the medico friends circle (mfc) which is an important 'thought current' for health in the country. Some fellows subsequently join the mfc as members, continuing to keep the connection. Some team members and alumni have taken important organisational responsibilities in the mfc on a voluntary basis, which is part of the ethos of the mfc. Similarly, CHLP Fellows have been encouraged to participate in activities and campaigns of the Jan Swasthya Abhiyan (JSA) and its state units. Some of them have continued to play a role in these campaigns, and have also taken organisational responsibility, including leadership roles subsequently. Smaller numbers have been attracted to the All India Drug Action Network (AIDAN); the Right to Food Campaign; the women's movement through Common Health and other local groups; the environment movement in collaboration with Thanal and other groups including that of organic farmers; the Community of Practice on Social Accountability for Health (COPASAH); the bio-ethics movement initiated by the Forum for Medical Ethics Society; and the Catholic Health Association of India (CHAI). They have made significant contributions in each of these networks and the various specific theme based campaigns and efforts for health initiated by them. CHLP participants are introduced to these varied initiatives and networks during the learning programme classroom sessions. Articles, books and other material produced by these organisations and networks are part of the reading lists and journal clubs. The flexibility of the programme allows fellows to join, whenever there is an event or campaign taking place during the collective teaching, or in the community based placement. The energy, fresh ideas and leadership brought in by alumni in these seemingly different but inter-connected networks, and their campaign themes, enables in a small way these important network initiatives to sustain and grow. This could be identified as one of the important outcomes of the CHLP.

CHLP Fellows, Partners, Team members at Shillong Meeting , August 2016

Within the group the team has organised Annual Alumni Meetings and Annual Mentor's Meetings during which thematic discussions are held. This helps both in networking through sharing of work experiences and in mutual updating of knowledge. This issue of mentorship is always on the agenda of the mentors meetings, which is a learning forum. The alumni have developed a CH Friends WhatsApp group across many CHLP batches for exchange of information and solidarity. The December 7th 2015 Alumni Meeting after "discussing the need, importance, benefit and various models of networking finally agreed on the WhatsApp and Google Group. Everyone agreed on the need for common goals, need to break language barriers, etc. At the end the focus was given to the sustainability of networking.(41)" Batches have their own e-groups established during the CHLP for easy communication. They tend to keep in touch with each other. The Fellows (alumni) in Madhya Pradesh have formed a Fellows Collective and have been meeting regularly and keeping in touch. Very recently in August 2016 they have registered themselves as a Society.

Discussion during the Dissemination Meeting, December 2015

Dissemination of the CHFS in phase one led to SOCHARA itself developing the two year Hindi Madhya Pradesh Community Health Fellowship Programme (MPCHFP) conducted in Hindi which was supported by the SDTT and other donor partners; and to the second phase of CHLP developing in Bengaluru, with younger team members in-charge.

During the second phase SOCHARA, organised two workshops in 2008 and 2010 for discussion and dissemination. The MP CHFP programme launched in 2009 profited from the workshops in terms of ideas regarding curriculum and teaching learning methods. There were other workshop participants/organisations from civil society who were part of the workshops and experimented with Fellowship Programmes in different ways. The National Health Systems Resource Centre (NHSRC), a quasi-governmental body in Delhi, that provides technical assistance to the Ministry of Health, Government of India conducted ASHA fellowships for a few years, through which young professionals were placed in different states to support the ASHA programme and communitisation of the public health system. Basic Needs India (BNI) ran a very creative and meaningful Fellowship Programme for Community Mental Health over a few batches for urban and rural poor, addressing important determinants of mental health through the agency of persons with mental illness,

the primary stakeholders, and carer's. SATHI CEHAT of the Anusandhan Trust ran a Fellowship for a batch. The EHA (Emmanuel Hospital Association) also conducted a Fellowship in public health with a research focus for a batch. Lack of continued funding and the complexities of managing such programmes have been some of the challenges faced, resulting in discontinuation of some of these programmes. The Public Health Resource Network (PHRN) developed a programme for those professionals working in the public health system sector., and linked it with the Indira Gandhi National Open University (IGNOU) which helped to embed and sustain this work.

Different strategies for dissemination and sharing were developed during the CHLP phase three. The website www.sochara.org was paid much more direct attention, with greater funding,. This was based on a suggestion from the earlier phase from the person managing the website then on a voluntary basis. Several Fellows and students have reached us through the website, which also reaches out to many people. The number of hits and unique visitors have also increased.

The bi-monthly E-SOCHARA newsletter also reaches out to over 1079 subscribers as of mid 2016. The Newsletter DIMENTIONS (now called COMMUNITY HEALTH DIMENTIONS from Issue No. 4, June 2016) is now available both in print form and electronically.

CHLP Phase Three Dissemination Meeting, Bengaluru, December 2015

A CHLP phase 3 Dissemination Meet organised on 8th December 2015, was widely attended by 169 participants. The annual alumni meeting, mentor's workshop, annual meeting of the Academic and Research Council held concurrently on 7th December ensured intermingling among different groups. This was an effort to build community across different sub-groups. Though planned as a final meeting, the Dissemination Meet became the first of a series of seven meaningful workshops and meetings. Organised from December 2015 till October 2016, during the SOCHARA silver jubilee year, these workshops enabled discussions on important thematic issues such as community action for health, environment and health, sustainable development goals etc. Alumni, mentors, and partners joined and energised each other through the networking events. Workshops in Bengaluru (April, September and October 2016), Bhopal (April 2016) and Shillong (August 2016) through the CHLP have helped in dissemination, dialogue and networking. The April 2016 workshops are reported in COMMUNITY HEALTH DIMENTIONS (43,44) and are available on the website www.sochara.org.

The dissemination meeting on 8th December started with two minutes silence for the people affected by unprecedented floods in Tamilnadu, which had resulted in much destruction and suffering. Our team and office building and equipment were also affected, but nevertheless the team rose up and participated energetically in the disaster response, as did the citizens of the state. Team members together with members of ARC and SISEC shared their experience with the CHLP. While there was discussion it was felt that it would be best to organise smaller group workshops to discuss key aspects of content and teaching learning process. This was done in September and October 2016. There were important presentations with keynote addresses on the health situation in India by the former Union Health Secretary, Mr. Keshav Desiraju and on postgraduate courses in public health by Dr. S Chandrashekar Shetty, former Vice-Chancellor University of Health Sciences and member NAAC (National Accreditation Council). Both presentations demonstrated energy, experience and attention to detail. Certificates were distributed to fellows completing their fellowship ■

CHAPTER 6

MAINSTREAMING

As mentioned earlier, one of the objectives of SOCHARA is to evolve educational strategies that enhance the knowledge, skills, and attitudes of persons involved in community health and development (14). ***As a small group playing a catalyst role, networking, engagement with diverse stakeholders including in particular the public health system, and mainstreaming have been important approaches in our work to have a larger impact*** (9). Even prior to the establishment of SOPHEA, SOCHARA hwas been involved in various activities, ranging from training programs to research studies, conducted by us and through contributions to other groups which have provided an opportunity for mainstreaming (ibid). Proactive participation in building the Peoples Health Movement (PHM) in India and globally from 1999 grew from an external cum internal organisational review in 1998. Two main recommendations from the review were to build a broad based social alliance for health and to initiate a learning progamme in community health. Mainstreaming The efforts at mainstreaming have been were integratedl into these activities, with the understanding that ideas need to be spread and be institutionalised in a non-bureaucratic manner.

The need for mainstreaming the CHLP experience more specifically arises since various aspects of community health and equity were not a part of the curriculum ofin existing academic courses for public health education, or they are not practised in spirit. The gaps were many and stem from the predominant use of a biomedical public health approach, rather than a social approach building on the agency of communities and on explicit values. Social hierarchies also run deep in many relationships in formal academic settings and avenues for challenge and transformation in a mutually respectful manner may be limited. especially Issues related to a deeper understanding of values and contexts, to health action and to action related to the social determinants of health, to social movements, campaigns and understanding health from a rights and equity perspective do not receive adequate attention.

In SOPHEA, mainstreaming has been discussed in various contexts; while the more obvious one, and towards which more efforts have been devoted, is to introduce the ideas that guide CHLP into the curriculum of existing academic courses or to facilitate teaching learning sessions on specific topics using methods that were used in CHLP. (see later for details of such efforts). The other use of mainstreaming has been in the context of achieving organisational financial sustenanceainability that

would involve SOPHEA either being absorbed into an existing academic institution or offering a course while being affiliated to a university. There have been many discussions on both these aspects of mainstreaming within the team, and with others, not limited to the reviewers. During these discussions the team was partial to mainstreaming through existing academic institutions, rather than affiliate SOPHEA to other universities which could lead to the essence and spirit of CHLP being lost due to academic regulations that need to be adhered to. To understand the mainstreaming process, it is necessary that the history of SOCHARA's involvement with medical and public health education be highlightedbriefly reviewed.

Efforts So Far:

Involvement in medical education and education of health personnel started even prior to its inception through the engagement of the co-initiators when they worked in the Department of Community Medicine, at St John's Medical College, Bangalore. They played an important role in the development of a three month residential programme for community health workers for graduates working in rural areas. They also took responsibility in running many field practice units of the department in six rural areas, and urban poor area and with tea plantation workers in south India. After its initiation as the Community Health Cell (CHC) in 1984, contributions were made to a bulletin of medico friend circle (1984) on the history of medical education starting from the William Bentinck appointed committee to National Health Policy, along with an analysis of factors which have contributed to inappropriateness of medical education in India i.(45). This was followed by contribution to another medico friend circle (mfc) publication, an Anthology titled "Medical Education Re-examined" (1991) in which an alternate curriculum was explored, in context of various initiatives undertaken in the 1980's ii.(15). After the registration of SOCHARA, in 1991, in partnership with the Catholic Hospital Association of India and Christian Medical Association of India, a project on medical education was undertaken for which a was study conducted and published in 1993 discussing 50 important innovations emerging in medical educationiii .(16). As a part of the study, feedback was obtained from graduate doctors on various aspects of the curriculum which led to recommendations being made on need for changes in the curriculum iv.(17). This was followed up with various professional bodies and associations. Following this SOCHARA was a part of the National Rural Health Mission's Task force on Medical Education and Allied Human Resource in 20046 v.(25). In 2015, SOCHARA contributed the background paper for the First All India People's Medical and Health Science Convention titled "Towards a Health Sciences Education Charter: Building an India Relevant Paradigm" which discusses the various initiatives on medical and public health education of which SOCHARA was a part of vi.(14).

The engagement with public health education started with the SOCHARA contributing a chapter on Health Human Power Development in the Report of the Independent Commission on Health in India in 1998 with action points on public health training and counter-vaeiling health movements vii.(18) This was followed by involvement with the Karnataka Task Force on Health and Family Welfare (KTFH), Government of Karnataka in 1999 with recommendations being made on need for public health education and on the need for development of a public health cadreviii. (19). This later led to involvement with the Mission Group on Public Health (MGPH) as a part of the Karnataka Jnana Aayoga (KJA - Knowledge Commission) in 2013 which recommended establishing a State School of Public Health ix.(34). In 2004, SOCHARA presented a paper on Public Health Capacity Building – initiatives by the Alternative Sector at a national consultation organised by the Government of India (GoI) discussing key challenges faced, key elements of a successful school of public health and getting involved the national schools of public health being consider by GoI. Between In 2004 and 2008, SOCHARA was a part of the WHO South East Asia Region Public Health Initiative developing a strategic framework for public health education, during whin which led to WHO-SEARO recognisinged the "alternative sector" of public health as a major contributor and resource tofor reform and public health renewal (21). At the same time SOCHARA conducted a workshop on "Learning Programmes for Community Health and Public Health" in 2008 where a two-year fellowship programme for Madhya Pradesh was discussed x.(12). SOCHARA was also a part of WHO-SEARO organised consultation of Public Health Profession and Epidemiologists and South East Asian Regional Conference of Epidemiology.

In 2011, SOCHARA as a part of an expert group of senior public health professionals in the country brought together by the Indian Public Health Association evolved a set of core and cross cutting public health competencies for public health capacity building in the country through various coursesxi. The contributions made were based on experiences of two phases of Community Health Fellowship scheme.

Some from the SOCHARA team have been members of the National ASHA Mentoring Group and of State Mentoring Groups. They have supported the scale up of the community based health worker concept and of community action for health at national level. This continued during phase three of the CHLP. These concepts have also been introduced into the 2014 National Mental Health Policy.

During CHLP Phase Three

As mentioned earlier, the recommendation of the **Karnataka Task Force on Health and Family Welfare** in 2001 (19) and the **Karnataka Jnana Aayoga Mission Group** on Public Health in 2013 (34) was to establish a State School for Public Health which

later translated into the **Rajiv Gandhi Institute of Public Health and Centre for Disease Control** (RGIPH&CDC), Bengaluru. SOCHARA organised a meeting of a "Public Health Network Group on Integrated Public Health Education" in 2012 which saw participation of representatives from six institutions located in Bengaluru. A subsequent meeting was held at the Rajiv Gandhi University of Health Sciences. Discussions on collaboration between various public health institutions, along with brainstorming on ideas on ways in which these institutions can contribute to, supported the Rajiv Gandhi Institute of Public Health in evolving its MPH programme.

SOCHARA was involved in the entire process of planning the Masters of Public Health (Honours) course offered by the institute, and still continues to do so through team members being a part of Advisory Committee for Curriculum Development. SOCHARA's inputs along with those of others were crucial to planning and launching the first three-year honours public health course in India whichapproved by the University Senate and Syndicate, has since been approved and later by the University Grants Commission (32). SOCHARA's commitments and contribution to this process to included conducting an analysis of existing MPH courses in India to identify areas lacking in these so as to build upon them,. Advisory group members, supported by others developinged a credit system and syllabus. As a part of the mainstreaming process, several various aspects of the CHLP including the pedagogy have been were integrated into the competency based curriculum of the MPH (Hon's) coursexii. (32). Building on the CHLP experience increased emphasis has been was placed on field work and field visits to NGOs and community based health action sites, with six months being devoted for a dissertation. Team members from SOCHARA-SOPHEA were involved in developing the syllabus for eight competencies, currently taught to the MPH (Hons) students, namely, Value orientation in Public Health, Socio-Cultural/Community Health, Universal Health Policy, Ecological Sensitivity, Plural Health Systems, Public Health Capacity Building, International and Global Health Competency, and Research. Further, team members have been made adjunct faculty and facilitate sessions for various competencies. SOCHARA also helped facilitate a meeting of "Public Health Network Group on Integrated Public Health Education" which saw participation of representatives from six institutions located in Bengaluru with discussions on collaboration between various public health institutions along with brainstorming on ideas on ways in which these institutions can contribute to RGIPH.

Similar engagements were haddeveloped with other universities and colleges located in different parts of India.

SOCHARA hads a fruitful collaboration with the **Azim Premji University (APU)**, Bengaluru over the past three years including hosting students of the MA programme

in Development Studies for placements; facilitating sessions on health movements and social determinants of health; and developing and running a course on Environment and Health. SOCHARA has been invited by APU faculty for discussions on starting courses on Public Health Ethics and for the Public Health Stream within the MA Development Studies course.

Working Linkages with **Christ University**, Bengaluru, have evolved particularly since 2012 (building on earlier collaboration) through offering placements for their students and taking part in Community Symposiums organised by them which provided an opportunity to interact and discuss with staff and students of Christ University and with other NGO's. Information given about CHLP to the students of the university led them to apply for the fellowship programme. A Memorandum of Understanding was signed between SOCHARA and the Centre for Social Action for collaboration on community health projects. A team member is on the Board of Studies for the MSW programme of the University.

With the **Savitribai Phule Pune University (SPPU)**, a team member has been involved in facilitating the session on environment and health mainly, among others, including interactions with staff and students. This partnership has now extended to offering students from SPSPU internships as a part of their academic courses such as the MPH programme and MSc Health Sciences. Faculty interaction also has taken place.

Other mainstreaming initiatives have been through sharing experiences of CHLP at conferences and seminars such as Dr. Thelma sharing experience of building capacity for health equity at the 22nd Canadian Conference on Global Health on "Strengthening Health Systems through Capacity Building" held in Montreal from 5-7th November 2015 at an International Development Research Centre panel. This conference was attended by over 400 participants. They included faculty and postgraduate students from all the Canadian Universities offering an MPH programme, with about 100 participants from academic institutions from other countries.

As a part of mainstreaming sessions with a focus on community health, engagement with the public health system, health movements and campaigns integrated with SOCHARA's perspective of equity and Health For All were facilitated for institutions/ groups located across three continents including Montefiore Hospital, Albert Einstein Medical School, New York; Johns Hopkins School of Public Health, Baltimore; Harvard School of Public Health, Boston; McGill University, Montreal; McMaster University, Ontario; Swiss Tropical Institute, Basel; Maastricht University, Maastricht; London School of Hygiene and Tropical Medicine; AID- India, PHM meetings in Montreal; and in India in Post- Graduate Institute for Medical Education and Research

(PGIMER), Chandigarh; M S Ramaiah Medical College, Jyoti Sadan, St John's Medical College and St. John's National Academy of Health Sciences, Institute for Social and Economic Change, Soukya Foundation, Foundation for Revitalizing Local Health Traditions and the Trans-disciplinary University in Bengaluru; various branches of Manipal Academy of Health (MAHE), National Institute of Epidemiology, Chennai and units of Indian Institutes of Public Health under the Public Health Foundation of India; AJ Shetty Institute of Medical Sciences, Mangalore; Madras Medical College, Chennai; and Chengalpet Government Medical College and others. Similar sessions were facilitated for students from various institutions who visited us as a part of an orientation to work of SOCHARA which helped to reach out in combination with offering placements for students as detailed in earlier chapters.

Apart from these engagements, SOCHARA has been a part of the **Tata Institute of Social Sciences** Academic Review Committee and chaired the Evaluation-Vision-Mission-Roadmap exercise for the **St John's National Academy of Health Sciences** as a part of the Golden Jubilee Review of St. John's Medical College. The final reports of both these intensive participatory exercises were given in 2015. A SOCHARA member is on the Board of Studies of the School of Health System Studies, TISS, Mumbai and was a member of a two member group reviewing/evaluating the collaboration between TISS and the London School of Economics through which MPH programmes were initiated in TISS

A SOCHARA team member is also an examiner for MPhil, and Doctoral students at TISS and Jawaharlal Nehru University (JNU) and has been on the selection panel for a Professor level faculty at TISS, and for faculty positions at RGUHS-RGIPH and the St. John's Research Institute.

Mainstreaming efforts have been through advocacy, partnerships, movement building and via a catalyst role. This has been enriching and haves provided thean opportunity to reach out to a wider student audience across countries and to people from varied backgrounds. These we believe are a part of activities towards capacity building of human resources towards achieving Health for ALL. Some of those who were a part of the sessions at other institutions then did their placements as part of their academic courses indicating that the idea of community health and perspectives of SOCHARA were taken up both resonated with the students and the faculty at these institutions.

In 2016, towards the concluding months of phase three of the CHLP, **two important workshops were organised by SOCHARA–SOPHEA to share and discuss key learning's** from the SOPHEA experience with academic institutions, universities, research organisations and key individuals working in public health and community

health. The focus was on content, curriculum, accreditation and teaching learning methods based on praxis in the Indian context. The need for ongoing dialogue and even the formation of a loose consortium was mooted with a strong case made for SOCHARA to take this responsibility to start with. Highlights from the detailed reports are given below.

The first National Workshop on *"Mainstreaming alternate paradigms: From teaching to learning facilitation in Community Health and Public Health Education in India"* on 2nd and 3rd September 2016 invited mid-level teaching learning facilitators (tutors, assistant professors, team members & mentors from NGOs and civil society organizations/ networks). **Participants came from 20 medical colleges, schools of public health, dental colleges, social work colleges and public health institutes from Karnataka, Kerala Tamil Nadu and Delhi.**

Core elements of the CHLP were shared by all team members, with participant feedback from alumni. Findings of the end review were shared by the external reviewers and all sessions had space for discussion. Keynote addresses focussed on 'Is public health education in a learning mode? Recognising the Paradigm Shift: From teaching to learning facilitation' and 'What makes public health education relevant in India?'. There has been a rich experience of public health education in India, and public health as a discipline has made a substantial contribution to improvement of health status of people in the country. However there are gaps that require to be filled. There is need for ongoing critical discourse about the developments in public health education since the turn of the century and particularly over the past decade during which there has been a rapid spurt in starting public health related courses. Historical events and broader forces shape the growth and focus of the discipline. Unquestioned teaching methods may limit the perspectives, learning, reach, contextual relevance and usefulness of the educational programmes. The World Public Health Association, a federation of national associations, had raised the need for a public health movement globally. The need for a public health movement to support the people's health movement had also been made. Distortions in public health are taking place, that would also reflect in public health education. For instance the recent approach to communicable diseases based on a premise that individual behaviour and life style are responsible, has distorted public health scope and focus.

Challenges in community health/public health education were discussed in small groups. The challenges identified were: courses around community health are either based on medical/nursing/social work disciplines, they do not attract students from other disciplines; this could be due fewer job opportunities and perceived lower social status. The relative neglect by the state/government of

community health and public health oriented educational programmes, and market preference for other courses were thought to be reasons for a low priority given to public health. Other key challenges discussed were: outdated teaching methodology and curriculum with little emphasis on skill development; inadequate field work and poor public health orientation at the undergraduate level; teachers unskilled to be learning facilitators. The public health profession is seen as more of a career oriented job rather than a calling or a vocation.

What works and what does not work in current public health education? Components that 'worked', the group felt were: non-conventional learning methodologies, learner friendly learning environment, reviews and SWOC analyses (strengths, weakens, opportunities and challenges), mentoring support, multi centric approach and networking. What does not work is an outdated rigid curriculum, examination based assessment system, conventional methodology, classroom based lecture mode of teaching and lack of networking.

Feedback by alumni about their experience Alumni of the Bangalore CHLP and the MP CHFP Community Health Fellowship Programme from Bhopal who were present said the learning programmes were unique and valuable. The primary emphasis was on social inquiry and critical thinking, unlike many other post-graduate programmes which are more didactic, theoretical and seem unrelated to social and community context. They all appreciated the socio-economic, political, cultural and ecological (SPECE) frame work used to understand community health and its determinants. Besides these they acquired skills to work with communities, and had improved self confidence to communicate in diverse settings.

Open session on learning from others

Six SOCHARA partner organizations were invited to share about their programmes. It was observed that different models are being followed using different teaching methods with demystification. The programmes emphasized field learning. 'Health for All' is the focus of the programmes and some have a development focus too. Service is the motto of the programmes with partnership and networking with other likeminded organizations.

National Workshop 2nd & 3rd September, 2016

In conclusion it was felt that there was need for deeper reflection on the epistemology of courses being initiated, and on the need for some form of accreditation.

As part of the way forward participants identified the areas to be added to their teaching learning programmes from the two day deliberations: gender equity, child protection, substance abuse, communication skills, research methods, health management information system and multi-disciplinary team work. Advocacy for change and evidence based policy were the areas they mentioned for collective work in the future. They all said there is a need for continuous collaboration to learn from each other in future by sharing each other's experience.

The Second National Workshop on *'Mainstreaming the Alternative: Community Health and Public Health Education Needs, Prospects and Challenges',* was held in Bengaluru on 4th and 5th October, 2016. The focus was on programme content, epistemology, accreditation and quality of public health education in India, inviting

medical colleges, universities, professional bodies and associations from multi-disciplinary backgrounds to share the learning experiences of CHLP and for cross learning. Two of the issues arose from the previous workshop. There were forty nine participants from 11 universities, 3 national institutes, 6 public health institutes, 2 civil society organisations and two consultants. Senior decision makers were invited for this workshop.

The rationale, philosophy and overview of the Community Health Learning Programme (CHLP) initiated in 2003, and processes in the development of the School of Public Health Equity and Action (SOPHEA) were shared. The focus of the CHLP was on strengthening of the civil society sector in community health and public health, especially with reference to the 'communitisation' components of the public health system. The public sector is crucially important and public health education efforts within this sector had been revitalised and strengthened through the National Rural Health Mission since 2005, and the National Health Mission after 2012, with support of many partners were involved. However this needs to be balanced by an equally strong civil society sector which is courageous, knowledgeable and evidence based in its approach to community health and equity.

A Situation Analysis and Challenges in Public Health and Community Health Education in India were presented and discussed. India has a long history of Public Health education. The **All India Institute of Hygiene and Public Health** (AIIHPH) established in Calcutta in 1932 trained public health professionals who have made significant contributions to addressing public health issues like eradication of Small Pox, Guinea worm etc and to strengthening the public health system. Various advisory committees since 1946 recognised the need for an emphasis on public health and public health education as part of the planning process of government policy in India. However the mid 1980s and 1990s witnessed an evolving policy crisis and paradox where public health was a concern. Public health education in India was traditionally the domain of medical colleges and national and regional institutes, but there has been conscious shift to the establishment of schools of public health in India and other institutions offering public health education that include health administration and hospital management recently. Discussants expressed concern that the character of public health education is changing and it is important to recognise the historic shifts taking place and their long term impacts. The challenges to public health and public health education at a broader scale are at two levels - the first being the managers of the system and the second the controllers of governance.

National Workshop, Bengaluru, Day One 4th October, 2016

Accreditation of public health education

There was consensus among participant's on the need for a self-regulating body which could accredit public health educational institutions and courses based on guidelines and standards set by a democratic consortium of public health and community health schools from India. Such a system was perceived as beneficial to improve quality of programmes, without affecting the autonomy and innovations of any programme. There was a strong suggestion that SOCHARA should play this role of establishing the consortium.

Several new initiatives in public health education were noted. These are located in diverse settings with Schools of Social Work and Universities for Social Sciences establishing postgraduate programmes in public health and its related dimensions. The knowledge base, experience of teachers, methods of student assessment, potential for application of knowledge and skills during the programme and thereafter are all issues that pointed to the need for accreditation.

Epistemology of public health courses

Public health is socially and not medically produced. Post graduate education in this field needs to go beyond the bio-medical model by being inclusive. There is need for de-medicalization of public health approaches. Attention needs to be paid to the language used and to inherent power dynamics within the discipline and in educational institutions and programmes, with social exclusion. The participants were of the view that the knowledge base stems from past success of public health, and its interdisciplinary and trans-disciplinary approaches.

Exploring a plural public health system

India has a rich history with wonderful examples right from the Travancore kings around 1850s of integration of health systems. There are historical records and texts about the various diverse traditional health systems in India and organisations have also been documenting and studying local health practices. Public health education needs to recognise the health promotion components of these traditional health systems and practices as part of their contribution to public health Discussants observed that the High Level Expert group (HLEG) report on on Universal Health Coverage (UHC) for India instituted by the erstwhile Planning Commission of India did not acknowledge the potential of AYUSH practitioners in their potential recommendations despite the presence in large numbers of trained practitioners of Ayurveda, Yoga, Unani, Siddha, Homeopathy, Tibetan medicine and also of traditional healers in the community treating many people who cannot and do not access the public health system and modern medicine. Public health education does not engage adequately with this knowledge base.

National Workshop, Bengaluru, Day Two 5th October, 2016

Way forward The Chairperson Dr Chandrashekhar Shetty, former Vice Chancellor of Rajiv Gandhi University of Health Sciences, Bangalore said that in India about only 30% of universities are NAAC accredited, and Jawaharlal Nehru University, Delhi and the University of Hyderabad are rated the highest. There is inadequate sharing between institutions on teaching-learning experiences. The participants felt that a diverse range of topics are being covered and values are often being addressed, but the weightage being given varies in different programmes. However, some felt that additional modules on the role of the informal sector, tribal health, school health, plural health systems, appropriate technology, communication skills, local self government, and rehabilitation programmes are needed in public health education. A common interest to take forward the accreditation process was expressed by the participants, and SOCHARA has been requested to play a role in that. The chairperson in his conclusion said advocacy is needed for transformative, innovative pedagogy. It is important for experts to talk to students and young faculty members and to ensure maintenance of quality in the programmes.

Though the current phase of the CHLP is ending, efforts at mainstreaming, both through working sharing with the curriculum, training modules and through facilitating sessions at educational institutions, would continue to increase the reach of the principles of community health and the perspectives of equity and rights. However, as a part of future planning and also in efforts to reach for financial sustainability enhance alternative ideas for mainstreaming have to be thought about and also implemented ■

CHLP Reviewers Meet with SOCHARA Team Members, 2016.

CHAPTER 7

MID TERM AND END TERM EVALUATION (Summaries of the reports by the evaluators – 35, 37)

There have been regular evaluations/ reviews of the Community Health Learning Programme since inception in 2003. These included: (a) a concurrent review and (b) end review of phase one; (c and d) mid-term review by two reviewers who gave separate reports, and (e) an end review of the Madhya Pradesh Community Health Fellowship Programme; (f) end review of phase two of the CHLP; (g) mid-term and (h) end review of CHLP phase three. Besides the eight reviews there have been three external financial management system audits. Internal team reviews have also taken place. The findings, insights and recommendations from each of these exercises have helped and enabled the initiative to grow. This scrutiny and the institutional mechanisms have been part of the governance systems for this initiative.

7.1 Mid-Term Review of the Community Health Learning Programme (CHLP) – Phase Three

As part of the three-year proposal (2012-15) it was planned to conduct an external review, undertaken in a participatory manner, after the mid-point of implementation of this phase of the CHLP to identify the key learning points that could contribute to mid-course correction on areas wherever considered necessary, and for the planning and development of the next phase of teaching learning programmes for community health by SOCHARA-SOPHEA. The objectives of the review are as follows:

Objectives (from the Terms of Reference)

1. To undertake a participatory review of the process and methods undertaken with reference to the objectives of this phase of the CHLP,
2. To study the organisational arrangements at various levels for the governance and conduct of the CHLP by SOCHARA-SOPHEA,
3. To comment on the teaching learning processes used by the CHLP that contribute to the learning of fellows and their understanding of the societal paradigm of community health,
4. To assess the role of CLIC in support of the CHLP,
5. To suggest and recommend steps for the consolidation and further evolution of the teaching learning programmes offered by SOCHARA SOPHEA, and its organisational work towards mainstreaming the teaching learning approach undertaken more recently, within the broader context of the 'Health for All' movement in India and globally.

The process and findings

The mid-term review was conducted over a 20-day period by a team consisting of Dr. Maya Mascarenhas, a community health professional working with MYRADA an NGO working in the development sector in Karnataka, and Dr. Arima Mishra, an anthropologist, senior faculty member at the Azim Premji University.

Methods used included focus groups discussions with the fellows, interviews with a sample of all batches: old and current, mentors and the team members, reviews of all relevant documents, observation of classes and presentations.

Over the years, this programme evolved from a 6-month programme to a year-long programme. At the time of the review, the programme in its third phase had covered 40 fellows between end 2012 and January 2015. The final batch of 20 was to be selected in February 2015 to complete the target of 60 fellows by the year 2016.

Key Findings

1. Profile of the fellows

A quick profile of the fellows shows that the majority have done their Masters in Social Work and have an average of 4 years' experience prior to applying for this course. The common expectations from the CHLP as expressed by these students has been to learn about actual problems in the community and how to solve them, maternal and child health, nutrition, community mental health, environmental sanitation and research.

2. Selection

A three-member interview panel drawn from the SOCHARA team and associates conducted the final face to face interviews. Prior to it there was telephonic or Skype interview. The final interview process followed 8 criteria covering various details of the candidates. Any person receiving a 'C' from more than 50% of the review team was not selected.

3. Structure of the Fellowship

In this phase, the programme is semi-structured and runs over a 12-month period. Of this, 6 months are allotted to classroom learning, field exposure and learning sessions. The remaining 6 months are spent in the field. The classroom learning and field work are divided into blocks of one to two months.

4. Curriculum

The overall focus of the programme is on a community-oriented public health based on principles of social justice, equity and social determinants of health. The curriculum envisages training of fellows in strengthening community health

advocacy thus contributing to the People's Health Movement. While a broad range of topics is covered, we are of the opinion that further organisation of these topics with specific learning outcomes (aligning with the overall learning outcome of the fellowship) would be required. This way the curriculum can be better structured unfolding the paradigm shift systematically and consistently (for e.g.: topics that clearly contribute to build perspectives while others allow the fellows to see the application of these perspectives in and through specific themes (occupational health, mental health etc.).

5. Current Fellow's Feedback

The orientation to SEPCE is much appreciated; but more focus could be given on developing skills around community health promotion. Students want topics such as proposal writing, action plan preparation and participatory monitoring and evaluation skills to be covered.

They say their learning of qualitative research could be better contextualised. Currently, it is more theoretical. Teaching of these methods could be done through actual carrying out of small research assignments.

Few of them have said language is a barrier to gaining full benefit from the programme. Many of them have said "The programme aims at teaching us how best to empower the community to solve their own problems, demand what their rights are". Others have said, "This programme enables one to realise one's hidden passion".

The fellows like the field work part of the fellowship and they perceive it as a strength. They say it has been an opportunity to pick up new skills and practical solutions to community based problems. All of them say they have learnt more than they expected. However, they say they could not get adequate practical skills such as mobilising people to attend group meetings, health education classes in the villages, organising a health camp, and planning programmes. The reviewers felt the need to strengthen the field mentoring component of the fellowship.

The fellows say the journal clubs being held have been very useful. All of them expressed a need to extend the course beyond a year so that they could internalise all their leanings in a more meaningful manner. They have all learnt the basic features of planning and conducting research which they have found useful because they have had an opportunity to actually conduct research in the field and document it in their reports.

They appreciated the commitment of their local mentors at SOCHARA and their ready availability at any time. Fellows find it overwhelming to be taught by SOCHARA leaders who have had such long standing engagement with the People's Health Movement.

6. Alumni Feedback

There was unanimous agreement that the fellowship is very useful to anyone who is interested in practicing community health. They have appreciated the fact that the course was developed into a year-long course. Most of the alumni of the first 2 phases were concerned that the new phase was too structured. They felt that the flexibility that their programme had enabled individuals to learn what they were really keen on.

7. Community Health Fellows Network

There is a very close "family" feeling and a definite bonding that has been developed between the fellows and the SOCHARA team facilitators. Alumni workshop was an opportunity for them to share their experiences in the field through presentations, as well as to advise the current fellows. The current batch was very motivated by their seniors and was happy to learn many practical aspects of community health. There is no systematic mechanism in place to follow up each fellow as they are scattered all over. Fellows strongly expressed the need for strengthening this network. One of the suggestions was to have regional meeting of alumni along with key stakeholders in health in that region

8. Discussions with the Team Facilitators

The schedule is prepared through active discussion with the full team; each facilitator prepares lesson plans which are shared, and finalised. The schedule also has specific checklists for learning during field placement. While there is a list of current mentoring organisations, there is no documentation of the profile of each of these organisations. The team has regular and largely informal reviews of the progress of the programme – sometimes 2- 3 times a week.

9. Discussions with SOCHARA Leaders

The issues discussed with the SOCHARA leaders include: affiliation, assessment, placement, and sustainability. The management has attempted to study the possibility of affiliating to the other universities but are wary of being subsumed into a very structured "academic heavy" course that will defeat the very core purpose of the CHLP that aims to offer an experiential learning to the fellow. At the post graduate level, there is a concern that some more thought needs to go into the assessment process to make it more meaningful and systematic, without making it "exam oriented". SOCHARA is aware of the need for a more structured assessment process, which the affiliation process would require.

Regarding 'placement', the reviewers felt that currently, most of the fellows are not sponsored by any field based organisation, and apply on their own. The reviewers

were of the view that fellows sponsored by NGOs would be a better option. About sustainability currently, it costs an average of Rs. 4 lakhs per year per fellow with all costs included which poses a major challenge to the programme.

10. Community Health Learning and Information Centre (CLIC)

The centre houses over 15000 reference books in all subjects related to community health and also subscribes to over 60 different national and international journals. The fellows use the library for reference and for preparation of their journal clubs. It was not evident if any of the fellows focuses on any specific topic in depth.

11. Suggestions and Recommendations

The reviewers feel very strongly that this programme is worth continuing. There is a dire need for experiential learning and the positives of this programme cannot be ignored. They also felt that the programme had made an honest and significant attempt to inculcate very important values in the fellows on the understanding and practice of community health.

The quality and reach of advertising must be available to the public domain and get sponsored candidates. Regarding curriculum, they said, it perhaps would be more prudent to offer each fellow the option of following an in-depth study in one field after the first cycle of classes and field work

Some kind of structure needs to be put in place for assessments, while it is sensible to avoid formal exams and tests, it is necessary to have specific opportunities to "evaluate' the skills and knowledge gained by each fellow over the year.

Provide information about field partners to fellows, it would be better to have 2 point persons in each organisation who will be responsible as field mentors. There can be a more systematic coordination between field mentor and organisational mentor. Regular consolidation and documentation of mentors' feedback and reflections would be helpful for review and reflection.

For financial sustainability, it would be advisable to explore affiliation with some universities. Part payment of tuition fees from sponsoring organisation could be explored.

7.2 End Term Evaluation, February- April 2016

Introduction, Context, Terms of Reference

The review was conducted by Dr. S Pruthvish, Professor and Head, Department of Community Medicine, M S Ramaiah Medical College, Bangalore & Dr. Shalini Chandrashekar Nooyi, Professor, Department of Community Medicine, M S Ramaiah

Medical College, Bangalore. The reviewers followed principles of participatory interaction with the CHLP fellows and faculty. The final batch of 20 was undergoing their fellowship during the review.

Having started in 2003, SOCHARA (then called Community Health Cell) began this venture with the idea of identifying and nurturing graduates from different disciplines who were interested in improving the status of community health. These individuals, called fellows, were mentored by a local team to understand and learn various processes, practices and policies in community health.

Objectives of the review (from the Terms of Reference)

1. To identify the key learning points that can contribute to the planning and development of the next phase of teaching learning programmes for community health by SOCHARA-SOPHEA.
2. To undertake a participatory review of the process and methods undertaken with reference to the objectives of this phase of the CHLP;
3. To study the organizational arrangements at various levels for the governance and conduct of the CHLP by SOCHARA-SOPHEA;
4. To comment on the teaching learning processes used by the CHLP that contribute to the learning of fellows and their understanding of the societal paradigm of community health;
5. To assess the role of CLIC in support of the CHLP programme.
6. To suggest and recommend steps for the consolidation and further evolution of the teaching learning programmes offered by SOCHARA SOPHEA, and its organizational work towards mainstreaming the teaching learning approach undertaken more recently, within the broader context of the 'Health for ALL' movement in India and globally.

Process

A participatory review was undertaken involving review of records, focus group discussion with current batch of CHLP learners, focus group discussion with present faculty, review of feedback questionnaires and two field visits. They interacted with the entire faculty and prime initiator of the programme - Dr Thelma Narayan, with the current CHLP trainees separately, interactions with Dr Ravi Narayan, one of the co-initiators of SOCHARA. They obtained written feedback from the current CHLP fellows and made field visits. The reviewers followed a Strengths, Weaknesses, Opportunities and Threat (SWOT) Analysis method. The key findings of the review are summarised below.

Key findings

1. Process and methods undertaken with reference to the objectives of this phase of CHLP

Participants and faculty were very open to interactions, questioning and curiosities and the review was conducted with total transparency. There was a unanimous declaration that the objectives of CHLP were very clear and the programme delivered on all the subjects. The CHLP has helped fellows become well rounded personalities; they have matured in their thought processes and the experience has helped widen their perceptions of people after the CHLP programme. Collaborative learning and good relationship between facilitator and student were always maintained. The facilitators were very motivating and they showed justice, equality and equity towards CHLP fellows who came from different backgrounds.

Most of the fellows felt that the curriculum was good and adequate; some of them felt that more field visits could be included. And two or three of them felt that the curriculum was little heavy to be completed in one year. The teaching of the research component takes different approaches which need more coordination, with less didactic teaching.

Methods adopted for teaching learning were very interesting and very practical. They were all made to understand. However, more written assignments could be included. The methodology adopted for teaching like focus group discussions, role play, art, debate, songs, games and cultural activities were excellent and helped the learning process. The most memorable was the story telling and sharing of life's journeys. The facilitators conducted themselves very professionally and this will be a good example for the CHLP fellows to emulate. All of them felt that the learning environment was very open without tension, interactive with a good mix of different teaching learning methods.

Commitment, transparency, good knowledge of mentors and resource person, good infrastructure, computer and internet facilities, good networking and team work, good relationship with Government and non-Government organisations have been identified as some of the best practices. All in all, the team spirit, family atmosphere, mentoring and constant support were liked by all the CHLP fellows.

2. Organisational arrangements at various levels for the governance and conduct of the CHLP

The CHLP is supported by IDRC, Canada and Sir Ratan TATA Trust. SOCHARA is grateful for the support and it will be a good idea for both IDRC Canada and Sir Ratan TATA trust to consider further support so that this highly innovative programme,

requires time to consolidate and to bring to the main stream which is worth the consideration because of following reasons:

1. The programme is offered to persons with 'masters in social work' and related master scholars who are mature and have basic understanding /comprehension of public health and have come to this course to advance their capability in providing health care support to the community.
2. The programme, as expressed by the participants emphasizes critical inquiry, learning from the community and learning from experiences and interactions, tailor-made to the needs /capability, linguistic ability of the participants.
3. The course offers teaching which focuses on how to solve community health problems in the Indian social context; helps CHLP scholars to build their capacity as facilitators of community health programmes and projects – in the government, NGO and private sector.
4. It is very innovative, has scope and potential to attract large number of learners. Customizing the programme/ developing the programme on the lines of MPH (master of Public Health), seeking accreditation from Universities/ National and International Bodies is feasible and useful to consider – by both supporters and staff of SOCHARA.

3. Teaching learning processes used by the CHLP

A Focus Group Discussion (FGD) with participants revealed that the curriculum is highly need based, contemporary, covering the entire gamut of public health, community health, biostatistics, relevant cultural, social, political aspects; approach to public health planning, implementation, evaluation and research and aspects of advocacy. The participants expressed great satisfaction at being welcomed and attended to, irrespective of their linguistic domain by the faculty and participants who knew different languages. During the learning process questions by the students were encouraged by all the faculty and mentors, thus paving the way for interactive discussion and deeper understanding of the issues in the society, which were quite different for each student.

Group and individual discussions and mutual respect for opinions, helped students to further improve their skills and clarify their concepts of community health. Although the participants were kept very busy with the substantial amount of course work, they were extremely happy that they were being taught so meticulously by the faculty. They expressed their great appreciation of the involvement and hard work put in by the faculty. The Flexi programme is an innovation which was similarly highly

appreciated. In the words of all participants "CHLP, we feel is a unique endeavour worth emulation, continuation, support, accreditation."

4. Role of CLIC in support of the CHLP programme.

One of the evaluators was associated with the Community Health Library and Information Centre (CLIC) since the inception of SOCHARA and has visited CLIC a couple of times. It is a unique resource centre where reports /research and advocacy papers, pilot project reports, books, and periodicals can be accessed. It has been found to be of use to many aspirants from Medical, Dental, Psychology, Anthropology, Social work students in Bangalore, Karnataka as well as CHLP students and trainees of other programmes offered by SOCHARA and what was previously called the "Community Health Cell".

Both the evaluators send their post graduate students of Public Health/Community Medicine for review and reference work to CLIC over the past 10 years. Further, Dr Pruthvish has found very rare resource materials in CLIC. They, as well as CHLP learners have found the organization and variety of resource material very user friendly. The staff of the CLIC are cooperative and communicative with them is without any hindrance such that, the system is of great benefit to anyone who wants to use it.

5. Consolidation and further evolution of the teaching learning programmes

Both reviewers were of the opinion that the CHLP programme should be continued in the same manner over the next three years –with the same vigour and planning. It would be useful to design and develop quantitative and qualitative evaluation to measure the learning of the students objectively, with theory and viva examinations at the end of six months so that accreditation procedures will be easier. Formal certification too will become easier.

This unique programme has the scope and the potential to be developed as a Master of Public Health (MPH) course – Human resource development in this area is the need of the hour in India and developing countries. The CHLP has opened up opportunities and the experiences of teaching and learning throughout the course has evolved it as an innovative, contemporary experiment worth sharing with universities, senior public health personnel at the national/international level. The demonstration of its feasibility and the practical approach is worthy of emulation in order to develop a band of public health professional which India will do well with. Field components/ postings can be revisited and strengthened further ■

CHAPTER 8

CONCLUSION

The conclusion of the third phase of the community health learning programme offers an opportunity to look back over the entire period from 2003. To start with the work by Alumni from the initiative provides a glimpse of the impact of the CHLP. The first three 'fellow travellers' have the following life journey thus far:

a) **Rev. Dr. Mathew Abraham** with an MD in Community Medicine completed his theological studies and was ordained a priest. Following a short period of work in Kerala he was appointed the Secretary, Health Commission of the Catholic Bishops Conference of India (CBCI), New Delhi, one of the youngest persons to hold this responsibility. After completion of his term there, he has recently been selected and appointed the Director General, Catholic Health Association of India (CHAI) based in Secunderabad. He has shown servant leadership in the large network of health institutions that come within the ambit of CBCI and CHAI. The Secretariat, CBCI Health Commission worked in partnership for the Revised National Tuberculosis Control Programme (RNTCP) with the Ministry of Health and Family Welfare, Government of India. CHAI has a network of over 3000 health institutions across India, organised into regional units. At a recent national consultation they have again given priority to community health along with a range of other work commitments. He will be leading this organisation during the 75th jubilee that it will be celebrating shortly.

b) **Dr. Naveen Thomas** with a science and social science background prior to the fellowship, joined the team on its completion, and worked with SOCHARA for some time supporting the CHLP, tobacco control work and the People's Health Movement. He then completed a doctoral programme at the Tata Institute of Social Sciences. Together with a collective of like-minded people he has established an NGO, called 'Headstreams' based in Bengaluru, which worked on livelihood issues of the urban poor. The organisation has grown well and they now do a lot of creative work on formative, transformative and reformative education with children and youth, with a value base and social inclusion. They thus address the social determinants of health and well being. A number of MSW students do placements with Headstreams. CHLP fellows have also done placements there.

c) **Dr. Abraham Thomas** a dentist since the past few years works at the Dr. TM Samuel Memorial Medical and Dental Centre, at Railway Koderu, Kadapa District, Andhra Pradesh. After the fellowship he worked with SOCHARA for a time supporting the People's Health Movement. He then opted to stay in a rural area and undertake community health oriented dental practice, after spending time at CMC Vellore to

update his skills in dentistry. He is linked to networks of dentists, as well as with the Jan Vigyan Vedike (People's Science Movement) of the state. His children study at the local government school. He and his wife Sheeba work with the school, and have upgraded the toilet facilities with child friendly toilets, and the class rooms with desks. He is deeply concerned about environmental issues and educates patients and communities regarding bringing back traditional crops and millets etc into the local agriculture and into their diet.

These are just snapshots of three young people who are change agents and leaders. There is a warm and mutually respectful relationship between the three young professionals and the SOCHARA team that has been maintained over the years. Within our own team we have alumni who play a very important role. These presently include Mr. Ameer Khan from CHLP phase one working since 11 years in the Community Health Cell Extension Unit in Chennai. He takes important organisational responsibilities and is a member of the National Coordination Committee of the Jan Swasthya Abhiyan (People's Health Movement, India) and Convenor of the Makkal Nalzhavalzhyu Iyyakam (Tamilnadu state PHM). Dr. Adithya Pradyumna from CHLP phase two has been with SOCHARA since six years and is developing the environmental health cluster at SOCHARA, besides taking organisational responsibilities.

Each fellow and participant of the community health learning programme is making a contribution to advancing the health of communities and the public health process in diverse ways. While a large number work with NGOs and civil society, some work in academic and research organisations, some with the public health system, with a couple in international donor agencies. The spread effect of each person grows with experience. Networking among the fellows across batches is taking place with active discussion around contemporary issues.

A Community Health Fellow in UP during a Health promotion session

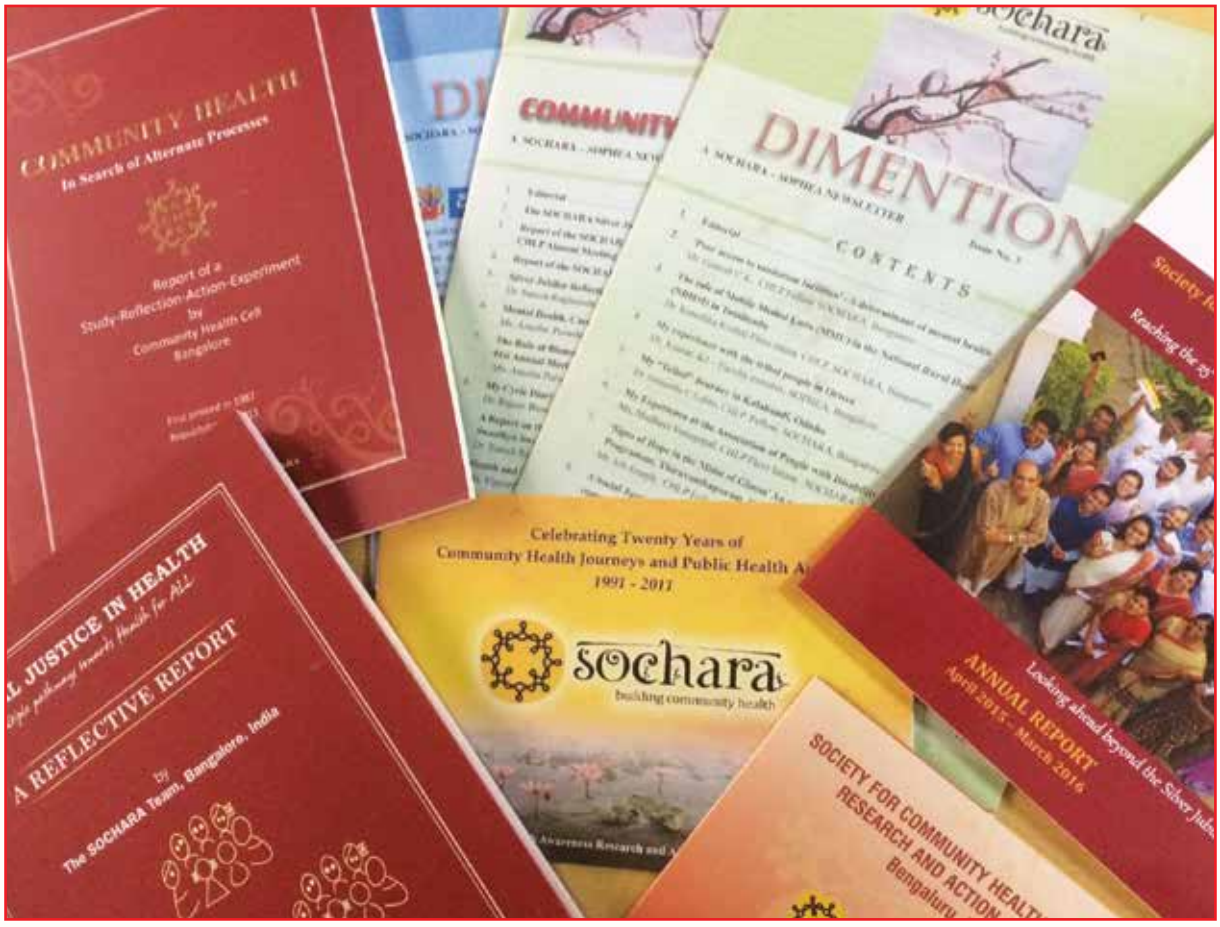
Batch 12 CHLP participants after receiving their certificates in April 2016 with the team

This final report of the Community Health Learning Programme – Phase Three, the two video productions, together with the issues of COMMUNITY HEALTH DIMENTIONS, the E-SOCHARA Newsletters, Annual Reports of SOCHARA, Health Digest and Health Round Up have added to the knowledge base about capacity building for health equity and community health action for equity in the Indian context. All these resources are available on the website www.sochara.org. Hard copies are widely distributed. Efforts at mainstreaming and dissemination have been made at various points across this phase. This rich, intense and valuable experience can be utilised by various organisations in their own efforts to promote community health.

There has been a leadership transition in SOCHARA during this phase, and the alumni in our team are playing a responsible and proactive role in the process with Ameer and Adithya as Co-convenors of the Transition Team. Several organisational

mechanisms and policies that have developed during this phase, building on the past, will take the work of SOCHARA further. The website, the community health. in wikipedia and a silver jubilee archival initiative as part of a learning platform of the Health For ALL movement is being built up. We are confident that this work of capacity building for health equity will grow from strength to strength.

There is a reason to hope! ■



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ANNEXURE I

THE 52 WEEK CURRICULUM for the COMMUNITY HEALTH LEARNING PROGRAMME (CHLP), Phase 3

Society for Community Health Awareness Research and Action (SOCHARA)

School of Public Health and Equity (SOPHEA)

C 1 to 25 indicates weeks for Collective teaching learning sessions

FW I, II, III indicates field work phases for community based learning

COLLECTIVE -1 (8 Weeks)Week:1-8	THEMES
Week-1	**C01-BUILDING BLOCKS FOR THE FELLOWSHIP – LEARNING TOGETHER**
	Understanding oneself - Intra personal and Inter personal skills
	Inside learning, outside learning, learning skills, social skills and self-learning
	What is health? Physical, mental, social, economic, political, cultural, ecological aspects. Differentiating the health and medical paradigms
	Values: equity, rights, gender, social justice, inclusiveness, respect for local health culture, solidarity, secularism
	Perspective on self-transformation while engaging in social action
	Developing personal learning objectives
	Becoming a community of shared learning and practice
Week-2	**C02-UNDERSTANDING COMMUNITY/ SOCIETY / DEVELOPMENT AND HEALTH**
	What is community, society, family, collective, cooperative
	Class, caste, gender, social exclusion, marginalization
	Structures, stratification, power dynamics, conflicts, transitions

	Understanding *dalit* and *adivasi* issues; agrarian distress
	Community dynamics, perceptions, mobilization, capacity building
Week-3	**C03-UNDERSTANDING COMMUNITY HEALTH/ PUBLIC HEALTH - PRINCIPLES AND AXIOMS and Primary Health Care**
	Community Health, Public Health, Community Medicine, Preventive and Social Medicine – what do they mean? Definitions
	Social, economic, political, cultural, ecological determinants of health and their inter relationships and dynamics
	Axioms and principles of community health
	History and relevance of comprehensive primary health care and the strategy / approach towards health for all
	Learning from community health initiatives and action for health
Week-4	**C04-SITUATION ANALYSIS OF HEALTH AND HEALTH CARE IN INDIA**
	Situation analysis of health and underlying health determinants in India
	Regional disparities and inequalities, trends
	Understanding the health care sectors - public, private, voluntary traditional, people's sector and local health traditions – strengths and weaknesses, opportunities, challenges
Week-5	**C05-SOCIAL DETERMINANTS OF HEALTH AND SOCIAL ACTION**
	Social determinants of health, action on health determinants and social vaccine
	Environmental sanitation and community led total sanitation
	Environment and health
	Culture and health and cross cultural dialogue
	Health as a human right
	Communication skills for health
Week-6	**C06-GLOBALIZATION AND HEALTH**

	Political economy of health and forces of liberalization, privatization and globalization
	What is globalization and its impact and consequences on health and equity
	Challenges for equity – geographical, gender, social exclusion and marginalization
	Challenges: social dimensions, health equity, health policy, access to health, disease risks, patents, trade and health, technology
	Globalization risks, responses, alternatives and solidarity from below (the People's Health Movement - PHM)
Week-7	**C07-RESEARCH- I – Measuring Health and Disease**
	Research for social change – research paradigms from the PHM
	Studying health determinants
	Measuring health and disease - why and how
	Basic biostatistics : concepts and tools
	Summarizing data- tables, graphics, pie-charts, maps, bar charts, line graphs, frequency distribution
	Defining health, measuring disease frequency
	Summarising numbers: mean, mode, median, variance, standard deviation
Week-8	**C08-HEALTH SYSTEMS AND HEALTH POLICY – 3 days**
	Health systems and health policy in India –introduction, history and evolution
	Health system at different levels – local, district, state, central, global
	Issues of access, acceptability, affordability, availability, quality
	CONSOLIDATING THE FELLOWSHIP PLAN – 3 days
	A recap on planning and reviewing the fellowship learning journey
	Goal setting, learning objectives and learning framework
	Interaction with mentors and planning field work

FIELD WORK - I (8 Weeks) **Week: 9-16**	**FW 1- UNDERSTANDING COMMUNITY** Understanding and describing a community, understanding community priorities, understanding the field placement organisation and their projects, social determinants of health and inter-sectoral collaboration, Framework for a Situational Analysis, Health Care Providers and medical pluralism, understanding the National Rural Health Mission/ National Health Mission and communitization from below, understanding mental health (checklists)
COLLECTIVE-II (4 Weeks) Week: 17-20	**THEMES**
Week-17	**C09-NUTRITION, and WOMEN and CHILDRENS HEALTH**
	Understanding nutrition & food security
	Understanding gender and health, women's health (beyond RCH)
	Understanding child health
	Understanding adolescent health and life skill education
Week-18	**C10-COMMUNICABLE DISEASES– Community health responses**
	Tuberculosis, HIV/AIDS
	Water borne diseases
	Vector borne diseases – malaria, dengue, filaria and other diseases
Week-19	**C11-RESEARCH-II – Epidemiology**
	Basic epidemiology – what, who, when, where, why, how
	Epidemiological perspectives and understanding data
	Data analysis
	Understanding steps in research and research ethics
Week-20	**C12-NON-COMMUNICABLE DISEASES - Community health responses**
	Heart disease, stroke, diabetes
	Mental health, community mental health, mental health policy

	Cancer, accidents etc
	Risk reduction, life style change, prevention and promotion
Field Work-II (8 Weeks) Week: 21- 28	**FW2-UNDERSTANDING A COMMUNITY HEALTH APPROACH TO PUBLIC HEALTH PROBLEMS and ISSUES** (learning and reflection on the community health axioms)
COLLECTIVE-III (4 Weeks) Week: 29-32	**THEMES**
Week-29	**C 13 HEALTH TECHNOLOGY AND INNOVATION**
	Understanding rational drug policy and prescription, pharmaceutical policy
	Immunization challenges, policy and action
	Appropriate technology and innovation
	Information and communication technology (ICT)
Week-30	**C 14 EQUITY IN HEALTH**
	Promoting community mental health and intervention
	Understanding social exclusion and marginalisation, including stigma and discrimination
	Persons with disability
Week-31	**C 15 RESEARCH**- III- DESIGN AND METHODS
	Qualitative methods in research
	Quantitative methods in research
	Mixed methods
	Research Ethics
Week-32	**C 16 OCC**UPATIONAL HEALTH AND URBAN HEALTH
	Occupational health of workers – organized and unorganized
	Social security and social protection and occupational safety
	Urbanization and urban health challenges
	National Urban Health Mission

FIELD WORK-III (9 Weeks) Week:33-40	FW3-CONDUCTING FIELD STUDY/COMMUNITY HEALTH ACTION
FINAL COLLECTIVE (10 weeks) Week:41-49	**THEMES**
Week-41	**C 17 HEALTH POLICY**
	Understanding health policy process and health systems
	Understanding health policy history and current situation
	Primary Health Care and Health For All
	Universal Health Coverage
Week-42	**C 18 PUBLIC HEALTH MANAGEMENT**
	Understanding systems thinking and management principles
	Public health management at community and district levels
	Managing partnerships with community and other sectors
	Health research project- planning basic steps
Week-43	**C 19 RESEARCH IV**
	Participatory action research
	Knowledge translation, dissemination and advocacy
Week-44	**C 20 HEALTH MOVEMENTS, SOCIAL MOVEMENTS AND SOCIAL CHANGE**
	Community health movement in India and networking
	People's health movement (global, national and state levels), Global Health Watch and International People's Health University
	Social Movements and Social Change (beyond PHM)
	Community action for accountability including monitoring , health watches, people's tribunals, COPASAH
	Decentralization in health and *panchayat raj*
Week-45	**C 21 SPECIAL ISSUES**
	Climate change and health

	AYUSH and public health, including Local Health Traditions – opportunities and challenges
	War, conflict, disaster, displacement
	Agrarian distress and farmers suicides
Week-46	**C 22 RIGHT TO HEALTH**
	Right to health and health care, entitlements and fundamental human rights
	Constitutional and legal aspects of health and health care
	Ethics of health and health care
Week-47	**C 23 HEALTH ECONOMICS**
	Health equity and universal health coverage
	Basics of health economics including health financing, budget analysis
	Community financing and insurance for health
Week-48	**C 24 SPECIAL COMPETENCIES – I**
	Leadership
	Governance and decentralization
	Partnership and advocacy
Week-49	**C 25 SPECIAL COMPETENCIES – II**
	Communication including informatics
	Monitoring and evaluation
	Conflict resolution
Week-50-52	**FINAL ASSESSMENT AND PLAN FOR NEXT STEPS / FINALIZATION OF REPORTS** (see FA-1, FA-2)
THE BEGINNING OF THE COMMUNITY HEALTH JOURNEY	

25 weeks of collective teaching learning with a focus on theoretical issues

24 weeks of community work based in partner NGOs/with our team clusters

3 week final assessment and next steps

Total 52 Weeks ■

ANNEXURE II

Community Health Learning Programme Phase Three– 2012-2015
LEARNING ACTIVITIES DURING COLLECTIVE TEACHING OUTSIDE CLASSROOM SESSIONS

1. Cluster A: Participation in Programmes and Events
2. Cluster B: Field visits to rural and urban areas to learn from the community based programmes
3. Cluster C : Visit to civil society organisations that focus on specific peoples groups and needs
4. Cluster D: Participation in viewing films, public events and protests
5. Cluster E: Sharing by SOCHARA society members and associates sharing by SOCHARA society members and associates

1. Cluster A: Participation in Programmes and Events

1. Building blocks for fellowship - learning together

a. Film viewing on ' Empathy' at St. John's Medical College, Bengaluru

b. A workshop on 'Low Cost Communication Technologies' organised by SOCHARA in Bengaluru.

c. Annual alumni meeting of the CHLP in Bengaluru

d. Poster presentation on their learning to 'Academic and Research Council' members during the annual mentors and alumni meeting in Bengaluru

2. Understanding community/ society / development and health

a. Sharing of experience on Participatory Rural Appraisal by Mr. Robert Chambers in Bengaluru.

b. A discussion on 'Social change and Health' and reflections from the WHO Helsinki Global Conference on Health Promotion in SOCHARA, Bengaluru

c. A session on "Transactional Analysis" by Bro. Pius (Jyothisadan) Bengaluru

d. A workshop on "Community Culture and Sanitation" organised by SOCHARA, in Bengaluru.

e. A book release event on "Challenges Facing the Left": Remembering Praful Bidwai in Bengaluru.

f. A "Conversations on Anti-Discrimination" organised by Alternative Law Forum in Bengaluru.

3. Understanding community health/ public health - principles and axioms and primary health care

a. A talk on 'Primary and Community Health Care in UK' at St. Johns Medical College, Bengaluru

b. A talk on 'A Republic's Dilemma: Constitutional Principles v/s Majoritarianism' at Indian Social Institute, Bengaluru

4. Situation analysis of health and health care in India

A public lecture on 'Unequal India' by Mr. Harsh Mander in Bengaluru

5. Social determinants of health and social action

a. Discussion with Swami Japananda about Water & Sanitation in Swami Vivekananda Integrated Rural Health Centre, Pavagada, Karnataka

b. Public awareness programme 'The Plastic Cow' The Plastic Cow uncovers the ghastly truth about the impact of plastic waste on the innocent Indian cow, which is now reduced to being a scavenger

c. Conference on 'Solutions to impending public health crisis through good governance in solid waste management' organised by Namma Bengaluru Foundation

d. A talk by Dr Bruce Lanphear MD, MPH titled, "Little things matter: impacts of toxins on the developing brain'' (organised by SOCHARA. St John's Research Institute (SJRI) and others at SJRI in Bengaluru.

e. A dialogue with the 21 member delegation of educationists and environmentalists from Pakistan, on the theme 'Securing our Common Futures, Issues of Land, Water, Seed Sovereignty and Consumption' organised by Pakistan India Forum for Peace and Democracy (Karnataka Chapter) in Bengaluru

f. Young environmental health researcher's national meet organised by Environmental Health Unit of SOCHARA in Bengaluru.

g. Community Health and Environmental Survey Skill Share- 5 workshop on Coal and Health organised by Corporate Accountability Desk in Bengaluru.

6. Globalization and health

Lecture on "Globalization, development and inequality" at NIMHANS, Bengaluru by Dr. Joseph Stiglitz who was formerly with the World Bank

7. Health systems and health policy

a. A Colloquium - Health Systems and Control of Neglected Diseases in Asia, Organised by Institute of Tropical Medicine (ITM) and Institute of Public Health (IPH) in Bengaluru.

b. A public lecture on "In Search of Health Care for the People" by Dr.Abhay Bang (organized by Azim Premji University), Bengaluru

c. A talk on 'Medical Negligence-Current Scenario' By Dr.Gopinath Shenoy at St. John's Medical College, Bengaluru

d. The Launch of the National Urban Health Mission, Freedom Park, Bengaluru

e. The Medico Friends Circle Annual Meeting held in Raipur Chhattisgarh. The theme of the meeting was on Urban Health.

f. Meeting with the IDRC president Dr. Jean Label at SOPHEA. Dr. Jean visited SOCHARA to know about it particularly about the Community Health Learning Programme.

g. 10th year celebrations of SOCHARA-Chennai Extension Unit in Chennai-Focus on community action for health

h. Involved in Implementing the Kolar Comprehensive Primary Health Care Initiative, a CSR initiative which made efforts to strengthen the functioning of two Primary Health Centres in Kolar District.

8. Nutrition, and women and children's health

a. Dialogue on "Idioms of distress: Expressions of women victims of domestic violence'' organised by Vimochana, Bengaluru

b. A dialogue on "Empowerment of Sex Workers" of Swathy Mahila Samasthe (SMS) at SMS in Bengaluru.

c. a "*Mahila Mela*" a cultural programme organised by the urban poor women of Headstreams, Bengaluru

9. Communicable diseases– community health responses

A lecture on 'Vector Borne disease control' at PHFI – Bangalore

10. Non-communicable diseases - community health responses

a. A state level consultation organized by SOCHARA on 'Ban on Tobacco Advertisement, Promotion and Sponsorship' at Rajiv Gandhi University of Health Sciences, Bengaluru

b. A talk on "The 'Indianisation of Colonial Medicine'. The Case of the Ranchi Indian Mental Hospital and Lt-Col J.E. Dhunjibhoy, c. 1925-1940." by Professor Waltraud Ernst, Major General S.L. Bhatia Memorial Oration at St John's Medical College, Bengaluru

c. A talk on "The Voice in Music - The Many Chords a Singer Strikes" by T.M Krishna organised by the Health & Humanities Division of St. John's Research Institute, St. Johns National Academy of Health Sciences, Bengaluru

d. A consultation on "Maternal & Neonatal Health"co-organised by Common Health and SOCHARA, in Bhopal.

e. A lecture-demonstration of a "A Dancer's Story: the two sides of life" by Odissi dancer, Ms. Ashwini Raghupathy organised by Department of Health and Humanities, St. Johns Research Institute, Bengaluru

f. A talk on "Mental Manadhil: Reclaiming Madness; Conversations on Mental Health Part II" organised by Alternative Law Forum, Bengaluru

g. A workshop on Exploring Mental Health through Creativity organised by Ms. ReshmaValliappan at Atta Galatta, Bengaluru.

11. Research- III- design and methods

National level seminar cum workshop on Qualitative Research Techniques in Social Sciences organized by the Post Graduate and Research Department of Social Work, Kristu Jayanti College, Bengaluru

12. Occupational health and urban health

Dialogue on "Health of the Urban Poor' focusing on People with disabilities, mental illness and elderly"- organized by CPHE- SOCHARA

13. Health movements, social movements and social change

a. Jana Arogya Andolana Karnataka (JAAK) Convention on Universal Access to Health Care

b. 'NGO Mela' organised by Christ University, Bengaluru

c. "Health in Slums" symposium co-organised by SOCHARA with Bangalore Baptist Hospital, Zyud University and Maastricht University, in Bengaluru

14. Special challenges

A talk on "Food security and Agriculture: Implications of current policy and budget" organised by Centre for Budget and Policy Studies, Bengaluru

15. Right to health

a. A talk on 'Human Rights Lawyering' at National Law School of India University, Bengaluru

b. Workshop on 'Promoting patient's rights and ensuring social accountability' BY SAATHI and SOCHARA in Bengaluru

c. A session on " Right to Information Act" by Ms. Kathyayini Chamaraj from CIVIC at SOCHARA, Bengaluru

d. A workshop on "Access to Toilet, Gender and Mental Health Perspective's" organised by SOCHARA in Bengaluru.

e. 5th National Bio-ethic Conference, in Bengaluru

f. A panel discussion on health rights and private sector reform co-organised by Society For People's Action For Development (SPAD), SOCHARA and SATHI at Bengaluru.

2. Cluster B: Field Visits to rural and urban areas to learn from the community based programmes

1. Understanding community/ society / development and health

a. Konankunte village to participate at a Adolescent health awareness campaign on the outskirts of Bengaluru

b. Hakki Pikki Colony, near Banneraghatta in Bengaluru to learn from the work carried out with the gypsy community.

c. Rajendranagar, Mangaman playa and Siddhapura slums in Koramangala, Bengaluru to understand the urban poor communities.

d. Old Byappanahalli slum in Bengaluru to understand the life challenges of urban poor living in this slum.

e. Swasthya Swaraj, Kalahandi, Orissa to understand the health initiative by Swasthay Swaraj for the tribal population.

2. Health systems and health policy

a. A Primary Health Centre (PHC) in Dommasandra, outskirts of Bengaluru.

b. Two panchayat in Tamil Nadu covered under Community Action for Health (CAH) by the Community Health Cell Extension Unit (CEU), of SOCHARA in Tamil Nadu.

c. A community mental health programme by the National Institute of Mental Health and Neuro Sciences (NIMHANS) in Sakalwara, in Bengaluru rural district.

d. Urban areas of Basic Needs India (BNI) to learn from their Community Mental Health Programme in Bengaluru

e. Mugalur Primary Health Centre in Anekal Taluk in Bengaluru urban district to understand its role in rural health care.

f. A Primary Health Centre (PHC) at Bellandur, Bengaluru

g. State Health Resource Centre, Raipur, Chhattisgarh as part of orientation to Urban *Mitanin* Programme. They made visit to *Mitanin's* field work area.

3. Cluster C : Visit to civil society organisations working with peoples groups and specific needs

1. Understanding community/ society / development and health

a. 'Green Foundation', Kanakapura an organisation works for conserve local seed diversity, promote an increased reliance on biodiversity-based ecological agriculture,

b. Headstreams an organisation run by an alumnus of CHLP which focuses on livelihood issues for the urban poor.

c. Foundation for Revitalization of Local Health Traditions to understand its role in promotion of traditional systems of medicine.

d. 'Snehadaan a' Community Care Centre for HIV AIDS on the outskirts of Bangalore.

e. Karunashreya an institution that provides palliative care for the terminally ill cancer patients.

f. Kannur Association for Integrated Rural Organization and Support KAIROS, Kannur, Kerala to learn about their work on environment and health.

g. Shanti Pain and Palliative Care, Kalpetta, Waynad, Kerala

2. Nutrition, and women and children's health

Vimochana Bangalore based organisation works on women's rights and violence against women

3. Equity in health

a. Association of Person's with Disability (APD) to learn about the various programmes for peoples with disabilities.

b. Fernando School of Speech and Hearing understand disability sector, they also participated in a talk by Sr. Merly Tom on community based rehabilitation in Meghalaya and Northeast.

3. Cluster D: Participation in viewing films, public events and protests

1. Globalization and health

A march against ' Monsanto' for patenting seeds organized by Greenpeace International in Bengaluru

2. Health systems and health policy

A demonstration for improving the quality of care at the Burns Ward of the Victoria Hospital, a public tertiary care hospital in Bengaluru which was organized by Vimochana

3. Nutrition, and women and children's health

A campaign 'One Billion rising violence against Women at Frazer Town, Bengaluru

4. Health movements, social movements and social change

a. The 'Anti Sexual Assault Campaign and Protest Convention' organised by People's Movement Against Sexual Violence at Bengaluru

b. The International Women's Day Celebration organised by Student Christian Movement of India, Bengaluru

c. The BBMP election manifesto organised by CIVIC at SCM house, Bengaluru.

d. Protest organised by AIKYATA at Bruhat Bengaluru MahanagaraPalike headquarters to demand the immediate restarting of the unjustly stopped mid-day meal programme for the elderly

e. A public hearing on status of Anganwadi centers in BBMP area, Bengaluru

5. Special challenges

a. Film viewing- 'Have you seen the Arana' (a film about changing pattern in agriculture in Wayanad district in, Kerala.)

b. Film viewing - 'Trainer's guide on sustainable livelihood', Timbaktu community development project in Aanthapur Andhra Pradesh

6. Right to health

a. A vigil in remembrance of Bhopal Gas Tragedy at Town Hall, Bengaluru

b. A Memorial Event organized for Prof. Hasan Mansoor, a leading Human Rights Activist in Karnataka , He was associated with Peoples' Union for Civil Liberties (PUCL) in Bengaluru

7. Building blocks for fellowship - learning together

Inner learning by Ms. Edwina Pereira from INSA India (International Nursing Service Association) INSA focussed on Community Health training and HIV&AIDS.

8. Understanding community/ society / development and health

a. Meeting with Fr. Claude D'Souza, the first president of SOCHARA. Fr. Claude shared his life experience and his work on Education and youth.

b. Dr. Chandra, Vice President of SOCHARA shared with the fellows on the process of Community Action for Health in Tamil Nadu.

c. Dr. Sunil Kaul a SOCHARA society member from The Action for the Northeast Trust (ANT), Assam shared his life experience with the fellows.

d. Dr. Ravi D'sousa from SOCHARA, Madhya Pradesh shared his life experience and status of mal nutrition in Madhya Pradesh.

e. Mr. Sam Joseph, a SOCHARA society member and a Development Consultant shared with the fellows the Concepts of Community Understanding, Social Mapping

f. Mr. Ameer Khan from Chennai Unit, SOCHARA shared his life experience with the fellows.

9. Understanding community health/ public health - principles and axioms and primary health care

a. First Aid and universal precautions by Dr.Sheela Rajagopal at SOCHARA. Dr. Sheela is freelancer

b. Low Cost Communication Technology' by Mr. Krishna, Bangalore Media Centre, at SOCHARA, Bengaluru

c. Communication And Media for Empowerment, by Dr MagimaiPragasam from Research and Advocacy (CAMERA) Academy, Chennai

10. Communicable diseases– community health responses

HIV/AIDS and Sharing of Experience, by Mr. Elangovan from the Positive People's Network in India.

11. Special Issues

Mr. EP Menon from India Development Foundation. Mr. Menon is a pioneer activist in nuclear disarmament and world peace.

12. Right to health

Dr. Amar Jesani, Forum for Medical Ethics Society, Mumbai on Principles of ethics and Human rights, Integrity and Corruption in Health Care services and research, and. Bioethics ■

ANNEXURE III

Community Health Learning Programme Phase Three– 2012-2015

BACKGROUND READING MATERIAL

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ANNEXURE IV

CHECKLISTS USED DURING FIELD PLACEMENTS

1. UNDERSTANDING COMMUNITIES

Understanding and describing a community:

Understanding a community entails engaging with people and local institutions in a number of ways. Whether or not the community is defined geographically, it still has a local context -- a setting that it exists in, which to some extent defines identity. Getting a clear sense of this broad setting and context, with all the differences and converges that exist may be key to a full understanding. At the same time, it is important to understand the specific community you're concerned with. You have to get to know people -- their culture, concerns, and relationships -- and develop your own relationships with them as well.

- ***Physical aspects.*** Every community has a physical presence of some sort, even if only one building. Most have a geographic area or areas they are either defined by or attached to. It's important to know the community's size and the look and feel of its buildings, its topography (the lay of the land -- the hills, valleys, rivers, roads, and other features you'd find on a map), and each of its neighbourhoods. Also important are how various areas of the community differ from one another, and whether your impression is one of clean, well-maintained houses and streets, or one of shabbiness, dirt, and neglect.

If the community is one defined by its population, then its physical properties are also defined by the population: where they live, where they gather, the places that are important to them. The characteristics of those places can tell you a great deal about the people who make up the community. Their self-image, many of their attitudes, and their aspirations are often reflected in the places where they choose -- or are forced by circumstance or discrimination -- to live, work, gather, and play.

- ***Infrastructure.*** Roads, bridges, transportation (local public transportation,) electricity, land line and mobile telephone service, broadband service, and similar "basics" make up the infrastructure of the community, without which it couldn't function.
- ***Patterns of settlement.*** Where are those physical spaces we've been discussing? Communities reveal their character by where and how they create living and working spaces. Where there are lower caste group residing; substandard housing in areas with few or no services that are the only options for low- socio economic background people.

- ***Demographics.*** It's vital to understand who makes up the community. Age, gender, caste and ethnicity, marital status, education, number of people in household, first language -- these and other statistics make up the demographic profile of the population.
- ***History.*** The long-term history of the community can tell you about community traditions, what the community is, or has been, proud of, and what residents would prefer not to talk about. Recent history can afford valuable information about conflicts and factions within the community, important issues, past and current relationships among key people and groups -- many of the factors that can trip up any effort before it starts if you don't know about and address them.
- ***Community leaders, formal and informal.*** Some community leaders are elected or appointed others are considered leaders because of their activities or their positions in the community.
- ***Community culture, formal and informal.*** This covers the spoken and unspoken rules and traditions by which the community lives. It can include everything from community events to norms of behavior - turning a blind eye to alcohol abuse or domestic violence - to patterns of discrimination and exercise of power. Understanding the culture and how it developed can be crucial, especially if that's what you're attempting to change.
- ***Existing groups.*** Most communities have an array of groups and organizations of different kinds such as youth organizations, sports teams and groups formed around shared interests, the boards of community-wide organizations well as groups devoted to self-help, advocacy, and activism. Knowing of the existence and importance of each of these groups can pave the way for alliances or for understanding opposition.
- ***Existing institutions.*** Every community has institutions that are important to it, and that have more or less credibility with residents. Educational institutions, libraries, religious institutions, hospitals -- all of these and many others can occupy important places in the community. It's important to know what they are, who represents them, and what influence they wield.
- ***Economics.*** Who are the major employers in the community? Are there any village based artisans? Who, exercises economic power? How is wealth distributed? Would you characterize the community as poor, working, class, middle class, or affluent? What are the economic prospects of the population in general and/or the population you're concerned with?
- ***Government/Politics.*** Understanding the structure of community government is obviously important. Some communities may have local self governance members, whatever the government structure, where does political power lie? Understanding where the real power is can be the difference between a successful effort and a vain one.

- ***Social structure.*** Many aspects of social structure are integrated into other areas social relationships, politics, economics-but there are also the questions of how people in the community relate to one another on a daily basis, how problems are (or aren't) resolved, who socializes or does business with whom, etc. This area also includes perceptions and symbols of status and respect, and whether status carries entitlement or responsibility (or both).
- ***Attitudes and values.*** Again, much of this area may be covered by investigation into others, particularly culture. What does the community care about, and what does it ignore? What are residents' assumptions about the proper way to behave, to dress, to do business, to treat others? Is there widely accepted discrimination against one or more groups by the majority or by those in power? What are the norms for interaction among those who with different opinions or different backgrounds?

2. UNDERSTANDING COMMUNITY PRIORITIES

Gather Information from:

- Key informants like, leaders, opinion leaders, development extension workers
- Discussion with existing organized groups like SHG, Youth, farmers group etc
- Talk to individual from various age group from both gender

a. Livelihood

Sources of livelihood,

b. What are the wages for men women?

How many days in a year do they get work?

What are their concerns about income?

How do they see they way out for these concerns.

c. Education

Do people want education facilities? Who wants who does not, who uses the existing facilities who does not use, why?

d. Health

Is there anything people do to take care of their health? If yes, what?

When do people seek help for a health concern?

Where to people seek help for their illness, and why?

e. Basic Amenities

Housing, water, sanitation, transport, recreation

f. Others if any

When you have all the information gathered in that you can use, line up the expressed needs and work out your priorities. Prevalence: is the need widespread? Severity: is the need serious or only a minor inconvenience? Selectivity: is it expressed most by a particular segment of the community? Possible interventions: Some needs are going to be very real but out of your reach; you will have to pick out the needs that your organisation is capable of addressing.

3. UNDERSTANDING THE FIELD PLACEMENT ORGANISATION AND THEIR PROJECTS

We at SOCHARA inform you confidently that you have been placed in a very interesting and innovative project which is committed to health and development of their project areas. While there is a lot to learn from the community, there is a lot to learn from your field placement partner organisation. Each of you will have unique experiences, as each organisation is different. When you understand about the organisation's vision, mission, objectives and structure, you will have a better idea about what you can expect to additionally learn from them during your placement with them. Without understanding the organisation well enough, you may miss opportunities or have unreasonable expectations from them. Therefore, to best utilise your field placement, we recommend that you also understand the organisation, its principles and its functioning, besides understanding the local community. It is the project staff that will facilitate your interaction (at least initially) with the community, and it would be useful that you learn about their past and ongoing activities there before you step out into the community.

- Here are some guidelines to help you explore about the project based on which you are expected to prepare a short report and presentation about the project. Based on your presentation, the other CHLP fellows too can learn about your field organisation. It is important to note that this should not be conducted like an interview! Also this is not just a writing assignment, but rather an opportunity to improve your own understanding about the organisation, to help you plan your health promotion and research projects for terms 2/3. Consider enquiring about:
- Organisational vision, philosophy of work, and organisational objectives
- Number of staff and system structure – role of each staff position
- Geographical distribution of project areas (preferably with map)
- Current projects

- Objective of each project
- Activities under each project – describe them
- List out the various stakeholders of the projects – and their roles (with organogram)
- Community involvement in the project (with a flow diagram showing linkages)
- Process and outcome monitoring protocols used by them
- Source of funding

- Their previous experience with fellows/interns and training programmes

To find out about the above themes, we suggest that you:

- read organisational reports and brochures – if possible, before you go there (from their website or from SOCHARA library)
- speak with your field mentor and with community based staff and get their inputs during the first week of your stay there – learn about their role and experience there
- attend their team meetings when permissible, and observe (and take notes)
- participate in field activities and trainings as an observer and as an assistant
- copy or create a project area map

Remember that your role is to understand the organisation and its functioning, and not to critique it. Every organisation is faced with several challenges, about which you can discuss with your SOCHARA mentor either over phone or when you return to Bangalore in April.

4. UNDERSTANDING THE SOCIAL DETERMINANTS OF HEALTH AND INTER-SECTORAL COLLABORATION

The social determinants of health are the conditions in which the people are born, grow, live, work and age, including the ***health system*** *(WHO Commission on Social Determinants of Health).*

1. What are the major health problems of the community based on yours observation? Whether the hospitals in the community alone can address those health problems? If not, what is your opinion?
2. What are the social hierarchies and different social positions existing in the community? What are the forms in which exist and function? (eg- class, caste, gender and other hierarchies)
3. During your field work, could you observe any health inequity in that community? What are they?

4. Does a person being a male or female have something to do with his/her health condition? Could you think of this with an example of a disease?
5. Does social hierarchy and social position in the community have something to do with the health inequity in that community? If so, how does this operate? What are the pathways? Could you think further with an example of a disease?
6. What are the living conditions that need to be improved to work towards health equity in that community?
7. Could you think of some redistribution mechanism to achieve health equity for that community? Also, what needs to be redistributed?
8. Whom do you think needs to work to address the social determinants of health? And, at what levels? (International, local?)
9. Do you see a need for inter-sectoral collaboration at all levels to ensure the social determinants are addressed by and for that community?
10. What are the sectors that need collaboration, and by whom, at national, state and local levels to bring health equity for that community?

5. FRAMEWORK FOR A SITUATIONAL ANALYSIS FOR HEALTH

1. Assessment of the health district (and development of a district health profile)
   - 1.1 Geography
   - 1.2 Demography
   - 1.3 Socio-economic profile
2. Health Status and Problems
3. Progress towards Implementation of a District Health System
4. The Management of Support Systems
   - 4.1 Financial Management
   - 4.2 Transport
   - 4.3 Drug and vaccine supply, distribution and control
   - 4.4 Communication
   - 4.5 Health Information
   - 4.6 Human Resources
5. Public Health Sector
   - 5.1 Facilities
   - 5.2 Hospitals

5.3 Clinics and Community Health Centres

5.4 Referral system

6. Other Health Care Providers

6.1 Private sector

6.2 Traditional sector

6.3 NGO sector

7. Assessment of Key Programmes

7.1 Maternal and Reproductive Health

7.2 Child Health & EPI

7.3 School Health

7.4 Nutrition & growth monitoring

7.5 STDs/HIV

7.6 Tuberculosis

7.7 Environmental Health

7.8 Oral health

7.9 Mental health

7.10 Rehabilitation and disability services

7.11 Chronic diseases

8. Other Sectors which Impact on Health

9. Summary of Key Health Problems and Conclusion

6. HEALTH CARE PROVIDERS AND MEDICAL PLURALISM

1. Every community has a range of health care providers and it is important to understand the range and diversity of these resources and the services they provide in each community.

2. These can include one or more of the following:

a) Dai's or Traditional birth attendants (TBA's)

b) Local healers – these could be herbalists or healers who focus on some specific problems such as snake and insect bites, bone setting etc. They are sometimes associated with temples and religious places since local healing is often linked to rituals.

c) Practitioners of alternative systems of medicine in India. We have five major systems- *Ayurveda, Yoga, Unani, Siddha*, and *Homeopathy*. In different parts of India different systems are popular.

d) Practitioners of Allopathy or what is also sometimes called 'English Medicine' modern system of medicine. In this category you may have

- General Practitioners;
- NGO run health centres, mission hospitals and dispensaries;
- Government health centres and dispensaries with doctors and nurses;
- Private health centres and dispensaries or nursing homes;
- Others not listed above.

You can walk around the village or slum or *adivasi* community and find out more about these health care services. You can also sit with small groups of people in the community or with health workers, *Panchayat* leaders, teachers, self help groups, youth groups, and discuss the following: What do people do when they fall ill? Whom do they go to? For what? What do they feel about the available health services and practitioners? You can seek any other relevant information.

3. If possible meet some of these health care providers and spend a little time in their setting to know about and understand their work.
4. In every community people are knowledgeable about, and also practice local health traditions or use home remedies. Sit with a small group of local women (women are usually custodians of local health knowledge) and ask them what they do at the home level if they or some member of the family falls ill.
5. Another way to find out more about these different health care options, practices and services is to ask a group of people some questions.

   What do they do? And whom do they go to when they have the following health problems individually or at family level:

   a) fever b) diarrhoea c) snake bite d) for delivery (child birth); e) If someone is mentally unwell f) If someone has fits (epilepsy); g) joint pains.

6. Talk to the medical officer of the government health centre and or ANMs and or *Anganwadi* workers and or ASHA's - when you are studying PHC and NRHM and also ask them about the local health traditions and health practitioners of other systems of health care in the community. What is their opinion about them?
7. Write a short report on all the various plural medical options available to people in the community. We will later discuss further about medical pluralism, and how the AYUSH systems and local health traditions can become part of the public health system.

7. UNDERSTANDING THE NATIONAL RURAL HEALTH MISSION AND COMMUNITIZATION OF THE PUBLIC HEALTH SYSTEM

- Identify the different components of 'communitisation' of the public health system within the areas where you are placed
- Meet with one or more ASHAs (Accredited Social Health Activist) - What is the role of the ASHA? How is she contributing to NRHM programme? What is her future? What is the support system that she has? What are the realities in the community? Discuss with the people in respective communities regarding her contribution in health system? How do they perceive her role? What do they feel about her approach?
- Meet members of the Village Health and Sanitation Committee and understand about their roles and responsibilities. How often do they meet? What is the agenda of their meetings? How do they perceive the functioning of the public health system? Do they use the untied funds? How active is the *Gram Panchayat* / Ward *Panchayat* (elected local bodies) in the area?
- What is done in regard to community monitoring of health services in that area?
- Discuss about delivery of vaccines in a Primary Health Centre (PHC)
- Visit a PHC, health sub-centre and observe/study their role in promoting health. How does it work? What is the participation of the people? Is there a patient welfare committee that is functional? Is the citizen's charter for health put up at the health centre/ institution?
- Find out about JSY *(Janani Suraksha Yojana*). How does it work? Who is benefited from the service? Is this scheme contributing to the lives of the poor in the society?

9. UNDERSTANDING MENTAL HEALTH

1. What is mental health in your understanding?
2. What do you do towards maintaining your own mental health?
3. Who is a mentally ill person?
4. How does the community treat a mentally ill person, and why?
5. When and where do they seek help for mental health problems?
6. What has been the experience of people who accessed services from these places? ■

ANNEXURE V

Topics chosen by the CHLP Batch 12 fellows for field study

1. A study on the impact of drinking arsenic contaminated water on health status among the Kirdalli Tanda Village people, Yadgir district, Karnataka
2. A study on socio- economic and health states of *devadasi* women in Danapur village, and PK Halli village, Hospet taluk, Bellary district, Karnataka
3. An exploratory study on 'community culture' linked with maternal health, Yadgir district, Karnataka.
4. A study on availability and accessibility of health services for Soliga *adivasi's* (indigenous communities) in Mandare and Medaganene and Indiganatha villages Chamarajanagara district, Karnataka.
5. A study on health care seeking behaviour of Kondha *Adivasis* living in Kalahandi district, Odisha
6. Perspectives of local traditional healers on oral health among the Gudalur *Adivasi* population in the Nilgiris Tamil Nadu.
7. A study on factors affecting the nutritional status of children 0-3 years of age in Indiranagar, Bhopal, Madhya Pradesh
8. A study on factors associated with and health impacts of domestic violence in Hospet Taluk, Bellari District.
9. A study on the life skills and coping mechanisms of the Maleivasi youths resulting from seasonal migration in Sittelinge, Tamil Nadu
10. A study on health services utilization by *beedi* workers at Rahatgarh in Sagar District, Madhya Pradesh.
11. An exploratory study on the Health impact of alcohol and tobacco consumption on tribal community, from B Matkere in HD Kote Block, Mysore District, Karnataka.
12. A study of psycho-social effect on adolescent children of parental alcohol abuse in a slum community in Bhopal in Madhya Pradesh
13. A study on the impact of physical domestic violence on adolescent emotional and behavioural health in a slum community in Bengaluru, Karnataka.
14. A case study to understand the Foundation for Educational Innovation in Asia's (FEDINA's) work with the urban poor in Bengaluru, Karnataka

15. A study on pharmacy practices of general practitioners/ polyclinics owned pharmacies in Durgabai Deshmukh colony, Amberpet Hyderabad, Andhra Pradesh
16. A study on extent of and factor influencing treatment adherence among individuals utilising a primary healthcare centre in Th. Rampur Block, Kalahandi District Odisha.
17. A study on" Practices of the Saharia Tribe to maintain their health in Gwalior district, Madhya Pradesh".
18. A study on "Occupational Health Hazards Due to Mechanization of Tea Leaf cutting in women tea plantations workers in Munnar- Kerala" ■

CHLP Batch 12 Fellows with team members on Fellows Day

ANNEXURE VI

SOCHARA-SOPHEA CHLP MENTORING ORGANISATIONS DURING THE CHLP – PHASE 3

SOUTHERN INDIA

1. ACCORD, TAMIL NADU

SOCHARA has also been associated with ACCORD (Action for Community Organisation, Rehabilitation and Development), an organisation that was created to enable and empower, and thus protect the *Adivasi* (indigenous) community of the Gudalur valley in the Nilgiris district. Although the organisation is supported by professionals who play a catalyst role; its work is driven and executed by the *Adivasi's* themselves and work is focused on empowering their community to assert their rights across land ownership, health, education, housing and economic development while still preserving the pride of their people and heritage. ACCORD functions to provide training and mobilise resources for the *sangams* (collective groups) that address these different areas of *Adivasi* development. ACCORD's health programme has developed to acquire its own identity as ASHWINI (Association for Health Welfare In the Nilgiris). ASHWINI was born out of the community health programme that was launched to address high rate of women's deaths during childbirth and children suffering from preventable diseases. The programme focused on *Adivasi* community members to be trained as health workers, which soon expanded to training young *Adivasi* girls as nurses to staff the Gudalur *Adivasi* Hospital (GAH). 18 years on, these individuals have become highly specialised in conducting deliveries, assisting in surgeries, managing drug stocks and administration of the hospital. The programme has expanded to create health sub-centres staffed by locally trained Health Animators. This has helped balance the preventive and curative programmes.

Website: http://www.adivasi.net/accord.php
Other Sources: http://www.ashwini.org/

2. ASSOCIATION FOR PROMOTING SOCIAL ACTION (APSA), BENGALURU, KARNATAKA

APSA has focused on empowering the marginalised and underprivileged to fight against their exploitation since its inception in 1976, and advocates for 'Development Without Exploitation'. A majority of their work particularly involves helping children in distress. The organisation works with various projects across Hyderabad and Bengaluru. Some of APSA's projects include the Dream School which provides education to children rescued from labour, street children, children out of school and

dropouts; *Nammane*, a residential and educational home for children rescued from distress; a24-hour, toll-free Child helpline; the *Navajeevana Nilaya* girls' hostel which is a cost-effective and safe home for young girls who have recently completed their training and apprenticeship at *Nammane*; a media centre, the *Inchara* project to promote the talents of those who are interested in sports and culture; and the *Kaushalya* Skill Training Centre. APSA's activities also include promoting the right to education, the special juvenile police unit and juvenile justice, young person's empowerment, the formation of self-help groups, stopping child trafficking and slum outreach. APSA has contributed to mentoring our full-time fellows of the CHLP as well as our short-term interns, by providing them with experience in observing and participating in their own projects.

Website: http://www.apsabangalore.org/

3. ASSOCIATION FOR PEOPLE WITH DISABILITY

The Association for People with Disability (APD) is a non-profit organization based out of Bangalore, formerly known as 'Association of the Physically Handicapped' was registered under the Mysore Societies Act on 20th May 1959. The focus of their work is on a Training and Rehabilitation Centre.

They reach out and rehabilitate under privileged people with disabilities. Their aim is to create an inclusive society, where people with disabilities are accepted into the mainstream economy and social life. A culture where they can earn, live and sustain with dignity and respect.

Website: http://www.apd-india.org/

4. ASHA NIKETAN, BENGALURU, KARNATAKA

In addition to organisations that accommodate the CHLP fellows for their 6-month field placements, some organisation in and around Bengaluru have also served to provide the CHLP fellows with a space for learning about various social issues and interacting with local communities through day visits. Among these is Asha Niketan, a part of the L'Arche community, located in Koramangala, Bengaluru. The organisation serves as a home for individuals who are faced with severe physical and intellectual challenges. The home provides residents with a creative space that enables and encourages their talents and abilities while also being therapeutic. Activities include candle-making, batik, embroidery, weaving, bamboo craft and papermâché.

Website: www.larchefmrindia.org/communities/asha-niketan-bangalore/

Source: http://www.owcbangalore.org/CharityArticles/AshaNiketan_2009-03.pdf

5. BASIC NEEDS INDIA, BENGALURU, KARNATAKA

Basic Needs India Trust (BNI) works on community mental health and development. The BNI approach was crafted through a process of consultation, held at their home, with persons living with mental illness and their families, in rural poor communities. BNI believes in promoting the rights and basic needs of people living with mental illnesses by engaging these individuals and their carers to address their concerns, enhance their capabilities, build sustainable livelihoods and create a supportive environment that gradually promotes their sustainable recovery. BNI supports persons with mentally illness and their carer's to work towards recovery, using health services judiciously with a focus on psycho-social care. The organisation has trained NGO partners and mental health fellows from impoverished communities to integrate persons with mental illness with the local community, enabling them to realise their rights, develop livelihood skills and utilise all entitlements through various government schemes. The organisation's work is spread across Tamil Nadu, Kerala, Karnataka, Andhra Pradesh, Jharkhand, Bihar, Orissa and Maharashtra.

Website: http://www.prajadwani.org/

6. DAS-CBR, TIRUPPATUR, VELLORE DIST., TAMIL NADU

Community based rehabilitation is an essential part of health care, and is particularly significant when dealing with disability. DAS-CBR (D. Arul Selvi Community Based Rehabilitation) was established as an extension service of the Health Development Project in Tamil Nadu, in order to enable early intervention and primary prevention of childhood disabilities in rural areas of the state. The organisation's activities include providing counselling to disabled children and their family members, care-givers, teachers and elected officials as well. Support includes assistance with medical and surgical management as needed, integration of disabled children with the regular school system and wider community. Raising awareness and campaigning for promoting early detection, intervention and prevention of childhood disabilities is also one of DAS-CBR's main objectives. SOCHARA has a long association with DAS-CBR which has given the CHLP fellows an opportunity to learn about community based approach to health.

Website: http://cahtn.in/dascbr.php#

7. DEPARTMENT OF COMMUNITY MEDICINE, M.S.RAMAIAH MEDICAL COLLEGE, BENGALURU, KARNATAKA

The Department of Community Medicine, M.S. Ramaiah Medical College is engaged in providing access to healthcare in both rural and urban areas. The medical college has initiated a school health programme across 67 rural and 25 urban schools

where health check-ups are conducted so as to screen students for health issues. Appropriate treatment is provided and where necessary, referrals are made to the hospital. Health education is also given as part of the programme, although the focus is primarily curative. Other outreach programmes include the establishment of urban and rural health training centres that focus on maternal and child healthcare. The medical college also has an established Healthcare Waste Management Unit and has worked on a number of projects including waste management in tsunami affected areas in Banda Aceh, Indonesia and Sri Lanka. Their work addresses issues like environment, hygiene and sanitation that are among the social determinants of health.

Website: http://www.msrmc.ac.in/

8. DISTRICT MENTAL HEALTH PROGRAMME, THIRUVANANTHAPURAM, KERALA

SOCHARA engages with state health services as part of its efforts towards achieving Health for All. The District Mental Health Programme (DMHP) in Thiruvananthapuram was the first in Kerala, started in 1999, as a component under the larger National Mental Health Programme. The WHO recognised this to be the most successful mental health programme in India. The activities of the programme include holding clinics in PHCs, CHCs, *Taluk* hospitals and After Care Homes; training in mental health for doctors, allied staff and health workers; targeted intervention programmes that address school and geriatric mental health, suicide prevention, stress management and prevention of substance abuse; as well as rehabilitation and awareness activities. Team work is the essence of this DMHP.

Website: http://dmhptvpm.org/about.html
Other Sources: http://dhs.kerala.gov.in/docs/ar040912.pdf

9. FOUNDATION FOR EDUCATIONAL INNOVATIONS IN ASIA (FEDINA), BENGALURU, KARNATAKA

The Foundation for Educational Innovations in Asia (FEDINA) works across South India to empower and mobilise the marginalised, oppressed and poor to demand their rights. These include informal sector workers, *Dalits*, women, small farmers, landless labourers and slum dwellers. In relation to health, FEDINA works with senior citizens who previously worked for the unorganised sector and now do not have any form of social welfare to depend on. FEDINA works with senior citizens' groups based in urban poor localities, enabling them to have discussions over their health problems as well as develop their awareness about their right to access public primary health care at primary health centres (PHCs). FEDINA also works to ensure

that these public health services are appropriately provided. SOCHARA has a long standing link with FEDINA. CHLP participants visit and are placed with this team. A CHLP alumnus works there currently.

Website: www.fedina.org/

10. FOUNDATION FOR REVITALIZATION OF LOCAL HEALTH TRADITION (FRLHT), BENGALURU, KARNATAKA

FRLHT aims to enhance medical relief and healthcare in rural and urban regions through the creation of institutions for knowledge generation, dissemination, and community outreach in line with its vision of revitalising Indian medical heritage. FRLHT has created the Transdisciplinary University (TDU) focused on transdisciplinary health sciences and technology. TDU has a healthcare services arm called the Institute of Ayurveda and Integrative Medicine (I-AIM); and the Indian Health Systems Pvt. Ltd. (IHS), its business development arm. FRLHT's work has developed over the past 20 years, beginning with facilitating medicinal plant conservation areas across 13 states in India. FRLHTs other major accomplishments have since included the creation of a computerised database and herbarium of Indian medicinal plants, establishment of a folk healer's grassroots network across 9 states, contribution to the National AYUSH policy and the 11thand 12thNational AYUSH Five Year Plan, the establishment a centre for herbal landscaping, initiation of a PhD programme in Transdisciplinary Studies, institution of a 100 bedded Ayurvedic research hospital. SOCHARA has a long standing association with FRLHT around research. The CHLP participants and mentors also visit and learn from their experience.

Website: http://www.frlht.org/

11. HEADSTREAMS, BENGALURU, KARNATAKA,

HEADSTREAMS is a registered society that focuses on Health, Environment and Development by providing Support, Training, Research, Education and Mobilisation to the underprivileged. The society was formed in 2008 by a group of educationists, social workers and counsellors. One of the prime movers was a CHLP alumnus of the first batch. They primarily work with women, children and youth in urban poor localities, and have a number of rural initiatives as well. Their work with women includes community mobilisation, training and workshops, a focus on livelihood development, digital literacy and life skills education; these are together consolidated under their programme called Aalamba. Their programmes for child development include Arivu-Disha and Tackle. Arivu-Disha is a reading and comprehension programme that focuses on English proficiency, Life-skills and Digital literacy in

government schools across the state. 'Tackle' offers underprivileged children the space and opportunity to participate and explore their creativity through art, craft, music and dance. SOCHARA has associated with HEADSTREAMS to provide the CHLP participants with field exposure and community experience.

Website: http://headstreams.org/

12. INTEGRATED RURAL COMMUNITY DEVELOPMENT SOCIETY (IRCDS), TAMIL NADU

IRCDS is an organisation based in the Tiruvallur district of Tamil Nadu; and focuses its efforts on enabling local communities with knowledge, skills and values to form organised self-help groups and to actively participate in decisions that enable sustainable socioeconomic development. IRCDS addresses issues that are triggered by caste divide, poverty, illiteracy and exploitation and additional challenges that arise due to the district being located on the border of two states (Tamil Nadu and Andhra Pradesh). Some of the areas that IRCDS works in include women's development, child rights, elimination of bonded labour, housing, environment and sanitation, health and prevention of HIV/AIDS. IRCDS has collaborated with Government agencies for the implementation of a number of projects.

Website: http://www.ircds.in/

13. KARUNASHRAYA, BENGALURU, KARNATAKA

Karunashraya which means 'Abode of Compassion' is run by the Bangalore Hospice Trust (BHT) and provides palliative care to patients with advanced cancer and other diseases at the end stage of life. This was the first hospice to offer patients the option of receiving treatment and care, alternating between the hospice and their home. The hospice's mission is to provide medical, emotional, spiritual and social support to patients and their families. *Karunashraya* conducts a Residential Health Assistants Training Programme for women from lower socio-economic backgrounds, who are later employed by the hospice. This is a valuable livelihood option and Assistants are also sought by many families to help with home based care. The hospice also functions as a resource centre for postgraduate programmes in palliative care through the Cardiff University, UK. *Karunashraya* also has a number of satellite hospices set up across India. They also organise programmes together with the Indian Association of Palliative Care. The hospice is able to provide free services with the financial support of their donor partners. *Karunashraya* has also provided the CHLP fellows opportunities to visit, observe and learn about the hospice and palliative care.

Website: http://www.karunashraya.org/index.php

14. LITTLE SISTERS OF THE POOR, BANGALORE, KARNATAKA

A congregation of nuns called the Little Sisters of the Poor run a Home for the Aged. This is a well run and beautiful place where the elderly poor above the age of 65 who do not have families are given a home, irrespective of their caste, creed or religion. The Little Sisters of the Poor have succeeded in providing a shelter for the aged by creating a family spirit among all its residents. The management gives utmost importance in providing love, care, concern, attention and joy, which is needed and appreciated by all the aged persons. The Home for Aged provides a relaxed and peaceful environment for all its residents. Many volunteers from the city support the organisation.

Website: http://www.karnataka.com/old-age-homes/little-sisters-old-age-home-bangalore/

15. MYRADA, BENGALURU, KARNATAKA

MYRADA, initially known as the Mysore Resettlement and Development Agency began in 1968 when it assisted the then Mysore State in the resettlement of Tibetan Refugees. MYRADA's focus evolved into a new mission in 1987, where work began with the rural poor and marginalized in Karnataka, Tamil Nadu and Andhra Pradesh and now also provides technical support to other programmes across India and abroad. MYRADA functions through a group of institutions called 'Myrada Promoted Institutions' (MPIs) sharing a common mission. MYRADA has developed community-based activities and programmes in line with the eight Millennium Development Goals (MDGs).Some of these include addressing the social determinants of health through activities like the formation and strengthening of Self Help Affinity Groups, resettlement of displaced communities and micro-finance activities to address poverty and hunger; provision of educational support, support for the formation of women's self-help groups (SHGs) including empowering the devadasi women to work for their own social and economic development; training of community level Reproductive and Child Health (RCH) Resource Persons ; and its commitment to environmental protection and sustainability efforts.

As part of their field placement during the third phase of the CHLP, fellows have been mentored by MYRADA and have had the opportunity to gain a better understanding of MYRADA's community-based initiatives particularly in hygiene and sanitation in the Gulbarga district of Karnataka.

Website: http://www.myrada.org/myrada/

16. PAIN AND PALLIATIVE CARE UNIT, ST JOHNS MEDICAL COLLEGE HOSPITAL, BENGALURU, KARNATAKA

St. John's Medical College Hospital, Bengaluru, is part of the St. John's National Academy of Health Sciences and provides a tertiary medical service with specialty and super specialty services, including a Pain and Palliative Care Unit. St. John's Hospital has provided a space for our CHLP fellows to assist, observe and learn about palliative care; thus widening their focus in community health.

Website: http://www.stjohns.in/hospital/

17. RICHMOND FELLOWSHIP SOCIETY, KARNATAKA

The Richmond Fellowship Society (RFS) (India) has been working with community mental health since 1986, and was first started in Puttenahalli, a Bengaluru suburb. RFS (India) is an Associate Member of the Richmond Psychosocial Foundation International (RPFI), UK. The society was established to deal with mental health outreach and rehabilitation to create equal opportunities for persons with mental illness and is a registered charitable NGO with branches in Bengaluru, Lucknow, Delhi and Sidlaghatta in rural Karnataka. The facilities and services offered include halfway homes, long term care, day care with vocational training for persons with mental illness and manpower development and research in the field of Mental Health. The society also works towards advocacy, creating public awareness and protecting the rights of persons with mental illness by organising symposia and workshops. The society also liaises with the State and Central governments.

Website: http://www.rfsindia.org/

18. SAKHI TRUST, HOSPET, BELLARY DIST., KARNATAKA

Sakhi Trust is located in Hospet, Bellary District, Karnataka (India). The vision of Sakhi is to work with young girls and youth from the marginalised communities in Hyderabad Karnataka. Sakhi has remained a close associate of JMS (Jagruti Mahila Sanghatana) Raichur since 2002.

The Managing Trustee, Dr. M. Bhagyalakshmi has always been a staunch supporter of Dalit women's initiatives at JMS and gender empowerment. She is the President of Navnirman Trust.

- Sakhi youth volunteer at JMS to support research
- Sakhi youth intern with JMS for their learning
- Ranga Sakhi, the theater group of Sakhi has performed in JMS villages. Their
- performances were on right to food, women's empowerment and right to health

- Sakhi has participated in the campaigns of JMS
- Number of young girls from the JMS communities have been promoted for vocational and higher education through Sakhi programmes.

Website: https://jmschiguru.wordpress.com/support/sakhi-trust/

19. SOCIETY FOR PEOPLES ACTION FOR DEVELOPMENT (SPAD), BENGALURU, KARNATAKA

SPAD works for child welfare, education, health, human rights, local administration, rural development. The organisational aim, objective and mission is 'To Create a Just and Humane Society'. People have the inherent capacity to change the lives of individuals and communities. Development is a human process. Concentrated action is required to make it humane as well. Deprivation and disease need to be fought with knowledge, information and purposive action

SPAD has over the last several years been able to mobilize communities through awareness and education and directing them to assert their right on health in the public health system. The formation of solidarity groups in different locations, conducting community score cards for each of the hospital catchment communities, consultations with health personnel in the health centres, raising issues across the table by the community groups has led to marked changes in the quality and the practice of services at the government health centres. The combined voice of community is heard well. The communities also felt that they are capable of holding accountable the government health sector to the needs of the community. The project's concerted effort in the last one year has led to quantifiable changes at the local level.

Website: https://www.oxfamindia.org/partnersdetail/59

20. SOCHARA – CEU, TAMIL NADU

SOCHARA – CEU, Tamil Nadu, based in Chennai, has been working towards achieving Health for All since 2004. It started as a community health approach to disaster response after the tsunami. Much of their work involves efforts to strengthen the state's public health system through a community-based approach, through engagement with communities, elected representatives, government and policy makers. Efforts have been made to facilitate people-led action to strengthen the accountability, monitoring and quality of the public health system through the Community Action for Health (CAH) initiative as part of the NRHM (national rural health mission) in Tamil Nadu. CEU has been functioning as the secretariat for the People's Health Movement in Tamil Nadu called *Makkal Nalavazhvu Iyakkam* (MNI). The CEU also functions as a catalyst for promoting community health and

public health through training, awareness and technical support in strengthening community participation and social accountability.

Website: http://sochara.org/Tamilnadu

21. SWAMI VIVEKANANDA YOUTH MOVEMENT (SVYM), KARNATAKA

In 1984, a group of young medical doctors led by R. Balasubramaniam, driven by their zeal to make a positive difference to the lives of the marginalised, came together to start the Swami Vivekananda Youth Movement (SVYM). The initiated their work towards providing rational, ethical and cost-effective medical care to those in need. Starting small by distributing physician's samples of medicines among poor patients, organising blood donation camps and rural outreach clinics, the work of SVYM proceeded to address the health needs of the displaced indigenous people belonging to the forest-based tribes of *Jenukuruba, Kadukuruba, Yerava, Paniya and Bunde Soliga*; wherein they setup a medicare clinic and expanded their work in education and socio-economic empowerment of the tribal community. Their position has changed from provider to facilitator through a host of community-based programmes and activities. SVYM now focuses on tribal and rural health, *ayurveda,* reproductive and child health, hygiene and sanitation, care and control of HIV/AIDS, tuberculosis and disability in addition to their educational and socio-economic empowerment focus. SOCHARA has recently placed of one of our fellows with the organisation during the third phase of the CHLP.

Website:http://www.svym.org/

22. VIVEKANANDA GIRIJANA KALYANA KENDRA (VGKK), KARNATAKA

VGKK was founded in 1981, with the aim of bringing healthcare to the Soliga tribe. Over the years, the organisation has evolved a commitment towards the empowerment and holistic sustainable development of tribal people's while ensuring their culture is protected. Today VGKK's work encompasses health, education, livelihood and biodiversity conservation through an integrated and needs-based approach, particularly in Karnataka, Arunachal Pradesh and the Andaman and Nicobar Islands. VGKK has evolved to address community health needs of the tribal community by not only addressing their access to healthcare services but also by addressing the wider social determinants of health through establishing a school and a vocational training centre, community organisation towards the fight for land rights, protection of women, addressing labour exploitation among other efforts.

In the third phase of the CHLP, VGKK has provided our fellows with an opportunity for field exposure and interactions with the tribal community in the *Biligiri Rangan* (BR) Hills, Karnataka.

Website: http://www.vgkk.org/

23. THANAL, KERALA

Thanal began with a small group of individuals who began working together in 1986 to raise public environmental awareness. Thanal has since been registered as a public charitable trust and its work has evolved to build campaigns and programmes focused on people, planet and sustainability as their vision. In response to the detrimental effects of pesticide use, improper waste management, and deforestation on human and environmental health; Thanal has spearheaded the Ban Endosulfan Campaign in Kerala, as well as the campaign for the preservation of Paddy and Wetlands in Kerala, the Save Our Rice campaign and the Zero Waste Himalayas campaign. SOCHARA continues to seek newer opportunities to work with Thanal through the CHLP.

Website: http://thanal.co.in/

24. TRIBAL HEALTH INITIATIVE (THI), TAMIL NADU

The Tribal Health Initiative (THI) is a registered Trust started in a small village called Sittilingi in 1993 by doctors Regi George and Lalitha Regi. THI began with efforts to bring healthcare services to the *Malavasi* tribal people inhabiting the Sittilingi valley and Kalrayan Hills of Dharmapuri District, Tamil Nadu. Their efforts evolved from starting out with a small out-patient unit in a thatched hut to a full-fledged thirty bedded primary care hospital. Among its achievements, THI set out to train local tribal girls as Health Workers (nurse midwives) and a group of older women called Health Auxiliaries (chosen by their own communities) to address the high rates of infant and maternal deaths prevalent in the region. Besides health education, outreach clinics are held covering 21 villages. The rate of infant deaths within one year of birth and undernourishment has drastically dropped. Maternal health services, through health promotion have also resulted in increasing the number of pregnant women attending antenatal check-ups. THI has evolved its vision of achieving health for the tribal communities by also addressing wider health promoting factors like education and livelihoods. Organic farming, reintroduction of traditional crops, reintroduction and promotion with marketing of traditional embroidery with tailoring of a variety of garments and products have enhanced the economic and cultural strength of the community.

THI has supported the CHLP in its third phase, where two fellows have had the opportunity to spend six months of their field training under THI's mentorship in order to gain a deeper understanding of community health among the Malavasis including among the youth.

Website: http://www.tribalhealth.org/

25. DR. T.M. SAMUEL MEMORIAL MEDICAL AND DENTAL CENTRE, ANDHRA PRADESH

Dr. Abraham Thomas a first batch CHFS alumnus, who is in regular touch with SOCHARA carries out his dental practice along with rural health and development activities in Koduru, Andhra Pradesh, through this Centre established in the name of his grandfather who started a rural practice here decades ago. He works closely with the local government primary school where his children study. He has helped improve the infrastructure of the school with child friendly toilets, desks etc. Dental health education includes learning about the value of eating local millets and vegetables which he grows and demonstrates. He is active on environmental issues and has initiated work with the *pourakarmika's* (sanitation workers) in Railway Kodur town. Local culture, songs and poetry that are progressive are promoted. He is planning on setting up a small open air theatre. He is active in the *Jan Vigyan Vedike* (People's Science Movement) in Andhra and Telengana. Team members and an alumnus have visited Abraham and a CHLP participant was placed there too.

Website: none available

CENTRAL AND NORTHERN INDIA

26. CENTRE FOR INTEGRATED DEVELOPMENT (CID), MADHYA PRADESH

The Centre for Integrated Development (CID) is an NGO that began its journey in 1989 with all efforts focused on environmental issues in rural and urban Gwalior, Madhya Pradesh. The work of the organisation gradually evolved to address education for underprivileged children and to work with grass root communities to promote equality and equity among, especially when it comes to making decisions about and managing community resources. Today, CID has grown to execute a number of projects covering child rights and eradication of child labour, community empowerment, initiatives for persons with disability, poverty alleviation and rural development, gender equality, health, hygiene and sanitation, women empowerment, environment conservation, HIV/AIDS awareness. A large part of their work involves networking. Their health work is expanding to address female feticide, malnutrition and the pulse polio campaign. CID has an active health and sanitation programme, an initiative to promote behaviour change as defined by the World Health Organisation (WHO), coverage of vitamin A supplementation, adolescent health, a diarrhoea management program, reduction of underweight malnutrition, promote community action for health, addressing maternal and child health, iodine programme and the TB control programme.

Website: http://www.cidindia.org/?page_id=49

27. GRAM SUDHAR SAMITI, MADHYA PRADESH

Gram Sudhar Samiti(GSS) focuses on working with tribal communities and began in Sidhi district, Madhya Pradesh. GSS was established in 1987. The organisation is actively engaged in promoting health, education, tribal development and women's development. The organisation works towards equality, equity integrated livelihood development. GSS now works in Sidhi, Rewa and Satna districts of Madhya Pradesh.

28. LEPRA SOCIETY, MADHYA PRADESH

Lepra Society - India, was established in 1989 and is registered in Andhra Pradesh (Telangana areas); though its origin in India dates back to 1925, as an extension unit of Lepra-UK. It works closely with the Government, Ministry of Health and Family Welfare unit at all levels. Lepra works for health in action and is a member of the Andhra Pradesh and Orissa state leprosy and TB societies. Lepra has expanded its work to cover a population of nearly 12 million people in these and other states of India. Although Lepra started out, working with the National Leprosy Eradication Programme (NLEP); its work areas expanded to include HIV/AIDS, TB, and malaria and blindness. Lepra has been implementing the Link workers scheme designed by NACP-III to address HIV prevention, care, treatment and support to those affected in rural areas, using a community-centred approach. SOCHARA's CHLP fellows have conducted their field work with this programme in this 3rdPhase. The Arogya project, also implemented by LEPRA and co-funded by the European Union, was a five-year project implemented in four districts of Madhya Pradesh and was designed to address HIV/AIDS and TB, including co-infection among vulnerable groups. Our CHLP fellows also participated in this project through their field placement with LEPRA.

Website: http://leprasociety.org/news.html

29. MUSKAAN, MADHYA PRADESH

Muskaan an NGO was started in 1998, Bhopal, Madhya Pradesh. Their work focuses on education, identity, violence, health and nutrition, and livelihoods of those vulnerable in slum communities. *Muskaan* has based its work on building strong interpersonal relationships with the communities. The organisation is currently constructing a permanent campus where they will be able to continue their teaching work with children from slum communities. *Muskaan* basis its community work on their belief from experience, that education of the children within a vulnerable community is key to the survival of the larger community. They work primarily with scheduled tribes who have been dislocated and marginalised.

Website: http://www.muskaan.org/index.html

30. PRERANA COMMUNITY HEALTH DEVELOPMENT PROJECT - CHHATARPUR CHRISTIAN HOSPITAL, MADHYA PRADESH

Emmanuel Hospital Association (EHA) is a medical institution that works for the health of the poor in Northern India. Chhatarpur Christian Hospital, an EHA full-service health care facility in the rural Bundelkhand area of Madhya Pradesh, provides a vast range of services under general medicine, obstetrics, gynaecology, paediatrics, outpatient, dentistry, ophthalmology, and surgery at an affordable cost; and also hosts a nursing school. The hospital also works towards community-based development. The Prerana Community Health Development Project is a large extension of the services offered at the hospital aimed at improving the health of the people in surrounding villages. Their Tele-Clinic Project works on establishing community monitoring systems, developing water sanitation systems and providing primary health care by training Accredited Social Health Activists, Auxiliary Nurse Midwives, and Anganwadi Workers and building their knowledge of prevalent diseases.

Website: http://www.ehausa.org/hospitals_chhatarpur_christian.html

31. SATHIYA WELFARE SOCIETY, MADHYA PRADESH

Sathiya Welfare Society has been working voluntarily in Anuppur, Shahdol, Umaria and Dindori districts for the past 3 years. In Anuppur district we have been authorised for the Social Audit Process under NREGS.Also we running the Call Center under MDM Scheme in Anuppur district. Our main emphasis is on community mobilisation, women empowerment and skill development. We are also working on Panchyat Raj and providing trainings to elected representatives specially the women leaders on Panchayat system. We mobilise the youth to unite and work voluntarily for the development of their villages.

Children, Education & Literacy, Environment & Forests, Health & Family Welfare, Micro Finance (SHGs), Minority Issues, Micro Small & Medium Enterprises, New & Renewable Energy, Nutrition, Panchayati Raj, Rural Development & Poverty Alleviation, Science & Technology, Tribal Affairs, Urban Development & Poverty Alleviation, Vocational Training, Women's Development & Empowerment, Youth Affairs

Website: http://www.indiamapped.com/ngo-in-madhya-pradesh/bhopal/sathiya-welfare-society-16110/

32. SPANDAN SAMAJ SEVA SAMITI, MADHYA PRADESH

Spandan Samaj Seva Samiti, works with marginalised communities to empower them to secure their Human & Constitutional Rights and to lead a life of dignity. The

organisation works with the Kokru tribe community in Khalwa block of Khandwa district in Madhya Pradesh. The primary focus is to alleviate childhood malnutrition, enhance food security and preserve local language and culture. Their programmes include community based non-institutional management of malnourished children; transforming anganwadis into child friendly centres, running community crèches for children below three years, managing grain banks for most food insecure families to offset peak hunger times, and assisting Korku farmers to revive the traditional crops and tribal millet that once was the backbone of community nutrition.

Source:https://www.globalgiving.org/donate/18531/spandan-samaj-seva-samiti/info/

33. SOCHARA-CPHE, MADHYA PRADESH

SOCHARA-CPHE, SOCHARA's Madhya Pradesh cluster is based in Bhopal and functions as a resource centre for public health and is a part of SOCHARA's Centre for Public Health and Equity (CPHE), providing training and support for community health and public health practitioners. The unit runs the two-year Madhya Pradesh Community Health Fellowship Programme (CHFP)similar to the CHLP in Bengaluru. CPHE also supports the fellows from the CHLP in liaising their field placements with other relevant organisations in MP and providing them with technical support.

Website: http://sochara.org/Health-Bhopal

34. SYNERGY SANSTHAN, MADHYA PRADESH

Synergy Sansthan works in the socially backward areas of the Harda, Khandawa and Bhopal districts, Madhya Pradesh. The organisation for founded in 2006 with the aim of working towards the development of youth from marginalised communities, particularly addressing child rights, education and learning, building leadership and local self-governance, and women's health and empowerment. They are working towards achieving this through community-based development and advocacy. The organisation has also developed a disaster management programme which includes training, guidance in preparing a village disaster management plan and taskforce formation and capacity building.

Website: http://www.synergysansthan.org/

35. WATERSHED ORGANISATION TRUST (WOTR), PUNE, MAHARASHTRA

The Watershed Organisation Trust (WOTR), based in Pune, was established in 1993. They have worked on watershed development initiatives in over 3700 villages across Maharashtra, Telangana, Andhra Pradesh, Madhya Pradesh, Rajasthan, Jharkhand and Odisha. WOTR specialises in Watershed Development and Climate Change

Adaptation. The organisation has vast on-field experience and use a systematic, participatory approach in their work. The organisation enables rural communities to assess their climatic and non-climatic risks. Its approach is to empower villagers to lift themselves out of poverty by regenerating their ecosystems, conserving their resources, using them optimally; and building climate. WOTR has also expanded its areas of work to include the Sampada Trust (ST) for women's empowerment and micro-finance; Sanjeevani Institute for Empowerment and Development(SIED) which is the implementation wing of WOTR; and Sampada Entrepreneurship and Livelihoods Foundation(SELF) that has been set up to promote social enterprises and livelihoods.

Website: http://www.wotr.org/

36. STATE HEALTH RESOURCE CENTRE, CHHATTISGARH

The State Health Resource Centre (SHRC), Chhattisgarh, functions as an autonomous body and works to improve the quality and affordability of, and access to state healthcare and to promote equity and gender sensitivity within the public health system, by providing additional technical support to the State Department of Health and Family Welfare. The SHRC provides support in policy planning and strategic thinking, capacity development, development of innovative and adaptive programme designs, community based health programmes, conducting health system research, and assisting the Department of Health & Family Welfare, Chhattisgarh to implement innovative strategies. The SHRC approaches these tasks through community empowerment. Another major contribution of the SHRC has been in developing the successful and well planned Mitanin Programme. The SHRC has also developed life-saving skills training programme in emergency obstetrics and is now providing these services in the most remote areas of Chhattisgarh. SHRC continues to play a catalyst role in the public healthcare system, as a driver of change.

Website: http://www.shsrc.org/default.htm

WESTERN INDIA

37. SOCIETY FOR HEALTH ALTERNATIVES (SAHAJ), GUJARAT

SAHAJ was founded in 1984, to create and provide a supportive environment for people doing original work in health and development. The members of SAHAJ are from a variety of backgrounds and disciplines, with vast experience and contribute to alternative approaches to health and development. SAHAJ works to promote the people's fundamental right to health through projects that enable accountability for maternal health, undertaking community awareness of healthcare affordability, accessibility, acceptability and quality. SAHAJ basis their health programme on the

social determinants of health, rather than the biomedical model of healthcare; and also work in the areas of advocacy and action research for child rights and maternal health. Other areas of their work over the years include organising waste picking women and rural tribal women to educate them about their rights to basic needs and assisting them with practical solutions to water, fuel, healthcare. The organisation has also conducted training and consultation in healthcare management, setting up of alternative healthcare clinics that specialise in non-drug therapies, organic and sustainable methods in agriculture, fishing and other areas of skill development. The work of SAHAJ focuses on uplifting marginalised and deprived communities. SAHAJ works across Mumbai, Gujarat and Delhi. SAHAJ has also been involved in promoting education for children from poor communities and aiming to abolish child labour, through their division called Shishu Milap.

Website: http://www.sahaj.org.in/

NORTHERN INDIA

38. DOOSRA DASHAK (DD) -FOUNDATION FOR EDUCATION AND DEVELOPMENT (FED), RAJASTHAN

Doosra Dashak(DD) is a project that has been developed by the Foundation for Education and Development (FED) Rajasthan, to provide holistic, integrated and value-based education to adolescents from rural areas with the aim of making their lives more productive and meaningful. DD also addresses the learning needs of school-going adolescents from the most marginalised communities. The educational programme offers a four-month residential camp, short duration trainings and specialised training that cover life skills education, needs-based training, training of trainers. Examples of some of the subjects covered in the specialised training programme include Gender and Sexuality, Public Hearing, Right to Information(RTI) and Right to Education(RTE), Continuing education, Panchayati Raj, Challenges before our democratic system, and Rural journalism.

Website: http://doosradashak.in/

39. EMMANUEL HOSPITAL ASSOCIATION, UTTARAKHAND

The Emmanuel Hospital Association (EHA) also has a presence in Dehradun and the surrounding areas of Uttarakhand. EHA leads a partnership project with the Uttarakhand Community Health Global Network (CHGN) cluster called Project Burans. The work is spread across three communities Sahaspur, Majra and Mussoorie and focuses on people with mental distress, caregivers and their communities aimed at building knowledge and skills for mental health.

Project Burans has four implementation partners – HOPE (Agnes Kunze Society), OPEN (Organisation for Prosperity, Education and Nurture), SNEHA and Landour Community Hospital.

Website: http://projectburans.wix.com/burans

40. KIRAN SOCIETY, UTTAR PRADESH

Kiran Society, founded in 1990 and is now based in the village ofMadhopur, UP; is translated as a 'ray of hope'. The society works towards education, community-based rehabilitation, vocational and skill training, referral services and social integration for differently abled children and youth.

Website: http://kiranvillage.org/

41. RAMAKRISHNA MISSION HOME OF SERVICE, UTTAR PRADESH

Ramakrishna Mission Home of Service started out as a small dispensary and is now a230 bedded full-fledged hospital with modern infrastructure and provides health services under various specialties, and is located on a sprawling campus in Varanasi. In addition to hospital services, the mission home also provides financial help, clothing and food to several marginalised widows who travel to the Holy city in the hope of spiritual salvation. These women are also provided with medical and general health care. The organisation also conducts a non-formal healthcare training programme where students train to become 'nursing aids; and the mission also holds classes to educate the staff's children. Health education is provided with a focus on that of women and children; this is conducted in the surrounding rural areas as well as in the slums of Varanasi. The mission home also has a mobile medical service, its own laundry service, dairy farm and maintenance department to help keep their activities running smoothly.

Website: http://www.varanasirkm.org/

NORTH EASTERN INDIA

42. BETHANY SOCIETY, MEGHALAYA

Bethany Society was established 1981, in Mendal, the East Garo Hills of Meghalaya. The society began its work with supporting people with disabilities through formal and non-formal educational and livelihood programmes. They are now working for their access to public healthcare as well. Bethany has also commenced a B.Ed. programme in Special Education in collaboration with North Eastern Hill University, Shillong. The organisation also works towards enabling persons with disabilities and other such vulnerable groups to form self-help groups and have made Micro-

credit available to many towards livelihood initiatives. The society has established an Orthopaedic Rehabilitation Centre in TURA Other areas of work include education, 'Bokashi' farming and organic farming, livestock management, natural resource management and sanitation. SOCHARA has had a number of fellows join the CHLP programme through Bethany Society and some of these fellows have also had their field placement at Bethany Society.

Website: http://bethanysociety.in/

43. SHAMAKAMI, MEGHALAYA

SHAMAKAMI- "ONE WHO DESIRES ONE'S EQUAL" is a Community Based Organization of MSM/TG (Men having Sex with Men/Transgender) which was formed in the year 2008 bythe founding members Smti. Rebina Subba and Smti. Bathsheba G. Pyngrope which got registered on 27th January 2010 under the Meghalaya Societies Registration Act of XII 1983.

As SHAMAKAMI was a newly registered CBO and needed a mother NGO to support and guide it in the right path the Khasi Jaiñtia Presbyterian Assembly came forward as our mother NGO.

Mission

1.Shamakami visions of a society where MSM/TG population can lead a life of dignity and equal rights.

2.Shamakami aims to generate greater understanding in larger society of issues concerning MSM/TG and other sexual minorities, particularly the youth.

3.Shamakami aims at guiding MSMs/TGs to lead a disciplined lifestyle, have safe sexual behaviour, awareness on sexual health, distribution of condoms, etc.

Website https://www.facebook.com/Shamakami-Lam-Jingshai- 176022939104547/info

EASTERN INDIA

44. MITRA – CHRISTIAN HOSPITAL, BISSAMCUTTACK, ODISHA

MITRA (Madsen Institute for Tribal & Rural Advancement) is a programme that comprises the community health work of the Christian Hospital, Bissamcuttack. The CHB community health work in the area was initiated by Dr. Elizabeth Madsen in 1954, when she trained local people to deliver a variety of hospital services and reached out to tribal populations in the surrounding remote villages of Odisha to ensure their access to essential healthcare. Since, MITRA also promotes education for the tribal children at a high standard and low cost. Their established training

programmes include NERU (Nursing Education Resource Unit), the ROSHNI programme focusing on maternal-child healthcare for young girls, the Art and Science of Community Health that aims to create locally-rooted community health practitioners for tribal health, and an Internship offered to BSc Community Health Practitioners. In addition, the ASHA-MITRA Adivasi Education Project aims to give children a quality education amidst dysfunctional educational environments by placing motivated, home-trained Adivasi youth as Community Teachers in these existing schools or educational centres.

Website: http://chbmck.org/
Other sources:https://www.ashanet.org/projects/project-view.php?p=811

45. SWASTHYA SWARAJ, THUAMUL RAMPUR, KALAHANDI DIST., ODISHA

Swasthya Swaraj is a registered society that was started by a small group of professional women with a passionate desire and commitment to bring health to the marginalised, neglected and unreached tribal people of the Kalahandi district in Odisha. The organisation works to promote health within this tribal community but ultimately aims to promote community action for health and freedom from ill health, illiteracy and poverty, and to live as one with nature. Swasthya Swaraj bases its activities on human rights and the local tribal culture, ensuring that all their programmes are participatory and empowering. *Swasthya Swaraj* has set up a primary health care system that covers 75 villages in the region through a participatory approach, giving preventive, promotive and curative care equal importance. The team has *Swasthya Sathi's* and *Shiksha Sathi's* who receive systematic training to undertake health and education work among the community. The group also works on community based research initiatives that are related to health issues that are prevalent among the local tribal community. *Swasthya Swaraj* has developed a special focus on education in collaboration with the government and other organisations.

During the third phase of the CHLP, *Swasthya Swaraj* has been a field mentoring organisation to four of our fellows; who had a field learning opportunity with *Swasthya Swaraj's* Comprehensive Community Health Programme that is active across 75 villages of Thuamul Rampur Block, Kalahandi, Odisha.

Website: http://www.swasthyaswaraj.org/ ■

Annexure VII
List of CHLP Participants
List of CHLP Full-time Fellows in Phase 3, December 2012 - May 2016
CHLP Batch 9 (2012-2013)

No.	Name	Discipline	State Represented	Period	Duration
1	Mr. Mohammed Rauf Khan	Master of Social Work	Madhya Pradesh	10th Dec 2012 to 09th Dec 2013	12 months
2	Ms. Shanthi D'Souza	Master of Social Work	Kerala	11th Dec 2012 to 10th Dec 2013	12 months
3	Mr. Pravesh Verma	Master of Social Work	Madhya Pradesh	14th Dec 2012 to 13th Dec 2013	12 months
4	Mr. Ankit Vashishtha	Master of Social Work	Madhya Pradesh	24th Dec 2012 to 23rd Dec 2013	12 months
5	Ms. Shashirekha.P	Master of Social Work	Karnataka	26th Dec 2012 to 25th Dec 2013	12 months
6	Ms. Ranu Sharma	Master of Social Work	Madhya Pradesh	08th Jan 2013 to 07th Jan 2014	12 months
7	Mr. Gururaghavendra.C.E	Master of Social Work	Karnataka	15th Jan 2013 to 14th Jan 2014	12 months
8	Mr. Bhimraj Surpur	Master of Social Work	Karnataka	23rd Jan 2013 to 22nd Jan 2014	12 months
9	Mr. Rohit Kashyap	Master of Social Work	Madhya Pradesh	01st Apr 2013 to 31st Mar 2014	12 months
10	Mr. Banajara Venkatesha Naik	Master of Social Work	Karnataka	16th Apr 2013 to 15th Apr 2014	12 months
				Total no. of months	**120 months**

CHLP Batch 10 (2013-14)					
1	Dr. Samantha Christina Lobbo	Bachelor of Dental Surgery (BDS)	Karnataka	01st Jun 2013 to 31st May 2014	12 months
2	Mr. Job K Joseph	Master of Social Work	Kerala	18th Jun 2013 to 17th Jun 2014	12 months
3	Ms. Lekshmy. M	Master of Social Work	Kerala	20th Jun 2013 to 19th Jun 2014	12 months
4	Mr. R.Venkatesan	M Phil Social Work	Tamil Nadu	18th Jun 2013 to 30th Mar 2014	9 months
5	Mr.Suresh N	MA., Social Work	Tamil Nadu	18th Jun 2013 to 17th Jun 2014	12 months
6	Ms. Banri Kynti Shisha Diengdoh	Master of Social Work	Meghalaya	23rd Jul 2013 to 22nd Jul 2014	12 months
7	Ms. Nandaris Marwein	Master of Social Work	Meghalaya	27th Jul 2013 to 26th Jul 2014	12 months
8	Mr. C.K. Ganesh	Master of Social Work	Karnataka	29th Jul 2013 to 28th Jul 2014	12 months
9	Ms. Chongeithem Lhouvum	Master of Social Work	Meghalaya	23rd Jul 2013 to 22nd Jul 2014	12 months
10	Ms. Sabeena Lyngdoh	Master of Social Work	Meghalaya	23rd Jul 2013 to 22nd Jul 2014	12 months
				Total no. of months	**117 months**

Batch 11 (2014 – 2015)

1	Ms. Juliet Angel Shangrit	Master of Social Work	Meghalaya	17th Jan 2014 to 16th Jan 2015	12 months
2	Ms. Aphasana Khan	Diploma in Electrical Engineering	Rajasthan	17th Jan 2014 to 16th Jan 2015	12 months
3	Ms. Regina Ryngnga	Master of Social Work	Meghalaya	17th Jan 2014 to 16th Jan 2015	12 months

4	Ms. Huntiful Lyngdoh Marshillong	Master of Social Work	Meghalaya	17th Jan 2014 to 16th Jan 2015	12 months
5	Ms. Jyothy Lakshmi C R	Master of Social Work	Kerala	17th Jan 2014 to 16th Jan 2015	12 months
6	Ms. S. Saraswathi	Master of Social Work	Tamil Nadu	17th Jan 2014 to 16th Jan 2015	12 months
7	Mr. Pawan Vishwakarma	Master of Social Work	Madhya Pradesh	17th Jan 2014 to 16th Jan 2015	12 months
8	Dr. Bharti Sahu	Bachelor of Dental Surgery	Chhattisgarh	17th Jan 2014 to 16th Mar 2015	12 months
9	Mr. Amarendra Kumar	MA., Sociology	Uttar Pradesh	17th Jan 2014 to 16th Jan 2015	12 months
10	Mr. Vishan Devda	Master of Social Work	Madhya Pradesh	17th Jan 2014 to 12th Feb 2015	12 months
11	Mr. Rahul Pandit	Master of Social Work	Madhya Pradesh	03rd Feb 2014 to 2nd Feb 2015	12 months
12	Ms. Yeshodha. G	Master of Social Work	Karnataka	01st Feb 2014 to 31st Jan 2015	12 months
13	Ms. Asma. S	Master of Social Work	Karnataka	01st Feb 2014 to 31st Jan 2015	12 months
14	Mr. Syed. Toseef Husain	MA., in Urdu	Madhya Pradesh	24th Feb 2014 to 23rd Feb 2015	12 months
15	Mr. Krishna Pratap Singh	MA., Economics	Uttar Pradesh	03rd Mar 2014 to 2nd Mar 2015	12 months
16	Mr. Phool Singh	MA., Sociology	Madhya Pradesh	06th Mar 2014 to 5th Mar 2015	12 months
17	Ms. Ashma Jahan	Master of Social Work	Madhya Pradesh	17th Mar.2014 to 16th Mar 2015	12 months
18	Ms. Anusha Purushotham	BA., Molecular Biology	Karnataka (UG studies and work in USA)	1st July, 2014 to 30th June 2015	12 months
				Total no. of months	**216 months**

Batch 12 (2015 – 2016)					
1	Ms. Balentina T. Lamare	Master of Social Work	Meghalaya	09th Feb 2015 to 08th Feb 2016	12 months
2	Dr. Rajeev B R	Master in Dental Surgery (Public health Dentistry)	Karnataka	09th Feb 2015 to 08th Feb 2016	12 months
3	Mr. Jaision K Sebastian	Master of Social Work	Kerala	09th Feb 2015 to 08th Feb 2016	12 months
4	Mr. Azam Khan	BA., LLB.,	Madhya Pradesh	09th Feb 2015 to 08th Feb 2016	12 months
5	Ms. Dala Akor Khar Phanbuh	Master of Social Work	Meghalaya	09th Feb 2015 to 08th Feb 2016	12 months
6	Ms. Ayesha Begum	Master of Social Work	Karnataka	23rd Feb 2015 to 22nd Feb 2016	12 months
7	Ms. Fatima.B	Master of Social Work	Meghalaya	23rd Feb 2015 to 22nd Feb 2016	12 months
8	Mr. Khirod Bihari Sahu	Master of Business Administration	Orissa	23rd Feb 2015 to 22nd Feb 2016	12 months
9	Ms. Aruna. P	Master of Social Work	Karnataka	18th Mar 2015 to 17th Mar 2016	12 months
10	Mr. Anjaneya.B	Master of Social Work	Karnataka	10th Apr 2015 to 09th Apr 2016	12 months
11	Ms. Uma Chaitanya Vipparthi	M Sc. Pharmacy	Andhra Pradesh	12th May 2015 to 30th Apr 2016	12 months
12	Mr. Kamlesh Sahu	Master of Social Work	Madhya Pradesh	1st June 2015 to 30th Apr 2016	11 months
13	Mr. Chandrashekar. M. N	Master of Social Work	Karnataka	22nd June 2016 to 30th Apr 2016	11 months
14	Ms. Swetha.Y	M A. Psychology	Karnataka	1st Aug 2015 to 31st May 2016	10 months
15	Ms. Shanaz Begum.C	M A. Psychology	Karnataka	1st Aug 2015 to 31st May 2016	10 months
16	Mr. Kuleswar Majhi	Master of Social Work	Orissa	1st Aug 2015 to 31st May 2016	10 months
17	Mr. Samar Khan	Post Graduate in Insurance Management	Madhya Pradesh	1st Sept 2015 to 31st May 2016	9 months

18	Ms. Anu Maria Jacob	Master of Public Health	Kerala	1st Sept 2015 to 31st May 2016	9 months
				Total no. of months	**202 months**

List of Short-Term Stipendiary CHLP Fellows in Phase 3, January 2013 - May 2016

No	Name	Discipline	State	Period	Duration
1	Dr. Chandrakant K Dhanni	Bachelor in Dental Surgery, MPH	Karnataka	17th Jan 2014 to 19th Aug 2014	7 months
2	Mr. Pappu Pawar	Master of Social Work	Madhya Pradesh	17th Jan 2014 to 18th Aug 2014	7 months
3	Mr. Ershad Khan	Master of Social Work	Madhya Pradesh	17th Jan 2014 to 18th Aug 2014	7 months
4	Dr. Amrutha John	Bachelor of Dental Surgery	Tamil Nadu	6th Mar 2015 to 5th Jun 2015	3 months
5	Dr. Shivali Sisodia	Master of Public Health, BDS	Chandigarh	27th May 2015 to 26th June 2015	1 month
6	Ms. Shangmi Moyon	Master of Social Work	Manipur	09th Feb 2015 to 03rd July 2015	5 months
7	Ms. Priyanka Paul	Master of Social Work	Kerala	09th Feb 2015 to 30th May 2015	4 months
8	Ms. Manisha Shastri	M A., Social Work	Tamil Nadu	09th Feb 2015 to 30th May 2015	4 months
9	Ms. Pooja Venkatesh	M Sc., Human Development and Family Studies	Karnataka	09th Feb 2015 to15th June 2015	4 ½ months
10	Ms. Yomri Dabi	Master of Social Work	Manipur	31st Mar 2015 to 13th Aug 2015	4 ½ months
11	Mr. Shad Ahmed Khan	Master of Social Work	Madhya Pradesh	09th Feb 2015 to 30th May 2015	4 months

12	Ms. Shashikala P	Master of Social Work	Karnataka	10th Apr 2015 to 31st Oct 2016	7 months
13	Ms. Shwetha Gupta	Graduate in Textile Technology and Chemistry	Karnataka	11th Dec 2015 to 31st May 2016	5 ½ months
14	Dr. Suresh Raghunath	MBBS.,	Karnataka	9th Dec 2015 to 30th April 2016	5 months
15	Ms. Sujatha Khindo	M A., in Rural Management	Orissa	1st March 2016 to 31st May 2016	3 months
16	Mr. Sheikh Sami Ullah	Bachelor of Business Administration	Jammu& Kashmir	3rd June 2nd July 2015	1 month
17	Mr. Ahmer Khan	B A Journalism	Jammu& Kashmir	3rd June 2nd July 2015	1 month
				Total	**73 ½ months**

List of Flexi-Interns during CHLP Phase 3, January 2013 - May 2016

No	Name of the Intern	Institution from and Discipline	State	Period	Duration
1	Dr. Sarode Lalit Dinkar	National Institute of Epidemiology	Maharashtra	July 2012 to Oct 2012	4 months
2	Dr. Amutha	School of Public Health - SRM University Chennai	Tamil Nadu	Jan 2012 to May 2012	5 months
3	Ms. Shani John Sequiera	MSc., Community Health Nurse,	Karnataka	01st Jan 2013 to 30th May 2013	5 months
4	Dr. Mahesh Mathpati	Indian Institute of Ayurvedic Medicine and urgery, Banglaore	Maharashtra	23rd Jan 2013 to 30th Jun 2013	5 months

5	Dr. Devasenapathy (Chennai)	School of Public Health - SRM University Chennai	Tamil Nadu	25th Jan 2013 to 31st July 2013	6 months
6	Dr. Sharanya Thanapathy (Chennai)	School of Public Health - SRM University Chennai	Tamil Nadu	27th Jan 2013 to 31st July 2013	6 months
7	Mr. Vivek.A Rajan Varatharajan	B.Sc., (hon) in Economics, University of Toronto, Canada	Canada	03rd Jun 2013 to 06th Jul 2013	1 month
8	Ms. Tanuja Devarajan	Candidate of Medical Degree (M.D), Jefferson Medical College,	Pennsylvania, USA	17th Jun 2013 to 17th Jul 2013	1 month
9	Ms. Madhavi Venugopal	Under graduate, University of Chicago	Chicago, USA	21st Aug 2013 till Nov end 2013	3 months
10	Mr. Tejaswi Melarkode	BA., LLB., National Law University, Delhi	Karnataka	6th Jan to 31st Jan 2014	1 month
11	Dr. Kanishka Koshal	Bachelor in Dental Surgery, IDS Bareilly	Uttar Pradesh	23rd Aug 2013 to 31st Dec 2013	4 months
12	Dr. A S G R Rahul	Master of Public Health (Epidem), Guru Gobind Singh Indraprastha University, Delhi	Tamil Nadu	5th November to 31st Dec 2013	2 months
13	Dr. Joseph Sowyer	PG, London School of Hygiene and Tropical Medicine	United Kingdom	12th June to 12th July 2014	1 month
14	Ms. Anusha Purushotham	B.Sc., Molecular Biology, The University of Texas at Dallas (UTD), Richardson, TX	Karnataka	16th Jan to 31st May 2014	4 ½ months

15	Dr. Lakshmi Priya	MPH., School of Public Health - SRM University	Tamil Nadu	16th Jan to 10th June 2014	5 months
16	Ms. Preethi Reddy	MPH., School of Public Health SRM University	Tamil Nadu	16th Jan to 10th June 2014	5 months
17	Mr. Anuj Ghanekar	M Sc., Anthropology, University of Pune	Maharashtra	23rd Mar 2015 to 8th Oct 2015	6 months
18	Dr. Viraj Bharambe	Medical Graduate, University of Southampton	United Kingdom	06th Apr 2015 to 2nd July 2015	3 months
19	Ms. Malvika Govil	BA., Kinesiology-Health Sciences, Rice University, USA	Texas, USA	01st June 2015 to 27th June 2015	1 month
20	Ms. Maya Rao	High School, Torrey Pinas High School, SD USA	South Dakota, USA	6th July 2015 to 14th Aug 2015	6 weeks
21	Ms. Sayema Badar	BSc., Anatomy and Cell Biology, McGil University, Canada	Toronto, Canada	3rd Aug 2015 to 30th Aug 2015	1 month
22	Ms. Manasa Kambanna	Public Policy., Jindal School of Public Policy	Karnataka	23rd Dec 2015 to 23rd Jan 2016	1 month
23	Ms. Yesoda Bhargava	PG BTech., IIT, Gwalior	Madhya Pradesh	29th Dec 2015 to 31st March 2016	3 months
24	Ms. Rosalind Miller	Doctoral scholar at London School of Hygiene Tropical medicine	United Kingdom	Nov, 2014 to June, 2015	7 months
25	Ms. Rebecca Son	Nehru Fulbright scholar	Chicago, Illinois	Aug, 2015 to May, 2016	10 months
26	Ms. Pooja Prasad	12th Grade, Dougherty Valley High School, USA	California, USA	25th Jun 2014 to 5th Aug 2014	6 weeks

27	Ms. Niveditha G.D	II PUC student, Christ College,	Karnataka	18th April to 22nd April 2016	1 week
28	Ms. Shashin Singh	Health Management, Pokhara University, Nepal	Nepal	2nd May to 31st May 2016	1 month
				Total	**94 months**

List of students on placement at SOCHARA-SOPHEA, Bengaluru, Chennai and Bhopal clusters during CHLP Phase 3 from June 2012 to October 2016

No.	Name	Institution came from	State	Period	Duration
1	Mr. Jai Karthick	Master of Social Work, Loyola College	Tamil Nadu	1st June to 30th June 2012	1 month
2	Ms. Shashi Rekha.P	Master of Social Work, Bangalore University	Karnataka	16th Feb to 30th June, 2012	4 ½ months
3	Mr. Murali. T	Master of Social Work, Bangalore University	Karnataka	16th Feb to 30th June, 2012	4 ½ months
4	Ms. Arpitha V Krishna	Master of Social Work, Christ University	Karnataka	1st Sept to 30th Sept, 2012	1 month
5	Ms. Charishma Jones Sarman	Master of Social Work, Christ University	Assam	1st Sept to 30th Sept, 2012	1 month
6	Mr. Narayanswamy.V	Master of Social Work, Bangalore University	Karnataka	27th Sept 2012 to 26th Jan 2013	4 months
7	Mr. Dominic Thomas	Master of Social Work, Christ University	Kerala	01st Feb 2013 to 28th Feb 2013	1 month
8	Ms. Aleena Mathai	Master of Social Work, Christ University	Kerala	01st Feb 2013 to 28th Feb 2013	1 month

9	Mr. Gangadhar.B.K	Master of Social Work, Bangalore University	Karnataka	01st Mar.2013 to 14th Jun 2013	3 ½ months
10	Ms. Asha.K.T	Master of Social Work, Bangalore University	Karnataka	01st Mar 2013 to 14th Jun 2013	3 ½ months
11	Ms. Rajani.S	Master of Social Work, Bangalore University	Karnataka	01st Mar 2013 to 14th Jun 2013	3 ½ months
12	Ms. Sonu G Nair	Master of Social Work, Bangalore University	Karnataka	02nd Sept 2013 to 30th Sept 2013	1 month
13	Mr. Vinith.A	Master of Social Work, Bangalore University	Karnataka	02nd Sept 2013 to 30th Sept 2013	1 month
14	Mr. Pilla Anjanappa	Master of Social Work, Bangalore University	Karnataka	27th Sept 2013 to 27th Dec 2013	3 months
15	Ms. Satvika Krishnan	Law Graduate, Symbiosis University, Pune	Karnataka	27th Nov 2013 to 10th Dec 2013	1 ½ months
16	Ms. Nisha.K.S	Master of Social Work. Nehru Arts and Science College, Coimbatore	Kerala	12th May 2014 to 12th Jun 2014	1 month
17	Ms. Deeksha Katarki	Law, Indian Law Society, College, Pune	Karnataka	9th June to 24th June, 2014	2 weeks
18	Mr. Mukti Tirkey	Master of Social Work, Barkatullah University, Bhopal	Madhya Pradesh	20th Sept to 30th Sept 2013	10 days
19	Ms. Sunita Dangi	MSW, Barkatullah University, Bhopal	Madhya Pradesh	4th Oct to 26th Nov, 2013	1 ½ months
20	Ms. Sharatha Pant	Master of Social Work, TISS, Mumbai	Madhya Pradesh	26th Aug to 28th Sept 2013	1 month

21	Ms. Kirti Sharma	Master of Social Work, Barkatullah University, Bhopal	Madhya Pradesh	20th Sept to 30th Sept 2013	2 weeks
22	Mr. Mayank Botham	Master of Social Work, Barkatullah University, Bhopal	Madhya Pradesh	4th Oct to 26th Nov, 2013	2 months
23	Mr. Manoj Agrahari	Master of Social Work, Barkatullah University, Bhopal	Madhya Pradesh	3rd June to 7th July 2014	1 month
24	Mr. Rahul Yadav	Master of Social Work, Barkatullah University, Bhopal	Madhya Pradesh	3rd June to 7th July 2014	1 month
25	Ms. Priya Kanwar	Master of Social Work, Barkatullah University, Bhopal	Madhya Pradesh	14th May to 4th July, 2014	2 months
26	Mr. Atul Prakash Maske	Master of Social Work, TISS, Mumbai	Maharashtra	26th Aug to 26th Sept 2015	1 month
27	Ms. Deepali Mistry	Master of Social Work, TISS, Mumbai	Maharashtra	26th Aug to 26th Sept 2015	1 month
28	Ms. Mariyam Zaidi	Master of Social Work, Jamia Milia Islamia University, Delhi	Delhi	5th Oct to 7th Nov 2015	1 month
29	Ms. Preeti Verma	MA in Development, Azim Premji University	Uttarakhand	16th Nov to 28th Dec 2015	1 ½ months
30	Ms. Sarayu Srinivasan	MA., Social Work, TISS Mumbai	Maharashtra	26th Aug to 31st Sept, 2015	1 month
31	Ms. Cicil Vasantha	Master of Social Work, TISS, Mumbai	Kerala	1st Apr to 14th Apr, 2013	2 weeks

32	Mr. Harsha Ravi	Master of Social Work, TISS, Mumbai	Kerala	1st Apr to 14th Apr, 2013	2 weeks
33	Mr. Vineeth Koshi	Master of Social Work, TISS, Mumbai	Maharashtra	1st Apr to 14th Apr, 2013	2 weeks
34	Ms. Aanehal Shankar	Master of Social Work, TISS, Mumbai	Kerala	1st Apr to 14th Apr, 2013	2 weeks
35	Mr. Krishti Jacob	Master of Social Work, TISS, Mumbai	Tamil Nadu	1st Apr to 14th Apr, 2013	2 weeks
36	Ms. Anju Augustine	Master of Social Work, TISS, Mumbai	Kerala	1st Apr to 14th Apr, 2013	2 weeks
37	Mr. Kavikumar N	Master of Social Work, TISS, Mumbai	Tamil Nadu	1st Apr to 14th Apr, 2013	2 weeks
38	Ms. Devika Sharma	Master of Social Work, TISS, Mumbai	Maharashtra	1st Apr to 14th Apr, 2013	2 weeks
39	Dr. Karthick Rao	MPH SRM, University	Tamil Nadu	14 April to 13 May 2014	1 month
40	Ms. Sibija Bensigar.S	Master of Social Work, Loyala College, Chennai	Tamil Nadu	2nd May to 2nd June 2016	1 month
41	Mr. Nilanjan Bhor	MA., in International Family Studies, TISS, Mumbai	Maharashtra	30th Aug to 5th Oct 2014	1 month & 1 week
42	Ms. Shruthi Srinivasan	Master of Social Work, Christ University	New Delhi	2nd Jan to 31st Jan 2015	1 month
43	Ms. Priyanka Saha	Master of Social Work, Christ University	West Bengal	2nd Jan to 31st Jan 2015	1 month
44	Ms. Betty Mary Gigi	Master of Social Work, Christ University	Karnataka	2nd Jan to 31st Jan 2015	1 month
45	Ms. Celeste David	BA., Jyoti Nivas College	Karnataka	4th May to 3rd Jun 2015	1 month

46	Mr. Alfred Raju	Master of Social Work, Christ University	Karnataka	1st Aug to 31st Aug 2015	1 month
47	Mr. Alfred Raju (4th Sem. Learning contract)	Master of Social Work, Christ University	Karnataka	1st Jan to 30th Jan 2016	1 month
48	Mr. Nishanth Lawrence	Master of Social Work, Loyola College, Chennai	Tamil Nadu	2nd May to 31st May 2016	1 month
49	Ms. Niranjana Chater	MSW, Loyola College, Chennai	Tamil Nadu	2nd May to 31st May 2016	1 month
50	Ms. Agnes Scholastica	Master of Social Work, Loyola College, Chennai	Tamil Nadu	2nd May to 31st May 2016	1 month
51	Ms. Mishal Chrysolyte	Master of Social Work, Loyola College, Chennai	Tamil Nadu	2nd May to 31st May 2016	1 month
52	Ms. Sibija Bensigar.S	Master of Social Work, Loyola College	Tamil Nadu	2nd May to 2nd Jun 2016 (placed at CEU)	1 month
53	Ms. Jessamine Therese Mathew	Law Student, West Bengal, National University of Juridical Sciences	Karnataka	16th May to 26th June 2016	1 ½ months
54	Ms. Rishika Shaw	Master of Public Health, University of Pune	Maharashtra	16th May to 30th June 2016	1 ½ months
55	Ms. Anagha Joshi	Master of Public Health, University of Pune	Maharashtra	16th May to 30th June 2016	1 ½ months
56	Mr. Yassir Saleh Ahmed	Master of Public Health, University of Pune	Chad – Africa	16th May to 30th June 2016	1 ½ months
57	Dr. Ashwini Dhamaraju	Master of Public Health , Indian Institute of Public Health	Rajasthan	1st June to 30th July, 2016	2 months
58	Mr. Sam Thomas	Master of Social Work, Christ University	Tamil Nadu	June, 2016 to Aug, 2016	3 months

59	Ms. Pawath Sanjana Zacharia	Master of Social Work, Christ University	Maharashtra	1st to 31st Aug, 2016	1 month
60	Mr. Ningdaipou Kahmei	Master of Social Work, Christ University	Manipur	1st to 31st Aug, 2016	1 month
61	Ms. Rani Deepshikha	M Com, Christ University	Jharkhand	19th to 24th Sept, 2016	1 week
62	Mr. Karamvir Dewan	Bachelor of Business Administration, Christ University	Haryana	26th Sept to 3rd Oct 2016	1 week
63	Mr. Himanshu Agarwal	Bachelor of Business Administration, Christ University	Andhra Pradesh	26th Sept to 3rd Oct 2016	1 week
64	Mr. Garvit Sharma	Bachelor of Business Administration, Christ University	Haryana	26th Sept to 3rd Oct 2016	1 week
65	Mr. Harsh Purandare	Master in Public Health Administration, TISS Mumbai	Madhya Pradesh	22nd Aug to 12th Oct, 2016	1 month, 3 weeks
66	Ms. Nidhi Khare	Master in Public Health Administration, TISS Mumbai	Madhya Pradesh	22nd Aug to 12th Oct, 2016	1 month, 3 weeks
67	Ms. Shreedevi Moleganvi	M Com., Christ University	Karnataka	12th Oct to 15th Oct 2016	1 week
68	Ms. Jannath Ul Firdose	M Com., Christ University	Karnataka	12th Oct to 15th Oct 2016	1 week
69	Ms. Bryn Babbitt	B.A., Psychology, Sociology, University of Denver, Denver	USA	24th Oct to 2nd Dec 2016	1 week
70	Ms. Madeline Ford	B.Sc., Cellular & Molecular Biology, Seattle University	USA	24th Oct to to 2nd Dec 2016	1 week
Total (till 31st October 2016)					**84 ½ months**

ANNEXURE VIII

List of SOCHARA – CHLP Team Members & Full Team

(Many team members were with SOCHARA prior to the CHLP phase 3 and will continue)

Sl. No	Names	Designation	Period served fpr CHLP phase 3 (several were team members earlier)
1.	Dr. Thelma Narayan	Director – SOCHARA, SOPHEA	December, 2012 to October 2016
2.	Dr. Yuvraj.B.Y	Senior Programme Officer	December 2012 to December 2013
3.	Ms. Shani John Sequiera	Junior Programme Officer	June 2013 to July 2014
4.	Mr. Karthikeyan Kandaswamy	Training Facilitator	December 2012 to November 2013
5.	Mr. Kumar K J	Training Facilitator	June 2013 to May 2016
6.	Mr. Sabu K Joseph	Research Officer	June 2013 to May 2015
7.	Dr. Rahul ASGR	Training Facilitator, later Research Officer	January 2014 to May 2016
8.	Mr. S. J. Chander	Senior Programme Officer	December, 2012 to October 2016
9.	Dr. Ravi Narayan	Consultant Community Health	December, 2012 to October 2016
10.	Mr. As Mohammad	Consultant Research	December, 2012 to October 2016
11.	Ms. Janelle De Sa Fernandes	Research and Training Assistant	November 2014 to October 2016 (on maternity leave for six months, and part time thereafter)
12.	Mr. Mahadevaswamy HR	Librarian	December, 2012 to October 2016
13.	Ms. Anusha Purushotham	Training Facilitator	December 2015 to May 2016 (maternity leave replacement)
14.	Mr. Chandran.P	Web Manager	November 2015 to March 2016 (was with us on an earlier project too)

The following staff members were not paid from the CHLP project (SRTT/ IDRC), took frequent sessions for the CHLP fellows:			
15.	Mr. I.M. Prahlad	Training & Research Facilitator	December, 2012 to October 2016
16.	Dr. Adithya Pradyumna	Research & Training Facilitator	December, 2012 to October 2016
17.	Dr. Ravi D'Souza	Senior Consultant	December, 2012 to October 2016
18.	Mr. J.S. Santosh	Training and Research Assistant	November 2011 to October 2014
19.	Mr. Prasanna Saligram	Project Manager	December 2012 to January 2016
20.	Dr. Naresh Kumar	Research and Training Assistant	June 2012 to December 2013
21.	Mr. Ameer Khan	Research Associate	December, 2012 to October 2016
22.	Mr. Suresh.D	Communication & Website Officer	April 2016 to October 2016 (was a CEU team member before that)

Support Staff			
23.	Mr. Victor Fernandes	Administrative Officer	December 2012 to October 2016
24.	Mr. Naveen Roshan Pinto	Accountant	December 2012 to September 2015
25.	Mr. Mathew Alex	Accountant	October 2015 to October 2016
26.	Ms. Maria Dorothy Stella	Office Supervisor	December 2012 to October 2016
27.	Ms. Pushpalatha.B	Secretarial Assistant	December 2012 to February 2014
28.	Mr. Hari Prasad Ojha	Office Assistant	December 2012 to October 2016
29	Mr. Tulsi Chetry	Office Assistant	December 2012 to October 2016
30.	Mr. Joseph M S	Office Assistant	December 2012 to October 2016

ANNEXURE IX

SOCHARA Executive Committee members (in 2016)

1. Dr. Mohan K. Isaac - President	2. Dr. P.Chandra - Vice President
3. Dr. Thelma Narayan - Secretary (replaced by Mr. Sam Joseph from 15th October 2016)	4. Mr. As Mohammad - Treasurer
5. Dr. Mani Kalliath - Member	6. Dr. Kishore Murthy - Member
7. Dr. Sunil Kaul - Member (replaced by Dr. Maya Mascarenhas on 13th September 2016)	

SOCHARA General Body - Ordinary Members (in 2016)

8. Dr. Ravi Narayan	9. Mr. Samuel V.K Joseph (Secretary from 15th October 2016)
10. Mr. Abhijit Sengupta	11. Fr. Claude D'Souza, SJ
12. Dr. M.K. Vasundhra	13. Dr. Shirdi Prasad Tekur
14. Dr. Denis Xavier	15. Ms. Valli Seshan
16. Dr. N. Devadasan	17. Dr. Ravi D'Souza
18. Dr. Madhukar Pai	19. Mr. K. Gopinathan
20. Dr. H. Sudarshan	21. Dr. Susanta Ghosh
22. Dr. Neela Patel	23. Mr. Edward Premdas Pinto
24. Dr. Pruthvish Sreekantaiah	25. Dr. Anand Zachariah
26. Sr. Dr. Aquinas Edassery	27. Prof. Shanmugavelayutham
28. Dr. Muraleedharan. V R	29. Dr. K. Ravi Kumar
30. Ms. Padmasini Asuri	31. Dr. Arvind Kasturi
32. Dr. Maya Mascarenhas	33. Fr. John Vattamattom, SVD - Honorary Member
34. Dr. D.K. Srinivasa - Honorary Member	35. Mr. A. Arumugham - Honorary Member

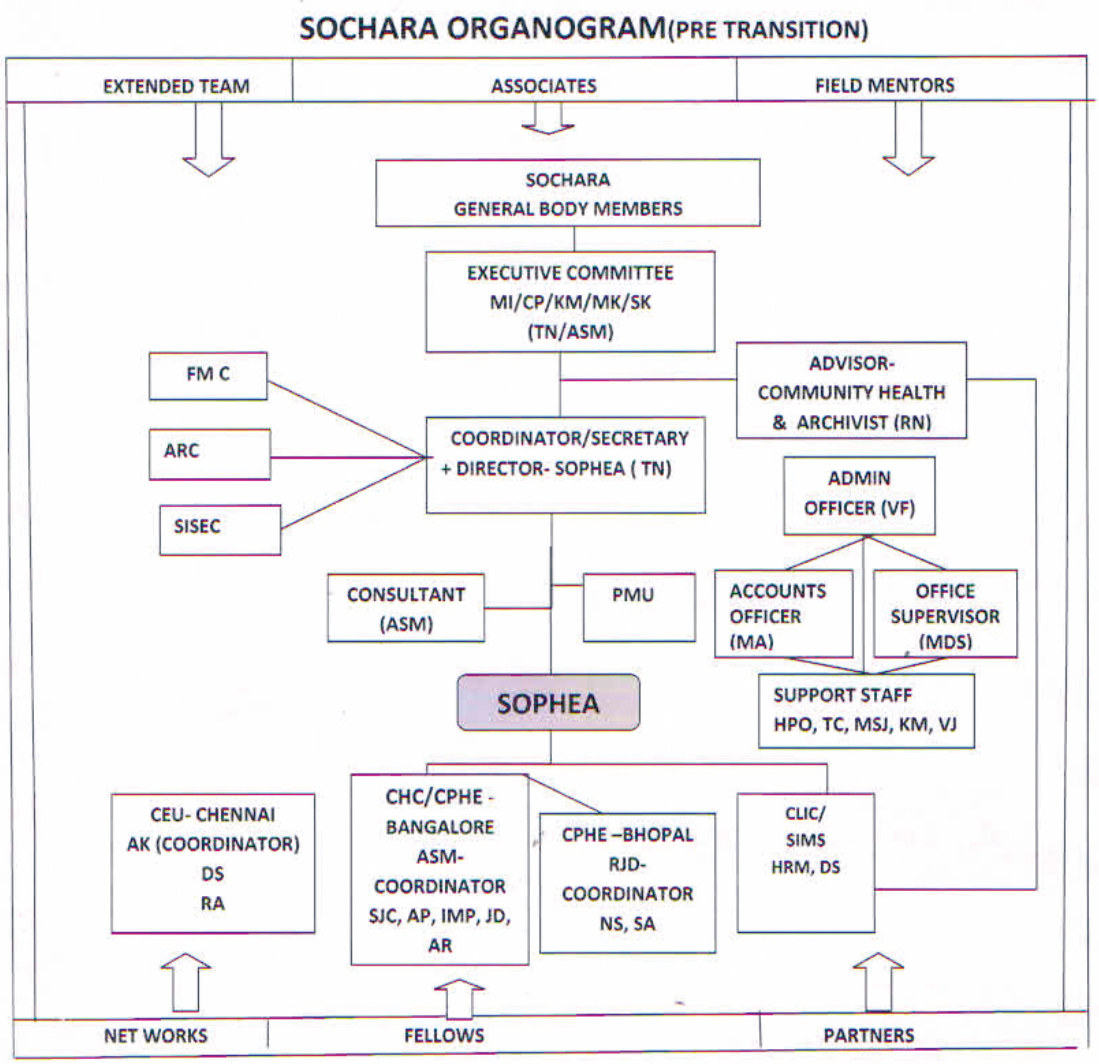
ANNEXURE X

SOCHARA LOGO - 2011 - 2012
SOCHARA AT THE 20TH YEAR MILESTONE

The SOCHARA LOGO is a new one developed during the 20th year, keeping in mind progress over the years and evolution of the SOCHARA School of Public Health, Equity and Action (SOPHEA). The colour yellow symbolizes optimistic hope and enthusiasm. The joyful figures symbolize community centredness and community participation as one of the core strengths supporting the work of the teams. The tag line 'building community health' captures in three words our mandate and direction. The intertwined design indicates the complex determinants of health that are interlinked and that need to be transformed as we progress as a society towards Health for All. The empty space within, suffused in yellow, indicates the creative inner space that all team members and members of the community can draw upon to get the energy to work for Health for All and to sustain this over long periods of time, through periods of struggle and achievement. (Ref. SOCHARA Annual Report 2011-12)

ANNEXURE XI

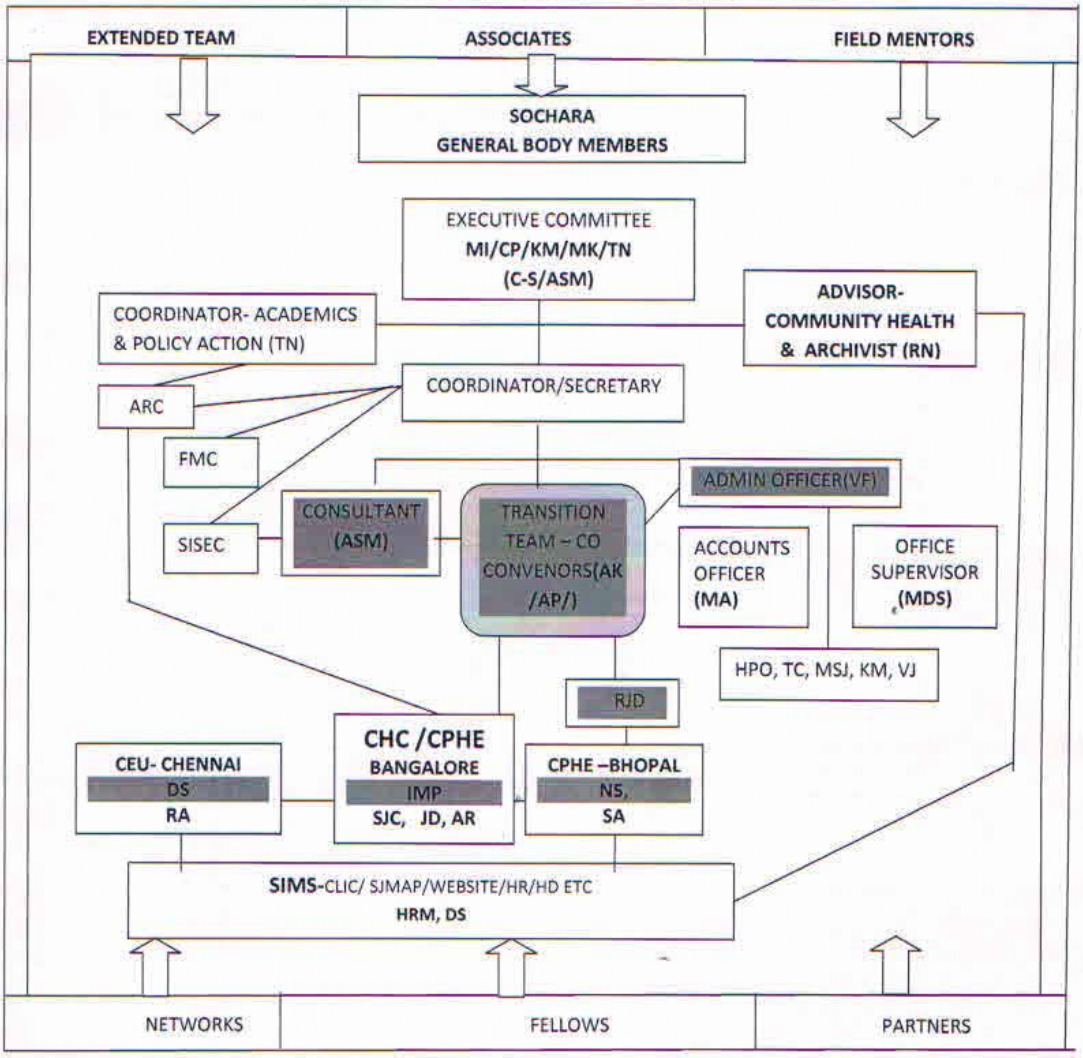
SOCHARA Organogram - Pre and Post Transition



NOTES:

In the organization there exists some committee to enable the governance which are indicated including : FINANCE AND MANAGEMENT COMMITTEE (FMC); PROJECT MANAGEMENT UNIT(PMU); ACADEMIC RESEARCH COUNCIL (ARC); SOCHARA INSTITUTIONAL SCIENTIFIC AND ETHICS COMMITTEE (SISEC) ; and project or other advisory committees appointed as required. These are all under the supervision of the Coordinator –Secretary. The linkage with SOCHARA members, Extended team, Associates, Networks, Partners, Field Mentors and Fellowsis maintained by the Coordinator-Secretary and team members since they represent the large SOCHARA network of resources that has evolved over the last 25 years. These links are shown surrounding the SOCHARA organogram.

SOCHARA ORGANOGRAM (Post Transition)



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- In the organization there exists some committee to enable the governance which are indicated including : FINANCE AND MANAGEMENT COMMITTEE (FMC); PROJECT MANAGEMENT UNIT(PMU); ACADEMIC RESEARCH COUNCIL (ARC); SOCHARA INSTITUTIONAL SCIENTIFIC AND ETHICS COMMITTEE (SISEC) ; and project or other advisory committees appointed as required. These will continue to be under the supervision of the Coordinator –Secretary.
- A transition team consisting of AK, AP, RJD supported by ASM and VF and linked to Bangalore (IMP) ; Chennai (DS) and Bhopal (NS) will be coached by the new CS for next generation leadership
- The linkage with SOCHARA members, Extended team, Associates, Networks, Partners, Field Mentors and Fellowsis maintained by the Coordinator-Secretary and team members since they represent the large SOCHARA network of resources that has evolved over the last 25 years.