SOCIAL JUSTICE IN HEALTH

Multiple pathways towards Health for ALL

A REFLECTIVE REPORT

by
The SOCHARA Team, Bangalore, India

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building community health

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Foreword

Viewed within a long historical perspective spanning centuries, thirty years is a short time. However in the life of a small group of like minded persons who have come together for a common cause, it is long enough time to sit back and reflect on our endeavors and soak in the experience.

This is the thirtieth year of the Community Health Cell (CHC) Bangalore and the tenth year of the CHC Extension Unit (CEU) in Chennai.

The CHC team in 1987, reflected on the early experiences, and the context in which health work in India was then situated. Looking ahead to the possible three to four decades of work several ideas emerged.

These were captured in a report, "Community Health: In Search of Alternate Processes" which stated "*Community Health could well become a movement linked to a wider development and social change process…"* **(8, p 32).** After a review of health, as it was then understood, across a spectrum of non-governmental organizations; government initiatives; in networks; in the science and environments movements; in mass organizations and others sectors, it concluded, "*Taken together all these developments, often independent of each other, create the necessary ethos and preconditions for the possibility of a wider, more intensive movement towards health policy and health structural changes emerging in the country*." **(*ibid*, p 35*).*** With academic backgrounds of teaching in a medical college, and the urge to 'define', community health was understood as "*a process of enabling people to exercise collectively their responsibility to their own health, and to demand health as their right. The community health approach involves the increasing of the individual*, *family and community autonomy over health and over the organizations, the means, the opportunities, the knowledge and the supportive structures that make health possible.****(ibid* p 44*).***

After six years of CHC as a study-reflection-action experiment, and subsequent to an evaluation of CHC, the Society for Community Health Awareness, Research and Action (SOCHARA) was registered in 1991. The team built consistently on the social and societal paradigm for health

through using a community health approach to public health problems, training, networking and research.**(66)** In the 1990s as part of a review it was felt that though there were good NGO initiatives and national networks in health in India, the collective with a broader perspective and common action was missing, and there was not yet a countervailing power in civil society that had significant influence in health policy and practice or in social and political change.**(9)** Health decision making and implementation processes were weak on democracy, accountability, and in professional content and quality. The need for a countervailing power was articulated. **(26)**

With the coming together of a significant number of groups and networks in India to form the *Jan Swasthya Abhiyan* (JSA) in December 2000 at Kolkotta, and with the launch of the global Peoples' Health Movement (PHM) soon after in Savar, a more vibrant civil society emerged linked to wider social groups and movements. **(1, 59)** There was a shift from being islands of excellence and thought currents to becoming a broader platform for health action. JSA and PHM are networks of networks adopting a variety of strategies undertaken as collectives, as well as by their constituents.

The ideas and processes of change at various levels in the efforts towards Health for All have been captured to some extent in this publication. Part One provides an overview of the conceptual understanding of social justice and health, health rights, inter-connected rights which link to the underlying social determinants of health, and social change processes that have evolved over a period of time. Part Two covers the proceedings of a National Workshop held in Bangalore in September 2013 on the Theme - 'Social Justice in Health and Universal Health Coverage: Challenges, Possibilities and Pathways'. Part Three is a compilation of articles written since the turn of the millennium on themes related to Social Justice and Health. This Part ends with a review of theoretical frameworks of social movement impacts offering an opportunity for health movements to learn from experience.

The SOCHARA team members, past and present, based in three centres in Bangalore, Karnataka; Chennai, Tamilnadu; and Bhopal, Madhya Pradesh have been the energy hub for the work that has been undertaken. To each one a BIG Thank You! Members of the General Body and Executive Committee of SOCHARA have provided the confidence, guidance and governance needed in such an endeavour. The Community health fellows and interns have brought in fresh ideas and energy as well as fun and song into our lives. The solidarity networks of the medico friend circle, Jan Swasthya Abhiyan, PHM global have been great fellow travelers providing space for sharing in solidarity, analyses and challenge. The process of constructive, critical engagement with the government at national, state and local levels has been most productive. Donor partners have been a consistent support. Misereor, Germany; the Sir Ratan Tata and Sir Dorabji Tata Trusts, India; the Sarathy Foundation and others have been partners since long. This initiative and the report is supported by the Ford Foundation. Our gratitude to all the above.

We hope this volume will be a background document for all those interested in issues concerning health and justice and that it will stimulate further reflection, research, as well as action on the ground taking us forward on the journey towards Health for ALL.

SOCIAL JUSTICE IN HEALTH: ACTION TOWARDS REALIZING PEOPLES' HEALTH RIGHTS

"The people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare"

The Alma Ata Declaration, WHO, UNICEF 1978

"The attainment of this goal (Health For All) depends, above all, on three things: (1) the extent to which it is possible to reduce poverty and inequality and to spread education; (2) the extent to which it will be possible to organize the poor and underprivileged groups so that they are able to fight for their basic rights; and (3) the extent to which we are able to move away from the counter-productive, consumerist Western model of health care and to replace it by the alternative model based in the community ……..."

Health for All, ICSSR & ICMR Report, 1981

"If the poor are organized enough to exploit the concessions that have already been made by the ruling classes in the fields of health, they can not only blunt the weapon of using access to health services to oppress them, but they can also use these concessions as a lever to join other forces in ushering in a more just social order."

Poverty, Class and Health Culture in India, D. Banerji, 1982

"*Since health cannot exist in isolation, it is necessary that the community health movement becomes part of a larger social movement towards greater equity and justice. Equally important, is the need for such a movement to focus on the existing health care structure, heath policy and health and medical education policy, to confront and challenge it to become more 'community health' oriented in its values and focus."*

CHC, Community Health: In Search of Alternative Processes, 1987

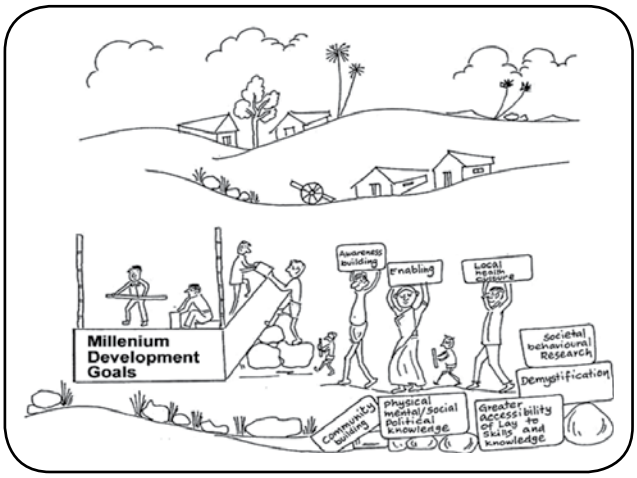
"For too long the medical profession and the medical education sector have been directed by professional control and debate. It is time to recognize the role of the community, the consumer, the patient and the people in the whole debate. …… What is needed is a strong countervailing movement initiated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

SOCHARA, VHAI, 1998

"The participation of people and people's organization is essential to the formulation, implementation and evaluation of all health and social policies and programmes. Strong people's organizations and movements are fundamental to more democratic, transparent and accountable decision making processes."

The People's Charter for Health, PHM, 2000

PEOPLE'S PARTICIPATION



IN HEALTH AND DEVELOPMENT !

Social Justice in Health: Multiple Pathways Towards Health for All

"Equity, ecologically - sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decision that shape our lives.

There are more than enough resources to achieve this vision"

Source : The People's Charter for Health - The People's Health Movement, Dec. 2000

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Part I

INTRODUCTION TO SOCIAL JUSTICE –

PROCESSES AND PATHWAYS

1.

Concepts of Social Justice and Health, Health Rights and the Health for all movement

Thelma Narayan & Ravi Narayan, SOCHARA

The Global People's Charter for Health (2000), the first of many progressive documents since the beginning of the new millennium, noted that:

"Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill health and the deaths of poor and marginalized people….. Health is primarily determined by the political, economic, social, and physical environment and should, along with equity and sustainable development, be a top priority in local, national, and international policy making." **(1)**

This Charter adopted at the first People's Health Assembly (PHA) in December 2000 at Savar, Bangladesh by 1400 participants from 75 countries is one of the most endorsed and translated Charters for health (www.phmovement.org). It forms the basic framework for the People's Health Movement (PHM) launched at Savar. Subsequently translated into over 50 languages, it continues to be endorsed through websites and country circles, and to inspire critical thinking, analyses and action towards Health for ALL among communities in several parts of the world (*ibid*). Later articles in this volume outline the progress of work initiated and influenced by the concepts promoted by the PHM and the Charter. However, efforts towards social justice are part of an earlier quest, and a social process with older roots.

The Charter drew from the WHO - UNICEF Alma Ata Declaration of 1978 endorsed by representatives from 134 member countries, which stated:

"The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace. .. the attainment of the highest possible level of health is a most important social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." **(2)** Social justice was the value base of the Alma Ata Declaration, which also clearly recognised the links between health and development. "*The Conference affirmed that the primary health care approach is essential to achieving an acceptable level of health throughout the world in the foreseeable future as an integral part of social development* ***in the spirit of social justice****" (ibid, p 17).* The Health for All movements preceding and following

Alma Ata draw strength from the powerful vision of social justice.

The People's Charter resonates with the Ottawa Charter for Health Promotion,1986 which noted:

"*Good health is a major resource for social, economic, and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioral and biological factors can all favour health or be harmful to it…… Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities- their ownership and control of their own endeavors and destinies."* (3) All these declarations and charters have a common running thread. They recognize and endorse the need for egalitarian social change. They emphasize that social change with peace and justice is a pre-requisite to better health; health is a crucial component of social change; and involvement and empowerment of communities to strengthen social change and the 'Health for All' goal is a crucial and significant component of the process.

The Charter and subsequent declarations of the People's Health Movement are rights based and take forward earlier global consensus documents such as the UN Universal Declaration of Human Rights of 1948 and the WHO Constitution, 1946, that health is a fundamental, universal, inalienable human right that is interconnected with other rights.

The Preamble to the WHO Constitution states, " ***The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States*** *"* (International Health Conference, New York from 19th June to 22nd July 1946, signed by the representatives of 61 States/countries). **(64)**

The Universal Declaration of Human Rights, which is the basis of all human rights as well as the primary human rights instrument in force, mentions the right to health in Article 25, in connection with other economic, social and cultural rights:

1) "***Ever one has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or lack of livelihood in circumstances beyond his control.***

2) ***Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection***"

UN, 1948, Universal Declaration of Human Rights – Article 25

The Right to Health is an affirmation of a standard of living adequate for the health and wellbeing of persons and their families. Inter connectedness to social, cultural, economic and political rights has long

been recognised. Commitments were made by governments, including India and people in the 1966 UN International Covenants on these issues. The States parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966 recognize:

> ***"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*** **Article 12.1**

For the Committee on Economic, Social, and Cultural Rights (CESCR) **the main body at the international level monitoring the realization of the right to health,**

"Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conductive to living a life in dignity" **CESCR 2000.**

The UN Special Rapporteur's Reports on the Right to Health in 2000 and beyond have also expanded the scope pointing to the need to address the underlying determinants in order that people could enjoy the right to health. All human rights are considered inter-related and indivisible. The interconnection of rights also needs to expand and include environment and ecology. The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health brought into focus the important role that public health systems play, stating in 2006, "*The right to health can be understood as the right to an effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.* ***Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system."***

Concepts of social justice have evolved over time in different contexts. The Constitution of India is based on the principle of Social Justice. A fair distribution of economic and social resources and benefits for all was initiated. To be realised this needs to be backed by adequate legal, financial, and programmatic support. The experience of over sixty years point to the social, economic, political and cultural (SEPC) interests that have become barriers to redistribution and to the Health for All dream. There is need for constant effort and pressure to trigger necessary change. Philosophers and economists such as John Rawls and Amartya Sen among others have spent lifetimes studying and deriving insights. Countries too have developed operational definitions to guide public policy.

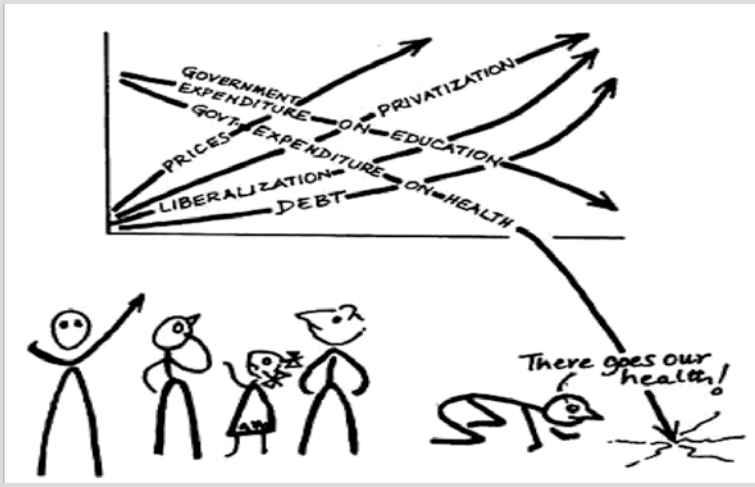
The WHO Commission on Social Determinants of Health (2005-8) and its Knowledge Networks (KN) with active participation of civil society gathered evidence from across the world and pointed to urgent evidence based action that is needed. **(58)** The health mission has expanded to include work on the root causes of inequalities in disease, disability and health by improving the social conditions in which people live and work. There is need for policies and practice that tackle the underlying determinants of health inequalities, within a framework of cross-cutting rights. ***(ibid)***

The World Health Assembly in 2009 adopted a Resolution WHA 62.14 '***Reducing health inequities through action on the social determinants of health*'. (67)** There was strong commitment at a follow up WHO World Conference on Social Determinants of Health in Rio, Brazil with the theme "***All for Equity***" in 2011with 1000 participants including civil society, and 19,000 other reached through webcasts. The Rio Political Declaration on Social Determinants was adopted with a pledge to work on five priority areas namely better governance for health and development; participation in policy making and implementation; reorienting the health sector to reduce health inequities; strengthened global governance and collaboration; and monitoring progress with increased accountability. **(*ibid*)**

Barriers to achieving Health for All have been discussed, debated at various levels and fora and also researched. While there is need for hope and concerted health action at levels of policy and practice, there is also reason for healthy skepticism and constant vigilance regarding appropriate, adequate and equitable resource allocation; infrastructure development; mechanisms for public and civil society participation along with the other pillars of health system development to ensure that there is progress towards Health For ALL**.(65)**

The realization of rights and progress in achieving social justice in health has been and continues to be a major challenge for people, communities, organizations, governments and the academic and research community. Declarations, policies and programs though necessary are not enough and have not been able to bring about the desired change in health outcomes, though they may be in the right direction. Good intentions are not enough! Recent quantitative and qualitative data clearly indicate the continuing and growing inequalities in health between and within countries. This is at a time when there is unprecedented wealth and knowledge. Indicators of nutritional status of young children under the age of six years in different states of India reveal the magnitude of biological poverty. Current levels of anaemia among children, women and even men show that it is a public health emergency, yet there is inaction together with a lack of accountability for the continuation of this situation. Increased knowledge and wealth alone are not sufficient to bring about change. "*Disparities hampering progress are systematic, reflecting hierarchies of advantage and disadvantage and public policy choice"* UNDP, 2005. However it is also realized that equity and justice is good for all – there are no losers.

What are the People saying about Health?



This article presents an overview of this complex mosaic of relationships

and possibilities that exist at the interface between society, community, families and persons, mediated through civil society and social movements together with the structures and processes of health policy, health systems and health actions. It also highlights roles and innovations in the process of critical and constructive engagement between several stakeholders, particularly with the public, together with the broad lessons and paradigms emerging from such engagement

2.

SOCIAL CHANGE AND HEALTH: CONTEXTUAL CLARITY

The phenomena of 'Social Change' and its complexity at a macro level in society and at micro level in communities - has fascinated sociologists, economists, historians and social science researchers, and challenged political economists and policy makers over the years**.(16 -22) Social movements and civil society have contributed conceptually and at process and practice level in the progress towards Health for ALL, as an integral part of the process of egalitarian social change.**

What are these changes? How do they affect different aspects of life at community, societal and family level – and through culture, education, economy, employment, social and political life? What are the effects on health? While these effects may be positive or negative – how do they impact on health culture and behavior, health systems, human resources in health and health policy? What are the outcomes from an equity perspective? What are the impacts on social relationships? Is it liberating at a personal level? What is the change needed at personal level for larger social change? What values should underpin the process?

While it is beyond the scope of this article to review the phenomena of social change and health in detail, four important aspects are explored to enhance contextual clarity.

2.1 Complexity

The complexity of social change includes an interplay of several factors : the level of change (global, regional, national and local): the geographical setting of change (rural, urban, or marginalized indigenous communities); the nature of change (internal factors such as family, culture, social habits and local structures or external factors such as conflicts, trade or external economic and political influence); the links with social processes like demographic pressure, class conflicts, migration of human power or displacement due to development, natural or manmade disasters and social conflicts; the consequences of change (new norms, new values, new relationships and new institutions), unintended consequences such as on environment and

ecology, impact of externalities and finally the pace of change (gradual, disruptive, conflictual or cataclysmic).

2.2 Effect of change on Health

All changes can have both positive and negative effects on health, health systems and on the Health for ALL goal. Understanding these changes will help to evolve processes, mechanisms and policies that tackle the negative effects on health, and sustain and promote the positive effects of change.

2.3 Agents of Change

Social change is not just spontaneous or an adhoc process. It is often facilitated by groups in society who perceive both the problem and also perceive a role they can play in responding to it. These agents of change may be intellectuals (academic or researchers); social activists and pressure groups such as trade unions, and other collectives including a wide range of groups in civil society – community based organizations (CBOs), non-governmental organizations (NGOs), social movements, media related persons and informed and active citizens.

2.4 Theories of Change

Various theories have been put forward in order to explain how change take place at individual and community levels. These are based on assumptions of why people act, and what influences play a role. Actions or non-actions are affected by factors such as culture, social norms, information, peer pressure and values such as approval, disapproval, expectations, positive rewards or negative stimuli. While health education and health promotion in the past have tended to focus on change at individual and family level – leading to a focus on behavior change communication (BCC), a shift is gradually taking place. Public health researchers, policy makers, professionals and activists are increasingly focusing on changes at community and societal levels. This is particularly important if the deeper and broader social determinants of health are to be addressed and transformed. Newer theories like social cognitive theories and theories of community organization and community empowerment, critical consciousness, especially among marginalized and socially excluded groups; diffusion of innovation and collaboration for change are evolving to handle the more contemporary and complex aspects of change. Rather than discussing the intricacies and dynamics

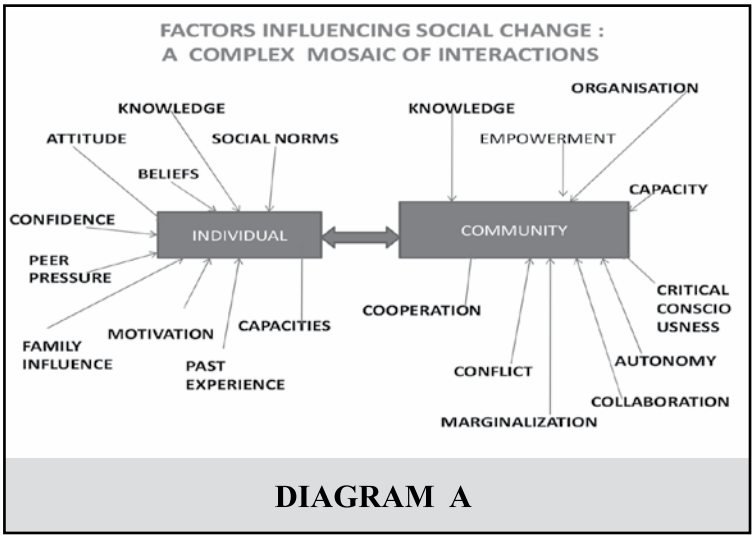


DIAGRAM A

of each theory, diagram A outlines several factors that influence social change at individual and community/societal level. At individual level the factors include knowledge, attitude, beliefs, motivation, history, past experience and skills, capacities and capabilities, confidence, peer support or pressure, social norms, and the influence of family, friends, co-workers, teachers and health professionals. At community level factors such as knowledge, organization, empowerment, capacity, critical consciousness, autonomy, collaboration or conflict, associations, networks, cooperation, dialogue, and membership of organizations, unions, and challenges such as migration, multiculturalism, alienation, marginalization etc have a role to play. The family, other social institutions and forces influence the connection between an individual and community. Diagram A highlights both the complexity and plurality of influence and effects.

3.
CIVIL SOCIETY AND SOCIAL CHANGE

3.1 Recognizing multiple contributors

Over the past decades moving beyond feudal situations, the role of government in bringing about change mediated through the political process and political institutions like elected local bodies, assemblies, and parliament is well established. Deepening democracy is an ongoing process and democratization of health decision making is part of this. Every government establishes institutions and procedures for making and enforcing rules, and collective decisions which include the evolution of policies, including health policies. The government is supported in this role by the judiciary which provides oversight on the legalities of the decision making process; by the military which provides national security and protection against conflict from external sources; by its foreign policies and international relations and by institutions and mechanisms at various levels that facilitate accountability and transparency. A process of dialogue and debate, checks and balances requires informed and active participation from multiple groups in a spirit of mutual respect.

3.2 What is civil society?

Many definitions have developed to understand the term 'Civil Society'. Two representative definitions in the box below highlight key characteristics and features of players included under this terminology**.(23)** The term 'Uncivil Society' in political science refers to terrorist groups or those who use violence, who are not part of civil society.

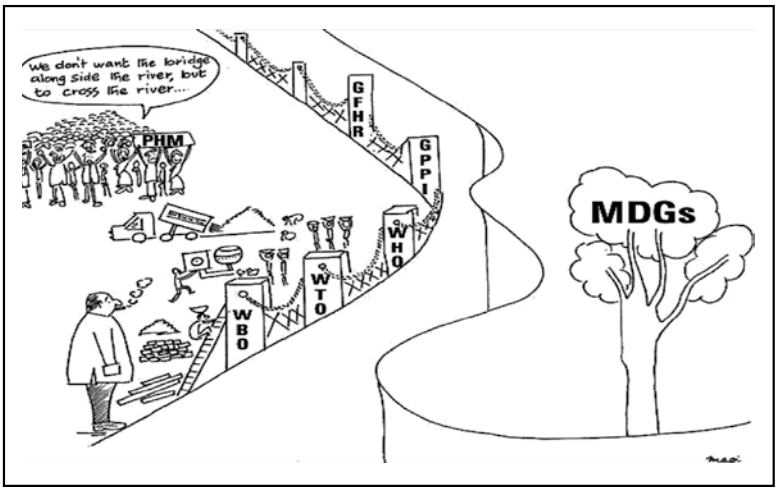
Civil Society includes NGOs (non- governmental organizations) or Volags (voluntary agencies) but is broader in scope. The issue of what constitutes public interest and private interest as well as what constitutes public good is a point of difference, and the terms 'for profit' and 'not for profit' institutions helps to clarify the difference.

UN organizations, national and international organizations and governments at different levels have increasingly recognized the phenomena of civil society. While large numbers of groups, associations, networks and institutions are being brought under this broad based term there is need for caution. There is active cooption of terms and capture of space by industry, business interests as well as political groups of different hues claiming this space.

Three characteristics of emerging civil society are highlighted before moving on more specifically to the roles played in the past decade towards work on Health For ALL, including the recent global discourse on health in all policies**.(13)**

a) **Diversity**: The diversity of civil society is well known. It includes local community based organizations of people, farmers, women, students or socially marginalized groups; and larger health and development institutions/projects that run programmes for clusters of villages and or larger geographical outreach. It also includes trade unions, workers groups and collectives like faith based organizations, associations of professionals -health care providers, teachers, development workers, academic and research institutions - all of which have a focus on communities. It can also include social groups, networks and associations; human rights groups; consumer groups; larger coalitions of farmers and other interest groups such as those with corporate business interests and emerging social movements. It is this diversity that makes their involvement in the policy process complex and confusing. The level of critical social consciousness also varies. The difference between civil society and social movements are increasingly being studied since movements arise from civil society. *A social movement has been defined as 'a form of collective action aimed at social reorganization……..not highly institutionalized but arising from spontaneous social protest directed at specific or widespread grievances'* **(16).** Another description is that social movements generally originate as a spontaneous reaction to a given social, economic, or political situation and may acquire a formal or quasi – formal organizational structure. For the sake of this article civil society and social movements for health and social justice are taken together, representing a growing phenomena of collective pressure and action at community level though processes of critical thought and deeper democratisation.

Health For All and Millennium Development Goals: Who Decides?



b) **Size -** Civil society organizations can be small at local or community level or larger institutions and networks at district, regional, state, or national level; with larger networks and associations at global level. In recent years the evolution of trans-national advocacy networks and coalitions have been a new and significant development. Two of the most well known recent trans-national networks that focus on social justice and health are: i) The People's Health Movement (24) and ii) the World Social Forum.(25)

c) The relationship to Democracy

There has been much analysis and debate on the role of CSO's in global, national and local change. Because of the complexity of CSOs- at least in two dimensions – size and diversity as stated above, many concerns have been raised, and studies on this sector especially applied action research is presently underway. There are concerns about representativeness, values, methodologies used, links to political process or absence of these links; accountability, capacity, transparency and sustainability. An important issue determining the presence and involvement of civil society is the type of political structure. It is largely in democratic social situations, that civil society finds a place and space for development and involvement. There is growing realization that civil society in turn helps to strengthen democracy, increase civic participation, enhancing the role of citizens in governance beyond the more formal political, judicial and state facilitated mechanisms for planning and accountability.

d) Countervailing Power

A study of health policy process in India with the National TB Program as case study between 1994-98 noted that "*there is thus little countervailing power to the strong interests'* (pp 63) namely of the economic interests of the pharmaceutical industry and the medical professional lobby in health policy and practice. **(9)** With debates about the role of the state, the increasing emergence of multi state actors – trans-nationals, and subsequent weakening of state institutions in health, there was a perceived need for a countervailing power supported by people and communities, and especially by those in the community who are marginalized or socially excluded by the current economic, political, social and cultural policies. It is the ability to demand, expand and occupy the space for social justice oriented engagement; to increase voice, negotiations, democratic dialogue in decision making processes; or even press for evidence based discussion; that is becoming the main justification for the salience of the civil society / social movement phenomena in health. This also explains the wide spectrum of the phenomena – with a range of campaigns and movements that have emerged at national and global level. In a civil society report in India in 1998 by the Independent Commission on Health in India (ICHI) SOCHARA contributed an article cited below highlighting the need for such a phenomena as a policy imperative.

Table B shows key global civil society movements from the early 1980s representing the democratic stream within society working to transform societal hierarchies and redress the associated injustices. Spaces have been developed by civil society and social movements while engaging with the socio political system. There was an evolution in India particularly after the 'Phase of Emergency' during the late 1970s when democratic functioning was suspended. This development of civil society was best exemplified by a critical thought current, the Medico Friend Circle (MFC) which celebrated its 40th anniversary in 2014 (www.mfcindia.org).

COUNTERVAILING MOVEMENT

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

Source: SOCHARA, 1998 (26)

These ten high profile initiatives focused on diverse health /social /economic /cultural or political challenges, provide an overview of an emerging countervailing power in global policy making. **(27-29)** Many address specific health related issues, while others are more indirectly related to health. In all of them civil society formations comprised an important element of a countervailing power initiative encouraging, precipitating, provoking, and sustaining change. Taken together they represent the varying potential roles that civil society could play towards Health for All.

Efforts towards social change in health, stimulated by civil society and social movements outlined in the table above have been well documented. The Global Health Watch 3 report of the PHM (29) records this phenomena succinctly by observing *'changed focused strategies deployed by social movements,…… include; practicing differently; policy critique and advocacy; service system reform and development; institutional reform and innovation; delegitimation and inspiration'*. There is much further grey literature together local knowledge and awareness about the myriad local groups addressing locally relevant issues. Much of this is in local languages.

3.3 Understanding processes and pathways of engagement

Policy studies emerged as an academic discipline in the 1950s focusing on the processes and impact of large social policies undertaken by various governments. Different theories and frameworks evolved from linear, rationalist approaches based on sequential understanding of problem, research, policy formulation, research, implementation, output, outcomes, impact, monitoring, evaluation, feedback and correction to more complex, interactive political economy based approaches (Narayan T 1998). State and society centric approaches evolved as did '*critical policy analysis'* and political economy approaches. The complexity of social and health issues

TABLE - B : Illustrative Key Civil Society Movements / Campaigns – 1981-2011		
Year	**Campaign**	**Issues related to Health Developments**
1981	The International Breast Feeding Action Network (IBFAN) (Europe)	Campaign led WHO and UNICEF to establish the international code of marketing of breast milk substitutes (The international code)
2000	First People's Health Assembly, Savar, Bangladesh)	The People's Health Charter adopted and global and country level people's health circles evolve.
1990s onwards	Treatment Action Campaign (TAC) (South Africa)	HIV/AIDS patients win the right to treatment and support in South Africa. This influences the global movement of People Living with HIV-AIDS
	Right to Water campaign, (Bolivia)	People protest successfully against the privatization of water in Cochabamba
2003	*Jan Swasthya Abhiyan* - JSA (PHM India) launched a Right to Health Care Campaign in collaboration with National Human Rights Commission (NHRC)	Right to health hearings and People Health Tribunals (*Jan Sunwais*) resulted in pressure on public health systems to become accountable, and raised awareness of health rights among masses. Led to national action plan to operationalize the Right to Health – jointly drafted by NHRC and JSA.
2003	Anti Iraq war, Global	30 million people in 800 cities joined the campaign against the US led invasion in Iraq (Probably the largest demonstration in history)
2003	Framework Convention Alliance (FCA) and network for accountability of tobacco trans-nations	The Framework Convention on Tobacco Control (FCTC) emerged through this process of civil society pressure.
2004	People's Health Movement India's pre election dialogue	Emergence of the National Rural Health Mission (NRHM) India, including a communitization component. Setting up of the NRHM Advisory Group for Community Action (AGCA)
2007	End Water Poverty	Coalition of Southern and Northern NGO's promoting access to sanitation and water supply as a human right
2010	The Moviemento Ciudadano por la Salud (Citizens movements for health) Guatemala	Part of the Global Right to Health Campaign and working for monitoring and evaluating health, equity, and human rights from citizens perspective. Now part of a Global Community of Practice of similar 'bottom up' approaches in India, Zimbawe, Peru, Uganda, and other countries.

and underlying issues of power and conflict that are intricately linked to iniquitous social relations received greater attention from scholar and activists in later years. (*ibid)* The need for strong social engagement and public participation in health decision making was recognised as a continuing gap 22 year after Alma Ata. (*ibid)*. Efforts have been made to redress this and to

create institutional mechanisms for widespread public participation. The International Poverty and Health Network (IPHN) initiated by the WHO in the late 1990s organized an important global IPHN Conference in Bangalore in late 1999. This was hosted and conducted by the SOCHARA Community Health Cell (CHC) team. An important outcome was a commitment by Indian groups present to participate actively in the first global Peoples' Health Assembly as an alternative to the World Health Assembly where governments represented by Ministers and bureaucrats make crucial decisions impacting on people's health. The People's Health Movement launched in December 2000 introduced the process of giving voice to people in health decision making, taking forward the idea that was implicit in the HFA process. Over the past decade there has been extensive and intensive experience with developing mechanisms for greater public engagement with the public health system across India (66). Proactive engagement with the political process through 'policy briefs' and participation in Task Forces led to development of state health policies as in Karnataka (2004) and Orissa (2003) and to active involvement in the National Rural Health Mission (NRHM) from 2005-12 and beyond **(71,40)**.

The NRHM of India is one of the largest public health programs globally. Mechanisms for community participation through establishing Village Health and Sanitation Committees (VHSC); *Rogi Kalyan Samiti's* (patient welfare societies) and the ASHA program (Accredited Social Health Activist) were introduced on a large scale.**(40)** By early 2014, with 900,000 women ASHAs (one in every village and hamlet) and 500,000 VHSCs comprising 15-25 members each, including local body representatives, there is huge potential for change (see NRHM website). Community based accountability systems also evolved through the NRHM Community Action for Health initiative which includes community based monitoring and planning.**(40)** Provision of untied funds have created space for local decision making.**(*ibid*)** The lessons learnt have been taken forward into the National Health Mission (NHM) for the period 2012-2017 which now also includes the National Urban Health Mission (NUHM).**(69,70)** There are a rich variety of innovations and experiments unfolding though there is variation in different states and villages. These processes of engagement are still work in progress and depend on capacity for informed discussion and dialogue on issues related to health and development. The presence of committed and capable NGOs and CBOs ensures that people's issues are put onto the agenda. The challenge lies in taking the agenda forward into health action which call for additional skills in engagement.

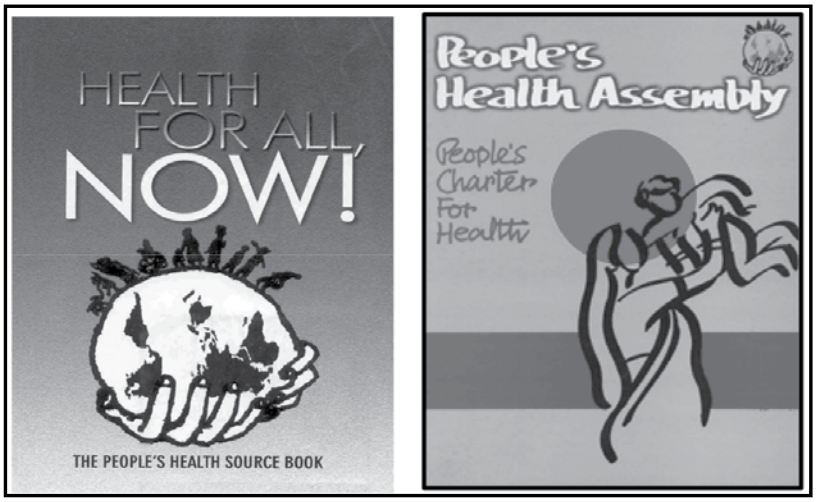
4.

ROLES OF CIVIL SOCIETY - PATHWAYS FOR ENGAGEMENT

Civil society organizations/ and social movements played multiple roles in recent decades to catalyse HFA and CPHC driven policies. It is impossible to make a complete or comprehensive list of the several roles played by civil society in recent decades. Ten key roles (adapted from **34**) illustrative of the diversity are described with relevant examples.

4.1 Representing the voice of the people

Some civil society organizations and social movements see themselves as representing the voice of the people especially the poor, marginalized or socially excluded, as the main role in health action and health policy evolution at various levels. The most well known example in the current global situation is the People's Health Movement **(24**) mentioned earlier which was launched at the first PHA in 2000 which discussed the causes behind the failure to reach the Health for All Goal by 2000 AD, and to explore ways and means to progress in this direction in the new millennium. The People's Charter for Health **(1)** evolved as a response to this global gathering and dialogue with suggestions for action at different levels (Table C).



Over the last decade many country and issue circles of PHM have evolved applying the goals and action points of the charter in national and local contexts. The use of the word 'People' is symbolic and a counter point to language used by government, private sector, academia, and researchers. Participants are involved as informed, concerned citizens with a sense of agency.

4.2 Advocacy and Lobbying

Many civil society organizations and or social movements focus their action on advocacy and lobbying for health systems responses and health policy changes. The best example in recent years was the Treatment Action Campaign, in South Africa**. (28)** This campaign by civil society led to availability of Anti retro viral treatment and access to generic drugs by persons living with HIV-AIDS in the country and beyond. It also had considerable policy influence.

TABLE : C - PEOPLES HEALTH CHARTER 2000 AD with SUGGESTIONS FOR ACTION AT POLICY LEVEL	
THRUST AREA	**POLICY CHALLENGES**
HEALTH AS A HUMAN RIGHT	• Formulate and enforce policies and practices that respect the Right to Health
TACKLING THE BROADER DETERMINANTS OF HEALTH	• Transform WTO to prevent violation of social, environment, economic and health rights • Cancellations of Third World Debt • Agricultural policies that guarantee food security and equitable access
SOCIAL AND POLITICAL CHALLENGES	• Public Health Rights protection in IPR • Taxation of speculative international policies • Health, equity, gender and environmental impact assessment
ENVIRONMENTAL CHALLENGES	• HIA/EIA for development project • Reduction of green house gases • Occupational and health safety policies and legislation • Laws to control bio-piracy of traditional and indigenous knowledge. • Environment and social audit of development projects.
WAR, VIOLENCE, CONFLICT AND NATURAL DISASTER	• Radical transformation of UN Security Council • End sanctions used as instruments of aggression against health of people • Policies for prevention and response to natural disasters • Policy against militarization of humanitarian relief organization
PEOPLE CENTERED HEALTH SECTOR.	• Oppose privatisation and commodification of health care • National drug policies including price control • Patients and consumers right policies • Radical transformation of WHO • Policies for Comprehensive Primary Health Care (CPHC) and Health for All • Policies against privatization of public health services.
Source: People's Charter for Health (1)	

Depending on the nature of the problem and the availability of democratic space for dialogue and engagement this form of engagement can take different shapes, being either participatory and consensual engagement or confrontational and oppositional, but the role is primarily to encourage /provoke the state to change its health policy in response to the needs of the people in general or the specifically affected group. The need for all round change in society and the state and all institutions has been felt over the past 15 years of active engagement as several issues such as gender and caste are deeply socially embedded. While the state leverages change following advocacy by activists, lasting change needs a society wide approach.

4.3 Watch Dog role

Civil Society organizations often gear themselves up to play a watchdog role on health situation, health programs, health policies, by watching, analyzing, and reviewing policies and their implementation in the field. A good example is the Global Health Watch **(27-29)** of the People's Health Movement which every few years in coordination with fraternal organizations, in different parts of the world and academics, researchers, health professionals, and health and development activist watches, by making situation analysis and policy reviews that result in the different global health watches. Since 2000 AD three reports have been published and they are also presented as alternative World Health Reports. The reports usually have four sections focusing on the health care sector; beyond the health care sector; holding to account different, global, multilateral health institutions, and finally resistance and catalysis towards change. This Watch dog role is also now emerging at regional and country level in South America and India. The People's Rural Health Watch **(35)** initiated by the People's Health Movement in India (*Jan Swasthya Abhiyan*) reviews the performance of the Rural Public Health System and analysis the issues arising out of its implementation. Women's groups in India also have a Health Watch which has influenced reproductive health policy. The CommonHealth group works on maternal death reviews through workshops titled 'Dead Women Talking' as part of efforts to improve maternal health and women's health.

4.4 Research and Policy Analysis:

Some civil society initiatives have focused on collecting data and conducting situation analysis and action research studies on a consistent basis focusing on theme such as equity, gender, social exclusion and other themes. Among the best known are the Global Equity Guage Alliance -GEGA **(36)** and EQUINET in Africa. GEGA is a key partner of PHM's Global Health Watch Alliance and GEGA members are spread out in many countries where the focus of equity watch is at national level. EQUINET is the regional network for Equity in East and Southern Africa. In 2012, EQUINET published the Regional Equity Watch **(37)** and has been gradually moving towards producing country level watches as well. The focus of research and policy analysis in all these efforts is on Social Determinants of Health, redistributed health systems, exploration of gaps in social participation, political support and public leadership in health.

In India a well known civil society research group in health is the Maharashtra based Anusandhan Trust run CEHAT – Centre for Enquiry into Health and Allied Themes, which recently has further divided into three focused units under the same trust on issues of Women's Health, Community Action for Health and Medical and Public Health Ethics. **(38)** The environmental and occupational health groups too have developed research enquiries starting with the Bhopal disaster and covering issues of silicosis, mining, pesticides, industrial pollution and now climate change. The work of SOCHARA over the decades on environmental issues including support to research, advocacy and action has been captured in a recent publication. **(77)**

The 2008 Bamako Global Ministerial Forum on strengthening Research for Health, Development and Equity took forward the debates that had taken place through the Commission on Health Research for Development (COHRED) and the Global Forum for Health Research (GFHR) on the need for greater institutional and financial support for research. **(68, 69)** Globally, research priorities and funding have been extremely skewed in the past. COHRED estimated that in 1986 only approximately 5% of spending on health research dealt with problems primarily affecting the poorest.(***ibid***) There is a strong biomedical dominance in health research with the Genome project exemplifying the intracellular focus of efforts. A SOCHARA member was part of the planning committee for the Bamako conference. Twelve civil society groups, including the SOCHARA Centre for Public Health and Equity, launched a Call for greater Civil Society Engagement in Research for Health for All (refer Part 3). **(69)**

4.5 Communication

Civil society and social movements have developed very good publications and education material for popular people's education on health, health systems and health policies to enhance their informed involvement. The People's Health Resource Book in India which brought together five little booklets prepared for public education in India as a buildup to the national health assembly and the first People's Health Assembly are well known**.(39)** Hafldan Mahler the Emeritus Director General of WHO and one of the key architects of the Alma Ata declaration described the booklets as " *the best expressions of primary health care concepts and its politics that I have ever read. They are the bible of the Primary Health Care, a glorious milestone on the tortuous road to Primary Health Care"*. The global PHM has also used communication through the website quite effectively through the PHM exchange which keeps a very large number of health policy activists, health professionals and contacts and associates of the movement on everything that is going on at different levels in system development or policy advocacy and engagement. Many other websites have emerged that communicate the broad philosophy, perspectives and actions at both community and policy level. Some additional examples apart from the People's Health Movement are shown in section 11 on websites and additional information. Some groups are also evolving websites on the Wikipedia framework eg: www.communityhealth.in; and others are using social networking methods to organize social action protests, and various forms of citizen involvement.eg: www.avaaz.org; and www.one.org

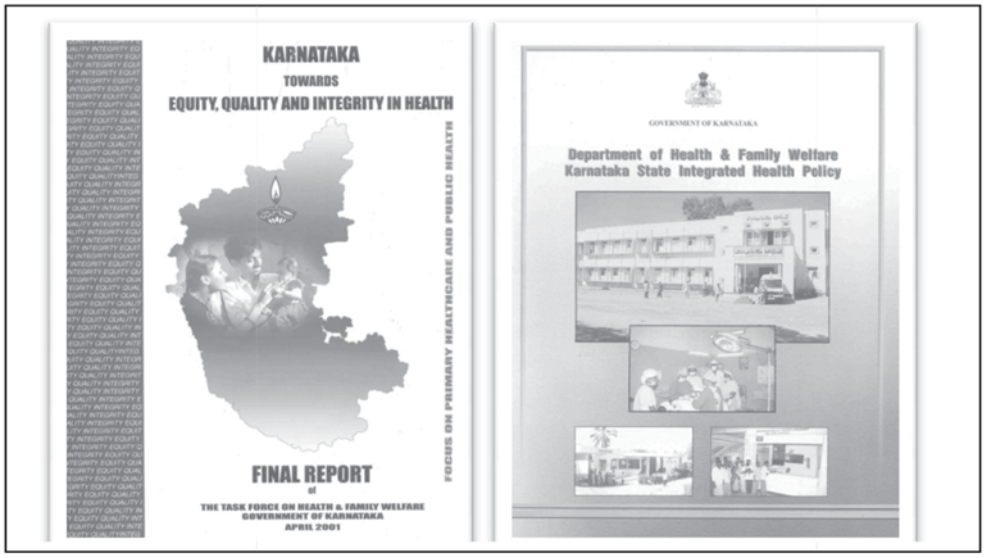
4.6 Participatory governance

In this role civil society actively engaged with health policy processes and public health systems through dialogue, monitoring and evaluation with development of formal mechanisms for participatory governance. Recent examples include the community monitoring of the public health system through the National Rural Health Mission in India developed through the Advisory Group for Community Action with active civil society participation at national, state and local levels**.(40**) While gains have been made from 2007 onwards, resistance has also been experienced. In Thailand through the National Health Act, civil society is formally involved in planning and monitoring through mechanisms such as the National Health Assembly which is an annual gathering of civil society to advice the government on health, equity, and policy issues. **(41**)

4.7 Involvement in multi-sectoral planning

All over the world civil society and or social movement representatives are increasingly being invited to participate in planning, for policy reform, health system development, and evolving responsive health programs and community action. In recent years such civil society involvement has increased in WHO reports and similar exercises (eg: World Health Reports 2008 on Primary Health Care had strong civil society representation **(41).** The WHO Commission on Social Determinants had civil society members as commissioners and in the knowledge networks, and also organized dialogue

with civil society all through the commission process at various levels.**(42)** In India the Planning Commission, Steering Groups on Health and also on Traditional and Complementary Alternative Medicine (locally term AYUSH) and all the ten Task forces of the National Rural Health Mission have had strong civil society representation. These have been multi-stakeholder dialogue and planning processes involving also private sector, academia, researchers, and experts from beyond the health sector. In some states like Karnataka in India mulit-sectoral planning exercises initiated by government have shown phenomenal openness to civil society participation by inviting civil society leadership to convene and facilitate the whole exercise with government, resource persons, being part of the exercise but not necessarily leading it. The two best examples are the Karnataka Task Force on Health and Family Welfare -2001 **(43)** and the recently concluded Mission Group on Public Health of the Karnataka State Knowledge Commission of 2012 **(44).**



4.8 Horizontal and Vertical Networking

Horizontal and vertical networks among civil society organizations and associations to evolve network and coalitions has been increasingly taking place at country, regional and international level to raise awareness and evolve advocacy, campaigning and policy action towards 'Health For All' at all these levels ever since the Alma Ata Declaration 1978. (2) Among the most well known of these networks is an informal circle of health professionals, health and development activists in India – the medico friends circle (mfc), which began pre-Alma Ata in 1974 and has remained an alternative '*thought* current ' and policy advocacy group all these years with its own bulletin and websites. **(45)** The Global People's Health Movement itself arose out of the coalition of 8 international networks that came together to organize the first People's Health Assembly. These were the International People's Health Council; International Organization of Consumer Unions; Asian Community Health Action Network; Third World Network; Women's Global Network for Reproductive Rights; Health Action- International; Dag Hammarskjold Foundation; and Gonoshasthya Kendra. (see section 11 for websites) All these evolved at

regional and global level in the period 1978 to 2000. In 2000 AD, in India initially 18 and later 23 national networks and resource centres came together to form the PHM India . The processes stimulated by the People's Health Movement at country level in many parts of the world and at state level in countries like India are good examples of such networking. (14)

Another such process of networking has been the annual World Social Forum (WSF) and the Regional and National Forum associated with the process initiated in Porto Allegre which has brought together social movements and networks to dialogue around global and national issues. (25) Most of these annual events also have health oriented groups, networks, and movements coming together to discuss share and dialogue around emerging health challenges at various levels. One such key health fora linked to the WSF process took place in Mumbai in 2004 when the WSF process moved for the first time from Brazil to India and the well known Mumbai declaration **(46)** was one of the definitive outputs of this significant gathering of health activists.

4.9 Building Capacity of Civil Society

Civil society organizations have evolved various capacity building strategies to build knowledge skills and attitudes among health and development activists to understand the health situation and challenges and be involved in advocating health in all policies. The International People's Health University of the People's Health Movement which runs courses on Health Equity and Globalization in all parts of the world in many languages for public health professionals and health and development activists and action initiators is a good example of this. At the national level a good example is the community health fellowships offered by SOCHARA in India which includes the one year community health learning program and the two year community health fellowship program for young professionals from multidisciplinary backgrounds. (see section 11 for websites)

4.10 Campaigns and Movements on Specific Health Problems

Civil society and social movements all over the world and at various levels – local, national, regional, and global have focused on campaigns and policy action around specific health themes, special groups and issues of concern, such as – HIV AIDS, Street Children, Mental Health, Rational Drug Policy, People with Disability, Elderly, Child labour, Sexual minorities, Women's Health, Child Rights, etc. Three of the most well known campaigns have been the Treatment Action Campaign (TAC) in South Africa; The Campaign Against displacement by dams (*Narmada Bachao Andolan*) in India and the Right to Water Campaign in Bolivia. (27-29)

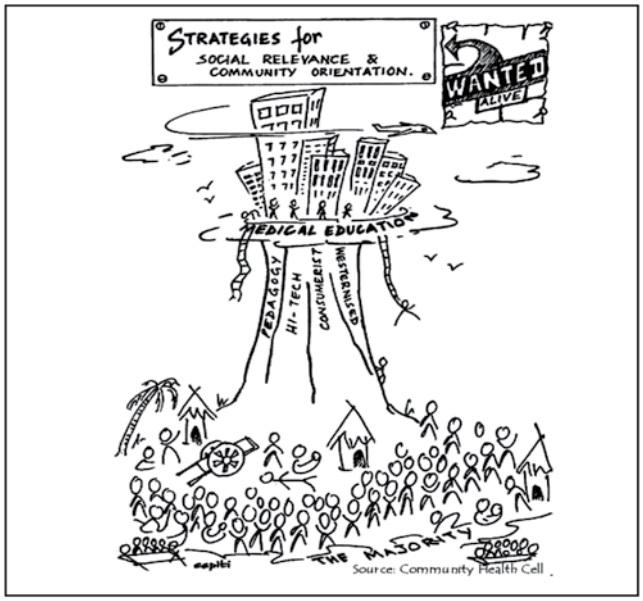
Among the larger international networks the IBFAN (International Breast Feeding Action Network working towards the International Code of breast milk substitutes; and WGNRR (Women's Global Network on Reproductive Rights) are significant examples. (27-29)

Over the last two decades, many civil society organizations and networks have begun to play one or more of these above ten roles as they engage with the process of health in all policies.

In Table D the experience of SOCHARA – India, a Community Health Resource Group, in playing all these 10 roles in the Indian situation at various levels – District, State and National levels are enumerated.(see section 11 for websites) SOCHARA is also one of the key groups that initiated dialogue on the concept of countervailing power, (26) described earlier and social vaccines and communitization, described later in the paper.

4.11 Roles – A case study: Society for Community Health Awareness, Research and Action (see table D)

Over the thirty year experience of the Community Health Cell (CHC) and SOCHARA there has been a realization that there are multiple streams and approaches that feed into the Health for ALL movement in India, and globally. In a document titled "*Community Health: The Search for Alternative Processes"* (CHC 1987, SOCHARA 2011) the postulates of a community health approach were articulated as ten axioms. Community health was understood '*as a process of enabling people to exercise collectively their responsibility to their own health and to demand health as their right'* (*ibid, pp 44-48).* The need for a new vision, a new value system and a perspective to shift from the prevailing over-medicalised model of health was articulated and acted upon consistently over three decades. The need for a paradigm shift to a social and societal paradigm was clearly articulated and promoted through training programmes, research and in all community health initiatives the group has undertaken, catalysed or been associated with. The concept of a '*community health movement'* was articulated in the 1980s and work started in this phase itself through active networking among a range of organizations, groups and individuals. The Bhopal industrial disaster, the worst in the world, brought together a larger section of society to respond to the health and related aspects of the affected communities. The Medico Friend Circle (MFC) played an important role as a '*thought current'* that facilitated a response at various levels in Bhopal from undertaking community based studies, bringing findings into the public domain, creating popular education booklets in Hindi for local communities, engaging with the government and NGOs as well as with the Indian Council of Medical Research (ICMR) (Vishwanathan & Kothari, 1985, MFC Bulletins). This experience led community health practitioners and activists to the study and use of epidemiology in a community and societal context.**(8)** There has been substantial work undertaken by the team at various levels through the conduct of teaching learning programs; research and policy analysis; community based work; active participation in the health movement (Table D). **(66)** The small



team adopted a catalyst role and through the Community Health Cell (CHC), the Centre for Public Health and Equity (CPHE), the School of Public Health, Equity and Action (SOPHEA) and the Community Health Library and Information Centre (CLIC) link with a number of like minded organizations through a process of solidarity, promoting the Health for All goal.

Table- D: Roles played by SOCHARA – India (1984-2013)	
ROLES	**INITIATIVES/ PROGRAMMES**
1. Representing the voice of the people	Participation in the evolution and facilitation of global and country circles of PHM • PHM Global : • PHM India (JSA) ; • PHM Karnataka (JAAK) • PHM Tamilnadu (MNI) • Also supported PHM circles in Pakistan, Srilanka, UK, Germany, USA, Kenya, etc
2. Advocacy and Lobbying	Campaigns have been facilitated and supported over the years on many themes, particularly : • Bhopal Disaster aftermath • Malaria – bio environmental control • Anti Tobacco Campaign etc
3. Research & Policy Analysis	Significant studies/ evaluation include • Social relevance and community orientation of medical education. • Evaluation of CHW (JSR) program in Madhya Pradesh • Evaluation of SHRC and Mitanin program, Chattisgarh • Health Policy Delphi - 1992 and evaluation of CHAI
	• Study of policy process and implementation with the National TB program • Study of global public private partnerships with WEMOS • Study of comprehensive primary health care with the Teasdale Corti group
4. Watch Dog Role	Participated in Global Health Watch- I, II, III
5. Communication Strategies	Facilitation of: www.communityhealth.in www.phmovement.org www.phm-india.org
6. Horizontal Governance Mechanisms – Engagement with state program	Community Monitoring in partnership with Tamilnadu – NRHM (National Rural Health Mission)

7. Involvement in multilevel governance mechanism – participation in multi-stakeholder committees and task forces.	Karnataka State Task Force in Health and Family Welfare (1999-2002) ▸ NRHM Task Forces (2005 onwards) - Indian Public Health Standards - ASHA Mentoring Group - Medical Education - Advisory Group for Community Action ▸ Plannning Commission Steering Groups - Primary Health Care - AYUSH (TCAM) and Public Health ▸ Karnataka Knowledge Commission - Mission Group on Public Health
8. Networking	Apart from PHM at different levels – also facilitated - Drug Action Forum Karnataka (DAF-K) - Consortium for a Tobacco Free Karnataka (CFTFK) - CHESS Network community health environment skillshare
9. Capacity building and teaching learning programs in community health.	State Level: - Women's Health Empowerment Training - Health for Non Health Groups National Level - Community Health and Environment Skill Shares for environmental activists - Community Health Fellowships and Learning programs for young professionals from different disciplines
10. Campaign on specific health issues	Many campaigns including : - Anti tobacco campaign - Bhopal disaster and Environmental health hazards - Bio Environmental control for Malaria - Patent and Intellectual Property Rights (IPR) issues etc
Source: 35	

5.

INNOVATIVE INSTRUMENTS OF ENGAGEMENT

An overview of roles played by civil society and social movements in the engagement towards catalyzing Health for All helped identify key innovative instruments of engagements, six of which are mentioned below:

5.1 Social Watches

The idea of monitoring and analyzing closely the emerging trends in situation analysis, data, statistics, and performance outputs and impacts by civil society groups outside the formal public health system, at all levels has been gaining ground over the years, providing space and opportunity for trend analysis and comment which is different from the official reports. The Global Health Watch of the People's Health Movement which is brought out every few years as an alternative World Health Report has been described earlier. (27-29) At regional level with a focus particularly on Africa, the EQUINET (37) and the Global Equity Gauge Alliance (36) has also been mentioned earlier. At a country level a good example of a Watch is the People's

Rural Health Watch which is a civil society monitor the National Rural Health Mission in India. (38) and The most innovative website that has been developed based on access to health and development data and indices from UN sources is 'Gapminder' which focuses primarily on Equity and related trends between regions and country. Today it has become a major teaching and training tool as well. (39)

5.2 Peoples Tribunals / Citizen Juries

Another instrument of engagement which has been developed in many regions by civil society, is the idea of people's tribunals and right to health hearings. In this innovation an informal jury of legal officials is setup and representatives of the community or patients/citizens at large are invited to share their experiences of the health services and programs, in the presence of health and development officials of the Government. This platform provides people opportunity to air their concerns and invites government officials to respond to the concerns and issues raised in generic ways. In India the Right to Health hearings organized by the People's Health Movement at regional and national level in collaboration with the National Human Rights Commission are good example of this approach.

A people's tribunal on the World Bank Policies in Health and Development has also been organized. In some countries these are also called citizen juries. In recent years the National Rural Health Mission strategy document has internalized this instrument providing space for *Jan Sunwai's* (people's hearings) (40) The Ministry of Environment in India has also recently included this instrument in the Health and Environmental impact assessment (HIA and EIA) which is mandated as part of emerging state and national environmental policy to mitigate the health and development hazards of unplanned development, migration and displacement . As part of this process the local community is also invited to assess the needs and the plans in a process of participatory planning .

5.3 Health Assemblies

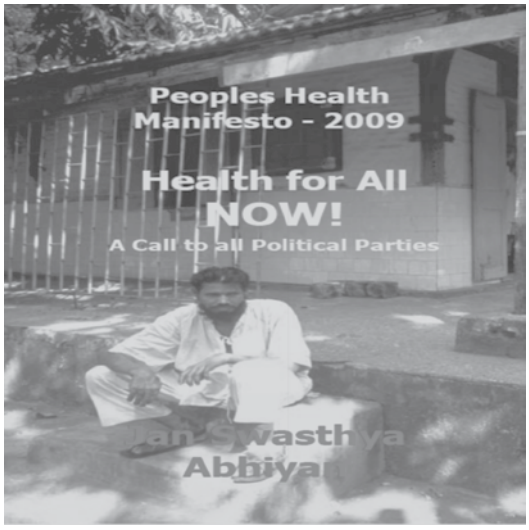
In the last decade regular, often annual assemblies of health and development activists have been organized at state level, country level, and internationally to bring civil society and social movement representatives together to share experiences, analyse the impact of campaigns and plan strategies locally, nationally, and globally in a spirit of solidarity. The most significant of such assemblies had been the people's health assemblies organized by the people's health movement in Savar Bangladesh, 2000 AD; in Cuenca, Ecuador in 2005 and in Capetown South Africa in 2012 leading to the People's Charter for Health, the Cuenca declaration and the Capetown statement. (1,24) Additionally the well known World Social Forum (WSF) process started in Porto Allegre Brazil which has also developed into country level, regional and global annual for a has included health as a key theme within the forum and often also as a satellite activity leading to various consensus declarations and documents. (25) The Mumbai declaration of 2004 which evolved from the international health forum associated with WSF, Mumbai 2004 is well known**.(41)**

5.4 Campaign Innovations

Campaigns have always been the sheet anchor of civil society action on health issues. Starting from the orthodox trade union type of protest /solidarity marches – the so called red flag demonstrations, campaigns have begun to innovate other forms of expressions of solidarity including human chains, candle light vigils, and in many parts of Latin America into all sorts of carnival oriented aspects which helps to innovate a new culture of protest and solidarity through music, street theatre, and other art forms. Groups like Green peace have taken this further through various forms of symbolic and creative action to get the message to decision makers and policy makers.

5.5 Health Manifesto's

As part of the political process it is not uncommon for civil society and social movement groups to dialogue with formal political parties before state and national elections. This has been going on for years with different civil society organizations raising issues and facilitating dialogue with different groups. However with increasing recognition that Health in All Policies requires also the All for Health approach and the evidence that Health for All requires action on Social, Economic, Political and Cultural determinants that go far beyond ideologically determined action, there is increasing effort to evolve health manifesto's, policy briefs, and charters that are then distributed to all political parties with a message that Health is too important to be left to one group or the other. This approach which has now begun to be applied by the People's Health Movement in India by the development of a Health Policy news brief in 2004 before the national elections and a people's health manifesto in 2009 before the national election has begun to increase the importance of health on the political agenda of the country. (42) In 2004 the process contributed along with other factors to the reorientation of the emerging National Rural Health Mission towards the policy of communitization even more emphatically, which was sustained by civil society participation in task forces and advisory groups of NRHM. This trend has now begun to emerge at state and district level before elections at this level. It is too early to demonstrate the impact but perhaps the increasing public dialogue on universal health care in the country is at least one obvious impact of such engagement. (40) The JSA developed a Health Manifesto in February – March 2014 prior to the General Elections in April- May 2014.**(76)** This was disseminated to political parties and movements. A meeting with political parties was organized. Four parties have significant sections in their manifesto's on health, with a major party placing the Right to Health as its top most priority!



5.6 Health Policy Processes

Sustained policy engagement and dialogue – whether as critical constructive engagement; oppositional and confrontational; or in consensus development mode are process instruments which are recognized and used as increasingly effective tools. The processes by which various strong interests in health influence health policy process in any country operate, are only more recently being studied, scrutinized, interrogated and engaged with**. (9, 48)** The evolution of the National Rural Health Mission in India; community monitoring and community action for health in the NRHM; in Thailand the National Health Act and National Health Assembly **(27)** and the changes in distorted childhood immunization policies in the state of Tamilnadu in India are examples of sustained processes in three very different contexts and levels. The World Health Report 2008 on Primary Health Care records the role of civil society and social movements in its section on 'Mobilizing the Communities' by recognizing these experiences and instruments of engagement in India, Bangladesh, Chile, Western Europe and Mali, demonstrating that this is now an increasing global trend. **(43)**

6.

EMERGING CONCEPTS AND PARADIGMS

An overview of the roles of civil society and social movements in catalyzing Health For All related community and policy action undertaken as background for this paper, led to the recognition of certain emerging new concepts and paradigms in health systems developments. These need to be understood by policy makers, public health academics, researchers and service providers, for the role of civil society and social movements and their related charters, declarations and formulations to be appreciated in the right context. Though there are many new ideas, just four are presented here. They are selected because they have been presented in international forums and or peer reviewed journals and publications.

6.1 The Paradigm Shift

Public health systems, health projects and programmes have most often been constructed in a narrow bio-medicalised framework, with a focus on disease rather than health and well being, despite the 1948 WHO definition which tried to shift focus to all aspects of well being – physical, mental and social. The Alma Ata declaration began a new approach by shifting the focus to social justice, equity, social development and rights. Civil society and social movements have tried to take this forward with limited success because the biomedical paradigm is so deeply entrenched. At the Global Forum for Health Research this paradigm was presented in greater detail to shift the bio-medical pre-occupation in all aspects of health systems – structure, focus, dimensions, technology, type of service, link with people and research (44).

New Public Health Epidemiology : The Paradigm Shift (Source 44)		
Approach	**Biomedical Model**	**Social /Community Model**
Focus	**Individual**	**Community**
Dimensions	**Physical/ Pathological**	**Psychosocial, Cultural, Economic, Political, Ecological**
Technology	**Drugs /Vaccines**	**Education and Social Processes**
Type of Service	**Providing / Dependence Creating/Social Marketing**	**Enabling /Empowering / Autonomy building**
Link with people	**Patient as Passive Beneficiary**	**Community as active participant**
Research	**Molecular Biology** **Pharmaco- therapeutics** **Clinical Epidemiology**	**Socio-epidemiology, Social Determinants, Health Systems, and Social policy**

This paradigm shift must be appreciated by policy makers if social justice in health through health in all policies is to become a reality. They must be encouraged to appreciate the seven shifts **(45)**

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

- A shift in structure from institutional based (hospital and health centric) work to community based and led approaches.

A beginning has been made in the WHO SEARO region, which brought together epidemiologists from the region to discuss 'Application of Epidemiological Principles for Public Health Action'. In the conclusion of the meeting the participants recommended – ***'the scope and reach of epidemiology, which is an integral part of public health, must be expanded to include the study of social, cultural, and constitute the keystone for use of evidence for development of public health policy…..such an approach will help in moving beyond health problems per se to new complex social and human developmental challenges such as the current crisis and threat to public health posed by the global financial meltdown and climate change'.(46)***

"Globalization of Health Solidarity from below"
(Academics describe civil society engagement with policy)

This movement is engaged in what amounts to 'globalization from below' as it builds support for its global 'Health For All Now' strategy, lobbies at the global level and mobilizes a grassroots based campaign to realize the vision and achieve the goals of the People's Charter for Health." (47)

The simultaneous rise of a global civil society movement pressing for political actions to shift the rules of contemporary globalization is significant (People's health movement et al 2005) (48)

A strong voice in the global health debate for free primary health care is the people's health movement which in 2000, presented the Peoples Health Charter. The charter argues strongly for a publicly financed health services and for development policies that favours health.... (49)

Recognizes the movements role in evolving the new health and human rights approach to Primary Health Care – with the necessity of tackling the broader social and political determinants of health (50)

6.2 'Globalization of Health Solidarity from Below'

Evidence from the global south and north countries increasingly point to the negative effects of the present models of globalization and the economic, political and social priorities encouraged by it, on health of people, health care, health systems, health equity and health policy. In all these situations health inequity seems to be increasing within and between countries. (27-29) Academics have described these policies as not only being prescriptive but also thrust from the top through the agency of international organizations, global partnerships and centralized national level planning processes. The resistance from people and communities to the globalization of ill health and inequity is described as a **'globalization of health solidarity from below' (47-50)**. See below for some of these descriptions).

6.3 'Social Vaccine'

The term social vaccine has been suggested as a new term to be adopted by the health promotion and health policy community 'to encourage the bio-medically orientated health sector to recognize legitimacy of action on the distal social, economic and determinants of health. Social vaccine would be promoted as a means to encourage popular mobilization and advocacy to change

the social and economic structural conditions that render people and communities vulnerable to disease' **(51,52**). There is urgent need to increase policy and health systems research on these larger social, economic, political and cultural parameters that influence health and social change. Social vaccines require more research to improve our understanding of the social and political processes likely to improve health equity worldwide. Compared with the resources invested in researching vaccines for just a single disease, the investment in research relevant to providing evidence for and testing social vaccine has been minimal **(53).**

6.4 Communitization

The term **'community participation'** was included in the Alma Ata declaration of 1978 as one of the key principles of the Health For All movement which it sought to promote at all levels. (2) The declaration mentions that primary health care **'requires and promotes maximum community and individual self reliance and participation in the planning, organization, cooperation and control of primary health care, making fullest use of local, national and other available resources and to this end develops through appropriate education the ability of communities to participate'**. Over the years civil society, and some governments efforts at primary health care all over the world have experimented and studied the phenomena of community involvement and participation in various ways. More recently this whole process of community involvement which now involves participation at all level, processes and stages – from planning, managing, monitoring and evaluating is becoming formalized in some primary health care strategy and public health systems. In the National Rural Health Mission of India, one of the world largest primary health care programmes, initiated in 2005 the new term '**Communitization'** to describe the institutionalizing and scaling up of community led action for health has been a major gain due to civil society pressure and NGO and state level experimentation.(40) Communitization now includes the village Health and Sanitation Committees, the selection and training of social health activists, the involvement of local self government and community based organizations, the availability of funds at community level to be utilized by local community discretion, a formalized method of community monitoring and planning for action in health and even a system of periodic peoples hearings (*Jan Sunwai or Jan Samvad*) at various levels to empower community members to engage in giving direct feedback and suggestions for improvement of public health services. It is now urgent to bring health systems research efforts to focus on this newest element of public health systems and promote more focused action research / participatory research at this inter face between the community and health systems (**54,55**). Recently a global network of Community of Practice on Accountability and Social Action in Health has emerged bringing communitization enthusiasts, innovators and researchers from many countries including India, Kenya, Zimbawe, Peru, Guatemala and others together to share experience and build effort into sustained community health and policy action. (see www.copasah.net)

7.

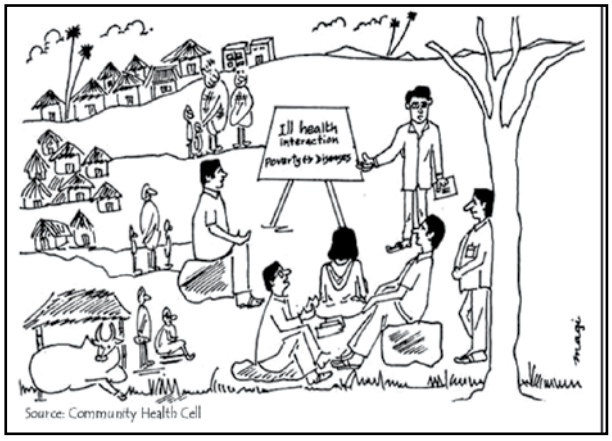
APPRECIATING THE DEEPER DETERMINANTS OF HEALTH AND SOCIAL CHANGE - 'SEPCE ANALYSIS'

In the 1980's two well known public health professionals, from the global South and North respectively first described the need for a new socio-epidemiological paradigm for health system development, health policy, and health research. Prof. D.Banerji of Jawaharlal Nehru University (JNU), New Delhi, researched 17 villages over time, visiting them year after year to understand community experiences and their views about health and health services, concluding that ***"Health service development is a socio-cultural processes, a political processes, a technology, and managerial process, with an epidemiological and sociological perspective."*** **(5)** Similarly Prof. Geoffrey Ross, at the London School of Hygiene and Tropical Medicine, Professor of Epidemiology, well known for his work on salt and hypertension wrote a book in which he stated ***"the primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social……. medicine and politics cannot and should not be kept apart.***'" **(7)** Inspired by both these academics many health researchers including those of us in SOCHARA often also linked to civil society and social movements have explored the social, economic, political, cultural and ecological determinants of health to get a deeper understanding of health challenges going beyond the orthodox bio-medical, techno-managerial framework**. Inequality, poverty, exploitation, violence and injustice are at the root (45)** The People's Health Charter **(1)** emphasizes this new understanding when it reiterates in its preamble

> ***"Health is a social, economic, and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill health and deaths of poor and marginalized people. Health For All means that powerful interests have to be challenged….. and that political and economic priorities have to be drastically changed."***

We would like to suggest in this paper that this is a new paradigm of public health and health systems policy research which will be at the core of our new efforts to bring health in all policies and promote the health for all goal. In a meeting of epidemiologists, in the WHO-SEARO region this new understanding has been accepted as the way forward. A consultation on the application of epidemiological principles for public health action in 2009, mentions in its final recommendation that:

'The scope and reach of epidemiology which is an integral part of public health must be expanded to include the study of the social, cultural, economic, ecological and political determinants of health and constitute the key stone for use of evidence for development of public health policy…… Such an approach will help in moving beyond health problems per se to new complex social and human development challenges such as the current crisis and threat to public health, posed by the global financial meltdown and climate change' (46)



In the way ahead our efforts towards Health For All in partnership with various sectors and engaging with civil society and social movements (as the countervailing power of health solidarity from below) must internalise the understanding of new paradigms; 'social justice in Health'; communitization; and 'sepce analysis'. Only then will we begin to move in a sustained manner towards the Health for All goal.

8.

IN CONCLUSION: THE WAY FORWARD

The Alma Ata Declaration,1978; People's Charter for Health, 2000; Bamako Ministerial Forum for Health, Equity and Development 2008; WHO CSDH Report 2008; Rio Declaration, 2011; and Helsinki Declaration, 2013 have covered conceptual ground, shifted paradigms as well as created greater consensus with new inclusive alliances in the journey towards Health For ALL. A large number of young voices have been included. New social arrangements and institutional mechanisms are evolving. While gains have been made, significant, unacceptable gaps continue on the ground, with the social majority still without adequate power or voice and with health indicators telling their own tale. Health disparities have widened and social exclusion and vulnerabilities continue. Social injustice shows a resilience and resistance to change. New challenges have emerged and deepened such as climate change and ecological damage with adverse effects on all, but most particularly the impoverished. This is a time as never before for a gathering together of forces for justice in health and development with peace, reconciliation and solidarity. There is need for multiple players, using multiple pathways, to recognize fellow travelers in the journey towards HFA. A significant player, sector and partner in the collective society-wide efforts towards realizing HFA is civil society and the social movements in health. They are increasingly becoming a countervailing power, embodying a process of health solidarity from below to keep national and

global efforts alive working energetically towards realizing health rights, health equity and social justice. Together with governments a difference can be made.

Recent WHO policy documents note the important role of civil society and social movements in revitalizing comprehensive primary health care and acting on the social determinants of health. Statements drawn from the most significant documents in the last decade – the World Health Report (WHR) 2008; Report of the Bamako global ministerial forum for Research in Health 2008; and Report of the WHO Commission on Social Determinants of Health (CSDH) 2008 (43,58) clearly emphasize a recognition at the highest level of the countervailing power of civil society and their crucial and significant role in the journey towards Health For All.

> An extract from the WHR 2008 (43) highlighting the importance of civil society mobilization, notes ***"The history of the politics of the PHC reform in the countries that have made major strides is largely unwritten. It is clear however where these reform have been successful, the endorsement of the PHC by the health sector and by the political word has invariably followed on rising demand and pressure expressed by civil society……..There is an important lesson there; powerful allies for PHC reform are to be found within civil society. They can make the difference between a well-intentioned but short – lived attempt and successful and sustained reform; and between a purely technical initiative and one that is endorsed by the political word and enjoys social consensus."***
>
> Another extract from the WHO CSDH report, 2008 (58) emphasizes civil society as champions of health equity, ***"As community members, grassroot advocates, service and programme providers, and performance monitors, civil society actors from the global to local level constitute a vital bridge between policies and plans and reality of change and improvement in the lives of all. Helping to organize and promote diverse voices across different community, civil society can be a powerful champion of health equity."***

We conclude with key questions, based on a premise that there is willingness to change:

- Can we move from policy statements to strengthening health systems with social mobilization and health action through creation of mechanisms for active participation by communities, civil society and social movements with the health sector?
- Can the entire health sector including research be oriented to primary health care, social justice and integrity?
- Are we ready to engage with civil society and social movements creating spaces for dialogue and engagement that will enable them to play different roles and use innovative methods of dialogue, exchange of information and ideas?
- Can there be indicators of progress regarding addressing the deeper social, economic, cultural, political, and ecological determinants of health, that act as obstacles to our efforts towards Health For All?

The progress and success of efforts in moving towards the Health for ALL goal will depend on the commitment to a process of wide societal engagement to address the underlying health determinants and to strengthening the health system. The evidence is there – will policy action and practice on the ground, together with social and personal action follow?

"The Meaning of Health for All"

- ***"Health for All " is a holistic concept calling for efforts in agriculture, industry, education, housing and communications just as much as in the medicine and public health…….***
- ***Health of the poor is largely the result of a combination of unemployment, poverty, level of education, poor housing, sanitation, malnutrition, and lack of the will and initiative to make changes for the better……***
- ***People must grasp that ill health is not inevitable and that to bring about better health account must be taken of a number of factors of a political, economic, social, cultural, environmental and biological nature strengthened by this understanding. People will be in a better position to exploit these factors that are favorable to health and to combat those that are detrimental…….***
- ***Such involvement requires communities to assume greater responsibilities in defining their needs, identifying solutions, mobilizing local resources, and developing the necessary local organizations…….***
- ***Such community involvement can be instrumental in bringing about the commitment of community leaders to support the health reforms required and through them it can stimulate the political commitment of the government to introduce and sustain these reforms……..."***

Source: Halfdan Mahler (61)

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i) Gapminder : www.gapminder.org
j) Community of Practice on Accountability and Social Action in Health: www.copasah.net
h) Society for Community Health Awareness, Research and Action: www.sochara.org

[This article has modified, expanded and built on a paper for the 8th Global Health Promotion Conference in Helsinki in 2013]

Part – II

“SOCIAL JUSTICE IN HEALTH & UNIVERSAL HEALTH COVERAGE - CHALLENGES, POSSIBILITIES AND PATHWAYS”

9.

"Social Justice in Health & Universal Health Coverage - Challenges, Possibilities and Pathways"

organised by SOCHARA on 10th and 11th of September, 2013

Venue: St John's Medical College, Bangalore, India

Report of the Workshop

Background to the workshop:

"Social Justice in Health: Research, Advocacy, Training and Action on Realizing Health Rights" is an initiative that builds on the history of the Community Health Cell from 1984 and of SOCHARA from 1991. It aspires to strengthen efforts towards realizing the global social goal of "Health for All" (HFA) first articulated in the Alma Ata Conference of 1978. A historical and contextual approach is being adopted in this initiative which has research, documentation and communication/ dissemination dimensions. SOCHARA as part of its commitment of supporting the health movement has embarked on a process of critical reflection of the movement in an effort to distil from our collective experiences lessons that we may take forward in our struggle for health. The group is reflecting on multiple pathways that contribute to the realization of inter-connected rights that lead towards the HFA goal. This national level workshop was conducted as a part of the initiative where participants reflected in depth on the collective experience and charted out possible directions for the future.

The deliberations included both theoretical and historical reflective discussions, as well as a focus on certain specific themes such as urban health, mental health, environmental health and privatization of health care which were otherwise inadequately reflected in the current UHC debate. The multiple approaches and pathways that have been used to address the social determinants of health in different parts of the country were discussed, and provided a framework for initiatives and action at several levels from individuals to families, communities and at a larger policy level. The participants, stating that this was a positive, useful experience, are keen to work with others in the field towards Health for All.

DAY 1

Introduction session

After a brief welcome by Mr Chander, SOCHARA, and an interesting session of introductions facilitated by Dr. Magimai Pragasam, Dr. Thelma Narayan, Director SOCHARA- SOPHEA in a brief introduction to the workshop stated that social justice is a concept linked to fairness and opportunity, It is a very old and deep quest that has moved people across the centuries through approaches such as spirituality, philosophy, ethics, governance, development, politics, social movements and evolving social arrangements. The debate on Universal Health Coverage (UHC), should keep social justice in health at the heart of its strategic thinking. UHC needs leadership from the bottom up, with democratisation of the health system and mechanisms for widespread public participation in health decision making. A comprehensive primary health care approach to health system strengthening will lead to the social goal of "Health for All". Keeping this social goal in mind, she stated that this is the time for critical reflection on the multiple pathways that have evolved over decades in achieving this goal. This includes a reflection on the roles played by the state, the voluntary sector, social movements, private enterprises and communities and how each relates to each other and community health. She emphasized the importance of understanding disagreements and conflicts between these groups, and the need for working together. The need for greater focus on neglected themes of mental health, urban health, environmental health and privatization of healthcare was also stressed. Encouraging active participation in the workshop, she urged the delegates to identify opportunities to work together and to bring social justice and determinants into each one's institutional agenda.

Following a brief and enjoyable cultural programme by SOCHARA fellows, Dr. M K Vasundhara, President, SOCHARA addressed the gathering and encouraged participants to work together for social justice using anecdotes from her experience and other stories.

Technical session 1: 'Towards Social Justice in Health and Universal Health Coverage' – a Contextual Overview

Facilitator: Dr. Mohan Isaac; Speaker: Dr Ravi Narayan

Respondents: Dr. Chandra, Chennai; Dr. Naveen Thomas

Key issues and challenges discussed:

- While "Health for All" continues to be a priority/challenge for all countries as witnessed by the WHO 8th Global Conference on Health Promotion at Helsinki in July 2013, and the Rio Political Declaration 2012 civil society and social movements are emerging as a countervailing power to existing mechanisms. This power is expressed through various instruments of engagement which include health watches, tribunals and public hearings, health manifestos and charters, creative and innovative campaigns and other initiatives.
- Two important issues discussed at the WHO Conference which became a part of the Helsinki Declaration were -

- It is time for healthcare innovators and governments to pay heed to and engage with civil society and social movements
- When the private sector is involved in "Health for All" there is a conflict of interest. Unless there are guards against these conflicts of interests, partnerships with HFA and social justice become difficult.

- All over the world there is proof of a Global Crisis. Neoliberal economic reforms, corporate led globalization have resulted in economic and other related crises which affect health too. The corporate sector is looking for government dole and tax payers money now. Poverty is increasing not only in the developing/under-developed countries but even in developed nations like Britain and several countries in Europe.
- The WHO Commission of Social Determinants of Health (2008) says –

- "Social Injustice is killing on a grand scale"
- "There is a toxic combination today in the world, of poor social policies and programs, unfair economic arrangements and bad politics"

- We need to move to distributive economics from growth economics.
- India, a signatory of the Alma Ata Declaration is slowly moving towards Universal Health Coverage in the 12th Plan. The Bhore Committee in 1946 reflected the same core principles as the Alma Ata Declaration. Three important policy initiatives have evolved with the People's Health Movement (PHM) and Jan Swasthya Abhiyan (JSA) playing the role of a countervailing power:

- In 2004, around 300 Jan Swasthya Abhiyan activists sat together with the whole spectrum of political parties in Delhi as a pre-election strategy discussing a policy brief and orienting the manifesto writers to the challenges of 'Health for All' in India. The coalition government that formed subsequently introduced some of these ideas into the common minimum programme which later resulted in the evolution of a more comprehensive National Rural Health Mission (NRHM). The government invited many of the PHM/JSA activists as advisors into the task forces that guided the NRHM process. There were other factors which also contributed to this, but the '*communitization'* element was largely inspired by this engagement.
- Similarly, the PHM-WHO advocacy circle engaged with delegates during every World Health Assembly after 2000 AD bringing evidence based pressure on the WHO to rediscover

comprehensive primary health care. PHM activists were invited to present the People's Charter for Health in the assembly, take in-house seminars and finally also participated in the planning and the review of the World Health Report 2008 –'Primary Health Care: Now More Than Ever'.

- The WHO Commission on Social Determinants of Health (CSDH) also saw a strong engagement with civil society all over the world including the PHM. One of the commissioners was invited from PHM. PHM members were part of WHO CSDH Knowledge Networks. The PHM facilitated civil society dialogue in different regions of the world and also wrote an alternative report to provoke the commission in a spirit of dialogue.

• *Health for All - An Alternative Strategy*, 1981 a joint publication by the Indian Council of Medical Research (ICMR) and the Indian Council of Social Science Research (ICSSR) that inspired SOCHARA in the 1980s was quoted. Its recommendations, given below, need to be considered while working towards universal health coverage:

- "Reduce poverty and inequality and spread education;
- Organize the poor and underprivileged to fight for their basic rights;
- Move away from counterproductive western model of healthcare and replace it by alternatives in the community;
- Provide community health volunteers with special skills and ability to see health as a social function."

• New emerging terminology – The concept of "Solidarity" (prevalent in Latin America) is now being taken up across the world. Apart from a role as academicians, researchers and activists, people also have a role as citizens to express social solidarity towards others.

• The time has come for forces at all levels - civil society, governments, social movements to come together, as previous efforts which were fragmented or ad hoc could not make "Health for All" a reality.

• ***Quoting Professor Geoffrey Rose - "The primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social. Medicine and politics must not be kept apart."***

• He concluded by citing the example of TB control from a doctoral study undertaken by a SOCHARA member – If TB is understood as poverty deprivation and unequal access to resources rather than just a medical disease, then land reforms and social movements will be looked upon as part of the solutions in addition to access to diagnostics, treatment and care.

Key responses made by respondents:

• A former medical college teacher and paediatrician Dr. Chandra reflected that the medical profession has poisoned the people, more so in recent times when things have changed for the worse with the poorest thinking that health is about injections and tablets. Stating that medicine only contributes to 10-15% of health development, she emphasized the need to focus on Education, Sanitation, Water, Environment and Nutrition.

- As movements may take decades to achieve their goals, it requires deep faith in the cause to keep going. Citing the example of the breast feeding movement in Tamilnadu which spanned several decades before the eventual enactment of Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act was passed in 1992. She felt this was a victory for several individual and organizational campaigners working for the promotion of breast feeding and child health. To make a movement sustainable, it is important to network and work together, and not let barriers like caste come in the way. Reiterating the importance of "Solidarity" for Social Justice, she referred to the People's Health Movement as a unique platform that has brought together people from all walks of life to work for HFA. This was a shining example of "Global Solidarity" and its contribution was lauded.
- Reflecting on Virchow's statement "medicine is a social science", she emphasised the importance of involving politicians in the process of change. Some leaders from Panchayati Raj Institutions (PRIs) are cooperative in health work, especially with regard to participation of youth.

- The Capability Approach expounded by Dr. Amartya Sen in *Development as Freedom* was mentioned as a useful lens to examine social justice. It provides a useful framework for the evolution of individual well-being and social arrangements, for the design of policies and to examine new proposals. It has 2 claims:

A. Freedom to achieve well-being is of primary moral importance.

B. Freedom to achieve well-being has to be understood in terms of people's capabilities, that is their real opportunities to do and be what they have reason to value. For instance, we think of public policies in terms of resources, structures and systems rather than in terms of increasing people's capability.

Further exploration of concepts:

- Ends vs Means - What particular people or a group of people can do practically rather than just focus on problem analysis.
- Subjective mental metrics vs. objective outcomes/standards - eg. working with women's self-help groups in urban slums highlighted the fact that people's thinking has not changed. Women who work 2-3 jobs or more a day, apart from looking after their children and homes said "We don't have time and hence don't seek healthcare, illness is part of our lives."
- Charity vs. Development – Giving an option/freedom is as important as provisioning the basic needs of the people.
- Being open minded – Social Justice with all its complexity, cannot be reduced to a few indicators. The capabilities approach focuses on people and their specific requirements

and conditions. One of the possible pathways for the future is diagnosing "Capability Failures" - when there are significant personal differences, it gives a clue to what needs to be addressed.

Possibilities and pathways – to be explored further

i) Paradigm shift from a biomedical, deterministic techno-managerial model to a participatory community-based, social model – people's role as an active participant rather than a passive recipient or observer.

ii) Solidarity from below – Outside of the existing systems of governance, a new force is emerging which is an additional pathway – people's movements as an emerging power, e.g., the Arab spring

iii) "Social Vaccine" – Resisting unhealthy social and economic structures. While it is a metaphor for health promotion, it has received mixed responses due to usage of the term "vaccine" which many feel represents a linear, biomedical, corporatized manner of thinking/ communication.

iv) Communitization – NRHM is the largest and first public health program which has given community participation a systems understanding with the development of mechanisms for people's voice and choice.

v) SEPCE analysis – Social, Economic, Political, Cultural, Ecological Analysis leading to action and further reflection.

Technical session 2: Reflections on Pathways, Challenges and Possibilities in the Journey towards Health for All in India

Facilitator – Dr. Sara Bhattacharji; Speakers: Dr. Amar Jesani (Historical Overview and Reflections), Mr. Venkatesan (PANS process);

Respondents: Mr. Prasanna Saligram, Dr. Anant Bhan

History and challenges

The history of the People's Health Movement and the evolution of the People's Charter for Health were briefly discussed, before the discussion on the PANS (Participatory Assessment for Network Strengthening) process. The JSA has adopted several strategies:

1. Engaging with public and the media:
    a. Public hearings, education and publications
    b. Media engagement during these processes
2. Working with other health groups
    a. Networking, building alliances, organizing people towards Health for All
    b. National level campaigns and engagement at New Delhi for health policy
    c. At global level

i. Global campaign for right to health

ii. Rational drug policy campaign such as Novartis campaign

iii. Campaign against gender based violence such as sex selective abortion

iv. Campaign for release of Dr Binayak Sen

v. Organisation of International Health Forum in Mumbai

d. State level formations in several states in India

i. Badwani maternal death fact finding mission

ii. Change in immunization policy in TN

iii. Tsunami response watch in TN

iv. JAA-Karnataka role in Task Force on Health was accepted with a state integrated health policy adopted by the cabinet in 2004

3. Engaging with policy makers and high level committees

   a. Advisory groups such as ASHA mentoring group at national & state levels

   b. NRHM Task Groups on Goals and objectives; IPHS; medical education

   c. Engagement with NHRC (National Health System Resource Centre)

   d. Creation of mechanisms for community monitoring and planning and community action for health through the Advisory Group on Community Action for Health.

The participatory assessment was facilitated through state level meetings in 2010-11 and also through the use of a questionnaire to build a collective understanding. The major findings were as follows:

- Strengths: networking; facilitation of a collective understanding;/, diversity of organizations and networks; documentation and publications; and opportunities to build knowledge, capacity and leadership.
- Weaknesses: lack of communication; arbitrary decision making; lack of transparency; conflicts of interest; diversity of opinions; feedback not taken seriously; non inclusion of many who have contributed
- Opportunities: taking forward the campaign of health rights and health for all; collective processes provide opportunity for-larger outreach; larger impact; decentralized action; wider dissemination; mobilization around health issues; influencing public opinion and policy; contribution to JSA analysis; broadening understanding; collaborative initiatives at all levels
- Challenges: network dynamics and administration; evolving more comprehensive strategies; meeting the expectations of member networks; financial and logistical support, communication and inter-linkages; mobilisation and coordination
- Larger challenges: presence of community-larger mass movements and links with them; dialectics between PHM as a network and a movement; balance needed between national,

state level and local interventions; how to enhance the networking effort keeping it inclusive and spreading it further? Developing links with other movements/networks.

During the second part of the session, pathways and challenges in the transition towards universal access to health care were discussed.

- The transition of focus from Primary Health Care to UHC / universal access and the existing divergent views were discussed. While the PHM and allied social movements have moved forward on campaigning for the right to employment, food security, education, and information, there has been inadequate focus on health care and/or medical care. Stating that expansion of markets had limits in healthcare, it was discussed that commercial entities are therefore interested in and coopting human rights dimensions of healthcare to facilitate a flow of governmental funds for private healthcare. The need for a stable democracy to prevent it from becoming fascist with institutionalized discrimination was expressed.
- Clashes of three approaches were elaborated:
  - expansion of market and private commercial sectors in financing and provisioning
  - public financing and private provisioning
  - increased public spending and expanded public provisioning
- Comparing the progress in UK, Canada, Brazil & Thailand in healthcare, India's historical progress towards the current situation was assessed – starting with Bhore committee report, and missed opportunities in consolidating primary healthcare in 1970s & 1980s, and now with the impact of a neoliberal approach to UHC/ universal access.
- The dilemmas in making choices were expressed: How do we know that we are making the right choice? How do we know that we are opposing a wrong thing? Do we accept a mix of various approaches – if so, what would be the consequences?
- A case study was drawn from the Canadian health system, which is based on five principles: Public Administration, Comprehensiveness, Universality, Portability, and Accessibility. The need for ethics, regulation and quality were also emphasised.
- The various alternatives for provision were discussed:
  - Universal public funding – involuntary contribution and taxes for all, plus rich to opt for availing of services by additional buying of voluntary insurance – dominant Western model
  - Funds to be administered by
    - Ministry
    - Public body/ies

- Private insurance

- Several challenges exist in provisioning for universal access:
  - By Public Institutions only
  - Public Institution + contracted in private non-profit providers
  - Public institutions + contracted in for-profit private providers
  - Private institutions – Purchase from private institutions minimum guaranteed services
  - Struggle for a legislated and justifiable package
  - Provisions for limits in waiting periods
  - Provision for what service to expect where – referral planning
  - Provision for upgrading the package
  - Ethical regulation & controlling quality
  - Human resources training and deployment – restricting "democratic right" to locate services, policy incentives and disincentives
  - Primary care with GPs, and using non-allopathic doctors

It was recommended that treatment protocols and medical auditing be included, in addition to monitoring judicious use of technologies and professional conduct. Also, that the number of issues we are focusing on as a movement be reduced, so that the focus on healthcare issues is increased. The role of the activist in the scenario of a neoliberal state attempting universal access needs further reflection.

Key points raised by respondents:

- Reflecting on the Bhopal disaster, the lack of quality evidence is one of the glaring inadequacies even 30 years after the incident. The importance of how we address these issues as a community, keep these issues alive in our memory and strengthen evidence based education and communication with the larger public together with long term engagement was emphasized. Currently, for public health issues like violence against women there is misconstruction even by professionals. Highlighting the need for greater engagement with media to keep a focus on these issues, platforms like social media were stated to provide a huge opportunity. Redirecting the focus to bioethics and public health ethics, solidarity, transparency in implementation of policies, accountability of health systems, and identifying and acting on patient needs is needed. There is a need for medical institutions to start going back to the communities.
- The dilemmas with regard to health, namely health or health care and public providers or private providers were also reflected upon further. An analogy to an episode of Tom and Jerry (popular animation series) was drawn, where Spike the dog gives Jerry the mouse a whistle, asking Jerry to use it whenever the cat troubles it. Similarly, whenever in dilemma, the whistle of social justice would help provide or guide the answers.

- The principles of Social Justice provide a very good reference framework for the advancement of public health goals. Social Justice is all about fairness and giving each one his/her due. In that sense all are entitled for public good. Also the principles of equity stem from the Social Justice framework. The world is unequal and hence the health outcomes are unequal. Equity is the unequal treatment of the inequalities to equalize the opportunities which is Social Justice. The principles of solidarity have its roots in Social Justice where burdens are shared more by the rich and powerful and less by the poor and marginalized. But the market logic fails to recognize the inherent inequalities and has a 'winner takes all' attitude. So whoever is ahead in the race would get more encouraged to finish the race rather than taking along the people who are left behind in the race. Also the market logic is too fixated on the powers of bio-medicine as a solution to ill health which has its roots in the social ills of the society. So whenever there is a doubt of what is the best path to take, it would be good to always go back to a Social Justice framework to see whether the actions being taken promote social justice or the market.

Technical session 3: Understanding the process of social change towards Health for ALL – Issues and challenges

Facilitator: Dr. Prem Mony, St. John's Research Institute; Speakers: Mr. Ameer Khan and Dr. Rakhal Gaitonde

Respondents: Dr. Magimai Pragasam, CAMERA Chennai; Dr. Kaaren Mathias, EHA

An account of the campaign in Tamil Nadu to revert the decision on shifting the site of immunization of young children from the community through village health nurses to Primary Health Centres; and the revoking of a central government order to close three public sector vaccine production units, were shared. A campaign was initiated in Tamilnadu to address both the issues at the same time. Since the strategies used to address both the issues were same, the issue of immunisation was taken to explain the campaign to the audience.

The death of three children following immunization in community settings had triggered the policy change in the location for immunizations to be conducted statewide in Tamilnadu. The campaign strategies used to reverse this were as follows:

- The *Makkal Nalavazhvu Iyakkam* (MNI is the Tamilnadu chapter of People's Health Movement) supported and worked with various civil society groups including women's groups, child right groups, Village Health Nurses (VHN) association, trade unions and academic institutions.
- Campaigns were held to sensitize people and groups through multiple-level meetings.
- Approaches, such as using post cards, telegrams, forming human chain etc were used. Through these various means, the department eventually set up a commission to review the entire issue.
- Media was used effectively and they were able to reach people and keep the issue alive.
- Indirect support was also given by those within the health system and governance levels.

- One of the challenges faced was when the VHNs stopped supporting the campaign (they were the ones who initially were strongly supporting the campaign) when they were assured that their jobs would not be jeopardized. People centric opinions / arguments were promoted and placed to get support from other groups. Building community and consensus among doctors was also done, though there was polarization within their ranks about the decision on immunization.
- Politicians were approached and given memorandums to raise their voice against the change and the closure of vaccine production units.
- As part of the campaign, with the support of Community Health department of CMC, Vellore a study was conducted covering 4000 mothers at the field level to get their views and document the costs in availing immunization in institutional settings. The results were sent to the media, politicians, and bureaucrats. The results were as follows:
    - Indirect cost - travel and related costs had gone up to access immunization at PHCs
    - They preferred to go to the nearest private practitioner keeping in mind the time, health of the mother, and travel cost – and hence had to pay for services which should have been available free of charge
- After two years the new government which came to power changed the policy and the immunization was shifted to the community/village level again.

Based on the above case study, theoretical frameworks were applied to understand social movements:

- The outcome of a movement is unpredictable, and there are many problems in the process of social change. In addition, many studies on local social movements have been published in the media and journals abroad, to which the local population may not have access. There are number of players who actually bring about change like bureaucrats, administrators, and politicians.
- To identify characteristics of movements, the example of the shift in vaccine policy was taken:
    - Resource mobilization: tap the huge expertise to bring about change through networks
    - Framing the issue: the role of critical communities and building "oppositional consciousness".
    - Impact of the policy on various groups:
    - Shifting of immunization to PHCs increased the power of doctors, but the ANM and VHNs felt like they were losing their power.
    - Awareness: Built relationship with various groups for e.g. auto drivers, trade unions, nurses association and VHN's union.
    - Political system: the change of political regime was a turning point in the process.
- In times of crisis in the system, changes are possible to happen.
- Three levels at which the processes were carried out

a. Micro level: focused on the grass root level as people centric.

b. Meso level: work with the department of health. In the campaign a few officials within the health department who were against the change, also extended their support.

c. Macro level: working at the higher level with policy makers.

When the system becomes weak then change can be brought about. Social change process is complex and the impacts are great when it is people-centred. In the process many things have to be kept in mind, for instance: the large number of causal factors; the many strategies that can be used in the process, utilization of diverse resources available.

Responses by respondents and audience

Based on the video documention experience of the Community Action for Health process under NRHM in TN, the success of community mobilisation and its impact was shared. The efforts made towards continuous contact with the media, negotiation with political leaders and networking with oppositional consciousness was appreciated. Working with everybody and keeping each other informed was stated as important. The use of conventional media, community media and the new social media platforms was encouraged (using Anna Hazare's campaign example). Identifying unresolved problem areas such as use of abusive language by staff members, and robbery of eggs/materials from ICDS centres, needs further work. Emphasis was laid on the need for: mindfulness (deep attentiveness to what, how and why it happens with much self reflection), solidarity (increased linkages with the people who are suffering and struggling).

In addition, it was also said that the role of the organizer that being people centric and involving leaders from PRIs kept the campaign sustainable. The media was also actively engaged, using recordings of statements from people at community level. It was suggested that the video documentation of the CAH process be shared with wider audiences.

Session: Reflection and Feedback on the Day's Discussions

Facilitator: Karen Mathais

Two reflections were put forward

- *'what is our voice with regard to the huge issue of private health care service providers?'* (reflecting on the discussion on alleged neglect of private health sector as emphasised in an earlier session) and
- *'Are we struggling to defend status quo?'* (reflecting on the Tamilnadu immunization case study, where it took a lot of effort to revert to status quo of community based immunization).

Some responses were made and comments were added:

- Important to understand within private healthcare system – mission hospitals and their health workers are included, and they are functioning well even at grassroots level. There

is however a need for capacity building in family practice. Referral to specialized care units continues to be a challenge – especially in the light of private sector facilities being the referral units for governmental hospitals in several areas, even for relatively common procedures such as caesarian sections. Corporate hospitals have high policy leverage which is an issue that the health movement has not addressed adequately. Focus has only been given on accountability of public health system.

- Health is now seen more as a commodity, and this creates scope for malpractice. A huge budget has been planned for 'Universal Health Coverage', but consideration has not been given for budgetary allocation for diseases preventable at household level.
- Also important to remember that private healthcare providers mainly focus on curative services – corporate sector is the big elephant in the room that we need to start looking at
- Universal health coverage, and related jargon including universal access to health care, universal healthcare coverage etc are all politically loaded and we need to be clear about what we mean.
- The role of AYUSH systems in universal health coverage should be taken into account for social justice in health in India – as currently, mainly the allopathic stream is receiving that kind of attention.
- There is also a need to address the issue of public-private partnerships influencing public health systems and it's functioning.
- Though the communitization process under NRHM is an innovation, there is lack of community engagement in research processes and inadequate sharing of findings of research with others. Opportunities to engage with and learn from the private sector should also been seen.
- Women have now got more freedom to speak about health compared to before, and 80% of VHSC members are represented by women in 'CAH' process in Tamil Nadu – important to see as women are crucial for family health. However, due to migration and related phenomena, death of single women/girls are not recorded – which needs to be done to assess the extent of the problem.
- Several schemes have not been adequately thought through eg. the ongoing fragmentation in society and other realities – this was explained through an example of exploitation of a woman under the 'Muthulakshmi Scheme' for maternity benefits.

The discussion was summarized as follows:

1. Defensive ideas could protect little social good.
2. Commercialization leads to inequity and injustice.
3. Quality of health care is an issue (including corporate sector)
4. Need to pay attention to PPPs in medical education and health care, and study it from an economic perspective
5. Need to provide space for traditional systems of medicine.

DAY 2

Following a cultural programme, reflection of previous day's discussion was requested from selected delegates:

Mr. Ameer Khan, Ms. Manjusha, Mr. Jeyapaul, Ms. Banri

Some of their reflections included:

- Social justice can only be achieved through widespread community participation. Media is one of the other agents of social change.
- We should not concentrate working only with marginalized sections of society but we have to work along with bureaucrats and politicians for an equitable distribution in health services.
- Health is needed in all the policies. The understanding of health as a human right is still being built with communities. Globalization has a major impact on the planning of health services. Respecting the dignity of persons and social justice should be our chief concerns.
- Key messages from the first day of the workshop are three-fold:
  a. Strengthen health solidarity from below
  b. Expand your horizons – not limiting only to strengthening the government health system but going beyond that
  c. Influence "others".
- As a health movement and as community health workesr are we not going to address the economic challenges including anti people policies, impact of economic recession and governments response to that etc.?

Parallel sessions on urban health, mental health, environmental health and privatization of health care followed by a Plenary session summarizing the discussions

Plenary facilitated by Dr Riyaz Basha, Bangalore Medical College and Research Institute (BMCRI)

Session I – Urban Health

Facilitator: Mr. A S Mohammad

Speakers: Mr. S J Chander – SOCHARA, Ms. Sudha N –JAABU, Dr. Prem Mony –SJRI

1. Background to Urban Health

   Urban populations are increasing, with the global urban population having surpassed the rural population in 2007. While the proportion of urban dwellers is still relatively small in India (30% and increasing), the challenge is due to the sheer absolute numbers, and that 25-30% of urban population in India are slum dwellers. The number of urban poor in India is rapidly increasing and is estimated to cross 500 million by 2030. The increasing numbers

in urban areas are mainly due to migration out of rural areas. Urbanization does not include just big cities, but also small and medium towns and peri-urban areas. Though these places contribute immensely, they often get left behind and are neither covered by rural nor urban development schemes.

2. Challenges in Urban Health

A. **Health Issues:** Slums have increased in number, as growth has outpaced development of the city and increase in health facilities. There is consequent overcrowding; poverty, poor sanitation, waste management and access to water; environmental pollution (air, water and noise); increasing expenditure and health problems such as infectious diseases, NCDs, psychiatric disorders, accidents.

B. **Policy Issues:** Urban health is relatively neglected, due to the apparent greater access and availability of health services including specialty care. Focus has always been more on reproductive health and rural health. Also, burden of ill health and health systems information is lacking about urban areas. Advocacy for urban health is also relatively much lesser. Within the urban setting, the policy focus on displacement of slum dwellers, pollution, mental health, domestic violence, alcohol, and accidents is even lower.

C. **Issues in health measurement:** Due to the size of urban administrative unit, the task of documentation can be intimidating (a ward consisting of 30,000 to 70,000 population). There are vested commercial interests in underprivileged population, and ethics of research is not maintained.

D. **Issues in inter-sectoral coordination:** In Bangalore, there are several big players in healthcare and services: BBMP (manages public health, RCH, police, solid waste management), State Department (heath, woman & child, food supply, medical education, social welfare), Autonomous- BWSSB, BESCOM, BMTC, KSPCB, BMCRI, and others such as ESI, BDA, BMRDA. They all play important roles, but coordination and communication between these stakeholders is poor.

E. **Issues with the health system:** Governmental hospitals in the city are often understaffed and understocked (Rs. 31 Crore annual budget for Bangalore). Patients end up paying out of pocket. The private health sector is poorly regulated, leading to irrational and unnecessary diagnostic and therapeutic procedures often carried out.

F. **Privatization of health care:** Staff are contracted-in, services are contracted –out, hospitals are empanelled to provide government schemes – weak contracts, poor monitoring, still huge out-of-pocket expenses for the poor. Corporate hospitals misuse government incentives for providing free treatment for the poor.

3. National Urban Health Mission (NUHM)

Plans include : 75-90 % of funds from the centre, to cover 779 cities and towns with more than one lakh population. Initially coverage is to be for 7.75 lakh population in selected cities/towns (one of which is Bangalore), with later expansion. The NUHM would cover unorganized sectors like slum dwellers, squatters and marginalized groups like street children, homeless. There is

an urban ASHA proposed; a framework for partnerships with NGOs; intersectoral coordination with the Jawarharlal Nehru National Urban Renewal Mission (JNNURM) for infrastructure, transport and services for the urban poor. Comments on the NUHM planning and framework for implementation:

- Good analysis of urban health problems.
- Detailed convergence with JNNURM, (Integrated Child Development Scheme (ICDS), etc.
- Focus on Primary Health Care with proposed evening hours at the Urban Health Centres (UHCs).
- Conditional sanctioning of funds.

Drawbacks:

- Planned budget for Bangalore city was initially Rs. 250 Crore for 2013-14. Now reduced to half of that for 3 cities in Karnataka. After roundtable discussions implementation yet to start.
- Over reliance on ASHA
- Empanelment of private hospitals.

4. The way forward

The WHO has identified certain key areas for improvement in urban areas: Employment, Housing, Diet, Education, Social support, Living environment, Health services which are pathways to better urban health:

- There is a need for a push for a stronger urban health policy, better health data, inter-sectoral coordination, public-private partnerships, increased public health care including strengthening primary healthcare, regulation of private health care, learning from best practice models, promote urban planning with regard to safety (especially for the poor) during disasters, improve living conditions with participatory governance, build referral systems, increase focus on smaller towns, involve NGOs in governance and service provision, strengthen Ward Committees with financial powers and with powers to make civic authorities accountable, make the Janaspandana grievance redressal forum functional.
- NUHM should not replicate the NRHM, as the needs and context are different. While focusing on services for the deprived and below-poverty line section of society, while this is logical, ethical and noble, in reality the quality of services end up being poor. The government should instead focus on good quality health service targeted at the middle class, which the poor can aloes access, but with social safety nets.
- **In conclusion,** urbanization often means "slumization". The solution lies in first and foremost providing basic standards of living for the urban poor. The focus must be on clean water, sanitation, waste disposal, healthful housing and public infrastructure. The problem is that NUHM is not going to address any of this. People need to be empowered because

if the government is not accountable, then peoples' participation will not amount to any change in urban health.

Reflections/ comments given from the floor:

- Some urban areas have good opportunities and some do not because of failure of planning in how to maintain urban into a standard, e.g., ground drainage is not effective
- Inter-sectoral linkages: PHC in urban areas is needed because most of women in urban expressed their needs that health care should be in one place
- Railway and platform children should be kept in mind for better health care in urban areas
- Sovereign population should give feed back to the government for effective services.

Session II – Mental Health

Facilitator: Dr. Mohan Isaac; Speakers: Dr. Mani Kalliath – Director, Basic Needs India (BNI), ; Mr. Jeyapaul alumnus of the CHC Community Health Fellowship Program; Dr. Tanya Sheshadri , Institute of Public Health, Bangalore

The gross neglect as well as exclusion of people who are mentally ill and their care-givers who are not given any support were raised as areas of concern, following which experiences and ideas were shared:

- BNI shared their experience with community based rehabilitation as an entry point in to community mental health work especially working with persons with mental illness (PWMI) in deprived rural settings and in urban slums in 30 districts across 6 states - currently covering 18,000 PWMI. Social exclusion, stigma and human rights violations of PWMI were earlier seen even within the family. BNI has focused on increasing the productivity and earning capacity of the individual PWMI. Policy changes were supported through partnering at *taluk* and *panchayat* level.
- A 'Stake-holder model' was employed in developing programs for the users of services and carer's of PWMI where they accessed services of the program based on their need. A program evolved based on need expressed by the community based organisations (CBO's). A community leadership for mental health fellowship was designed to address the need for enhancing community's capacity for mental health rather than focusing on care of mentally ill persons. The key features of the programme are solidarity, permanency and skill transfer. The programme believes in the inherent capacity of the individuals especially people with mental Illness. Experiential and reflection process were used in training the fellows who have demonstrated some leadership and commitment for common good in their community. Sharing by a fellow Manjamma from Bhattarahalli was very effective in communicating the transformation of the domestic workers union secretary into a community mental health resource, and on basic needs for community health such as sanitation and water – which are crosscutting needs for people with or without mental illness.
- Mental health issues as an impact of other diseases was also shared based on the experience from Namakkal of working with adolescents living with HIV. They observed neglect of

these children. Apart from the physical problems, they also have to deal with mental and psychological issues.

- Suggestions from the group ranged from school based mental health work to developing an optimal mix of services. The group concluded the discussion with the thought that there are big gaps, with gross neglect of mental health services. Social exclusion of persons with mentally illness is a reality even today. Creating solidarity is the basis of community based mental health work and a key challenge in this effort. Mental health is a complex issue. The need for initiatives to promote positive mental health was emphasized. Integrating mental health into general health services too was perceived as a huge challenge. Mental health services even today are replete with a legacy of laws and practices of colonial times, where the focus was on conditions that made people violent to self and others and thus a holistic approach is absent.
- Mental health should form an integral part of all health programmes, and the District Mental Health Programme (DMHP) should be well integrated into other programmes. Mental health promotion needs to adopt a life cycle approach. There is a need for greater funding for the DMHP, and to address the issue of exclusion of mentally ill from other governmental programmes. Currently, efforts are also being made to integrate mental health with primary healthcare, such as in an effort by Karuna Trust – but the need for sustained efforts was felt. There have been new efforts by the central government to create space for Mental Health with the setting up of a Mental Health Policy Group which is working on the development of a draft mental health policy, the revised DMHP which was adopted in 2012-13. A draft Mental Health Bill is also in Parliament. In Kerala there is an experience of training of ASHAs in case detection and referral. The DMHP in Thiruvananthapuram has different treatment options available and good documentation.

Session III – Environment Health

Facilitator: Ms. Manjulika Vaz, Division for Health and Humanities, St. Johns Research Institute; Speakers: Dr. Rakhal Gaitonde, CEU, Chennai; Mr. Juned Kamal, CPHE, Bhopal; Dr. Adithya Pradyumna, CPHE, Bangalore

An effort was made to use case studies to understand approaches for the health movement to address EH issues. Environmental health relates both to impact of environmental pollution/ degradation on human health, and the health of the environment itself. Environmental health problems were understood in three levels:

a) Biomedical challenges – with adverse health outcomes such as cancer or developmental anomalies.

b) Public health challenges – cleaning up contamination, providing safety against exposure

c) Socio-political, economic and cultural aspects – why is environment degraded? why are communities deprived of access to resources? why is pollution continuing unabated?

The Bhopal Gas Tragedy was discussed as the first case study, in the context of three processes:

- Research Process: The involvement of politics and foreign policy in the issue diluted research efforts. MFC was one of the only groups which made early findings publically available. Evidence is important for both treatment, rehabilitation and in courts of law. Initially there was misinformation as well, and the study by the Indian Council of Medical Research (ICMR) was stopped midway in 1994. The report has only been released in 2012. There is need for health systems research, and also on the long term impacts and needs of victims.
- Legal process: was carried forward due to pressure from the community – but there were several inappropriate strategies used. Eventually, some compensation has been received, but the guilty parties roam free, and the long term impacts have not been addressed.
- Social networking: Several campaign groups have emerged at national and international level to keep the discussion and issue alive, and for solidarity with local communities. E.g - There was international pressure to provide compensation to the victims of the tragedy.

The experience with the CHESS (Community Health Environment Survey Skillshare) network, workshops and collaborations was shared using case studies from Tamilnadu.

- Cuddalore – One of the most polluted districts of TN due to the presence of an industrial complex (paint factories, pharmaceutical plants, petroleum refineries, thermal power plants etc). An innovative local initiative for community environmental monitoring exists which documented the lived experience of pollution. The smell of chemicals as perceived by people (rotten egg, fruity smell etc) was documented systematically. They were also able to corroborate 17 of the identified smells with chemicals used in the processes in nearby industries. Based on the "Smell Index" developed by them, they regularly report to pollution control board, who have been slow in responding, but there has been progress.
- Mettur – Has a chemical factory, a now closed alumina refinery and a thermal power plant. Silicon dioxide, a defoliating agent, is one of the pollutants which even impacted the leaves on the trees. Health of livestock, specifically goats, termed "mad goats" was also noticed for the first time. Lay epidemiological processes have been attempted to bring a common understanding on the health and environmental linkages. In addition, fact finding missions have been conducted to provide evidence for a national green tribunal and for courts of law. "Lay Epidemiology" has been an effective means of creating awareness among the communities, and has an aura of validity and intuitive logic which is appealing at mass level.

There was a reflection on the roles that can be played by a group working on environmental health. At the moment, the main thrust has been given to research support – but involvement in policy advocacy and governance is very low. The PHM *People's charter for health* also speaks about what needs to be done for environmental health – it includes neglected aspects such as

impact assessment, overconsumption and climate change.

The participants of the parallel group and during the plenary added points:

- There is need for a platform where persons and groups passionate about these causes can share experiences and plan future strategy.
- Students, especially from social work and medical /health fields need sensitisation.
- A knowledge centre needs to be developed for environmental and social movements.
- There is a need to reflect on how to address circumstances such as in Bhopal where government tries to bury important information
- Mechanisms are to be developed for transparent reporting of pollution levels by industry for regulation to be more effective
- A multidisciplinary approach to this issue is required with scientists, doctors as well as community health workers and activists oming together. We should shift from a positioning in a victim mode to becoming active agents of change.

Session IV – Privatization of Health Care

Speakers: Mr. Prasanna Saligarm, SOCHARA; Dr Kishore Murthy, SOCHARA member; Dr. Esther Daniel, SOCHINI.

Stating that India suffers from 'Mixed Health Systems syndrome', a background was provided:

- A weak Public Health System (PHS) is complemented by an unregulated Private Medical Sector (PMS).
- Evidence from Public- Private Partnerships in the recent insurance schemes in Andhra Pradesh and other states suggest limited access to certain sections of people, expansion of secondary and tertiary care rather than primary care, no reduction in irrationality in service provision, cream skimming and supplier induced demand.
- The High Level Expert Group (HLEG) and medico-friend circle (mfc) suggested strengthening the Public Health System with tax based financing and contracting in of private providers for attaining Universal Access to Health Care. The Planning Commission suggests managed care to attain UHC.
- Management related challenges: Government provided land subsidy to private health care providers but the poor couldn't get treatment in private sector. Grading of hospitals, empanelment guidelines, regulation of pharmaceuticals industry, exclusion of communicable diseases in Health Insurance coverage, lacunae in the Clinical Establishment Act and identification of skill requirements are some of the challenges that need to be addressed. Evidence based treatment, skill based education and training of the health workforce, cross-subsidy models of health financing, value systems and ethics need greater understanding and focus.
- Health rights and equity: Health is a fundamental human right. Burden of non-communicable diseases are increasing alongside shortage of health care professionals. In addition, there

is a large disparity in urban-rural services. Strategy for coordinated healthcare services is unclear – there is a need for a strategic vision by the state. A focus on availability, accessibility, affordability and participation is needed.

Healthcare, Markets and Social Justice:

- Allocations based on a market logic favour the rich and powerful.
- Market mechanisms emphasize that people are entitled to those services that they have acquired by their own individual efforts. The market norms fail to allocate effectively and equitably those services that are needed the most by shifting the primary duty of prevention from disease and death to the individual's responsibility.
- It emphasizes individual responsibility and minimal collective responsibilities and obligations while public health – and in turn social justice – is all about collective efforts. In order to promote public health with a social justice ethic there is an obligation of the state to develop a strong public health system. This cannot be left it to the market as market failures in health are well recognised.
- Globally the People's Health Movement has advocated for a move away from neoliberal policies, bringing back the focus to Alma Ata, Comprehensive Primary Health Care and Social Justice. The concept of Universal Health Care resonates with the Health For All dream of the Alma Ata declaration, though the change in terminology allows for distortion with managed care models and further penetration of the corporate sector who see a huge market. The declaration posited health care beyond the narrow confines of biomedicine and into the realm of Health as a Human Right based on the principles of Social Justice and equity. It placed emphasis on the centrality of government actions together with communities for the goal of Health for All.

The floor was opened to participants to discuss on the need for 'Public-Private Partnership' (PPP):

- Our stand is not against private medical sector, but against commercialization of health care.
- There was an agreement among participants that PPP is essential because of low health budget, lack of infrastructure and staff in the public health system. As it may take long time to strengthen these aspects of PHS, it is wise to use Private Medical Sector towards achieving the objective of Universal access to health care.
- There is a need to regulate this large PMS while we contract in their services (This approach of rolling back private sector in turn will strengthen PHS). Today, not even 30% of RSBY is delivered through PHS. There is ignorance in how to regulate these support systems.
- An example, where PPP worked was in Andhra Pradesh where the implementation of 'Pulse-Polio Program" was carried out by contracting in private providers and it was successful.
- It is for this reason, there is a need to firstly dialogue with PMS and develop a comprehensive regulatory mechanism such as the State Clinical Establishment Act {CEA}) with high involvement of civil society.
    - CEA should restrict the freedom of locating medical services of private sector and

license should be given to open health centre where government wants them to work.

- CEA should award license to medical practitioners only when they are ready to work in rural areas/ areas where there is a huge demand for medical practitioners.
- Salaries of private medical practitioners should also be regulated, as this is biggest driving force, that practitioners prefer private sector over public sector.
- CES should also consist of standard treatment guidelines, standardization of rates and a mechanism to ensure protection of patient's rights.
- Diagnostic centres which induce demand and have varying rates should come under the ambit of greater regulation.

- There is an immediate need to redraft CEA at state level with all the above considerations and it needs initial dialogue with bureaucrats, politicians and other relevant stakeholders.
- The High Level Expert Group (HLEG) of India has suggested forming a 'Network of Providers' which is part of inter-sectoral collaboration towards attaining UHC.
- District level meetings to create awareness of consequences of unregulated private medical sector. People in large mass need to demand the government to regulate PMS.
- If PMS, is interested to contribute for attaining UHC, governments could engage them in Primary health care rather than in Secondary/ tertiary care.
- When we have community based monitoring of PHS, it is also equally important to have similar mechanism to monitor PMS. PMSs are also accountable to the community they serve. Increasing community participation should be the way forward.
- Under UHC mentioned in the 12th five year plan, it is important government don't contract in services of PMS which serve private insurance companies.
- Health is a state subject and the state government should allocate finance for monitoring the entire Health Systems.

Discussion points during the plenary

- PHM's role in healthcare advocacy should look into opposing of commercialization of health care in private sector. In addition, state should mandate, finance and monitor to achieve health care system. The public health system should be strengthened and no one should be excluded from PHC. The understanding of the public on services offered by public and private health systems should be strengthened.
- Private sectors should not be rejected or ignored, we should push private sector into PHC so that there will be a balance in both preventive and curative. Public sector should look to participate/coordinate with private sector for furthering achievements in healthcare delivery – to come up with a comprehensive plan. The regulatory aspects should however be focused on – including price regulation and accountability.
- Government should promote AYUSH in public sector. Indian systems have relevance for several health problems.

Session: The Role of Academia and Research towards achieving Health for All

Facilitator: Sr. Dr. Aquinas; Speakers: Dr. Thelma Narayan, SOCHARA; Dr. Arvind Kasturi, Professor & Head, Dept. of Community Health, St. John's Medical College

In what way has the Health for All movement engaged in academic research?

Experience form the *Research for People's Health, a Research encounter* at the Second Health Assembly, Cuenca (July 2005) was shared – which brought together researchers from all over the world to commit to people's health problems. Situation analysis from this Conference is as follows: Research has not been focused on fundamentals ie. to improve the health of the citizens of the world. Health has become increasingly commodified. Globalization with its lack of regulation has produced more inequities than solutions. The majority of the population does not have access to health or health care or access has been limited substantially. Based on the above situation, ideas that emerged were as follows:

- Research to be looked on as a tool for social transformation
- Rethink the relationship between researchers and the community - it is important to look at the community as the subject of investigations and not the object.
- New paradigms must therefore be advanced, including the genuine integration of researchers into the community.
- The distinction between scientific needs and social needs must be addressed
- To incorporate research into social mobilization and to use the findings to effect changes in Public Health Policies.
- To build real and virtual networks of researchers, regional networks; to encourage the development and participation in programmes and multicentre projects
- To use the internet widely for the dissemination of studies that contributes to the development of new research paradigms.

Declaration to Countries:

- Discussion on Health Research should include health sector officials who should be involved in the change processes.
- Research should aid in the revision and updation of agreed health standards to ensure that they remain within legal framework and contexts.
- Research should help to influence state policies and thereby help prioritize allocation of economic resources for health, education, and nutrition in addition to controlling and preventing diseases.

Declaration to Researchers:

- To value research principally from the point of view of health and life.
- Research should bring about social action by the mobilization of people and communities as participants and collaborators.
- Biomedical research should be integrated with social research
- There should also be a sincere effort to integrate quantitative and qualitative health research.
- Research should involve dialogue between investigators and representatives of communities as well as the people directly.

Following that, the functions of academic institutions with respect to the St John's Medical College experience was shared.

Training, services, advocacy and translation of research are important parts in the institution. The reach-out audience of the Dept of Community Health was reflected upon. This included: students, trainees, medical, nursing, paramedical, community health workers, program personnel/ government official and others. Apart from the trainings, the role of academic institutions and research is to:

- Involve informal groups such as NGOs and Religious/ Mission.
- Focus on the third of the country (BPL), their problems, their diseases, their health and social determinants of health.
- Service programs should be targeted towards urban and rural population, vulnerable population (elderly, disability), adapt technology, low cost solution, work in teams, participation at every level and demonstrate equitable distribution.
- Skills: communication and competence should be at primary care

No survey without service ethic should be kept in mind, and research should focus on asking the right questions, incorporating the use of qualitative methods and make the findings available in the public domain. The role in training, research and make the trainees to feel the reality of the community is immensely important to achieve Health for All.

Comments from the participants:

- During our research we always have people who help and assist us. As researchers we should keep in mind that research findings should be shared with members of the community with whose assistance research findings and conclusions came about.
- There is a need to network more with national, regional and international forums of health research.
- Researchers should internalize social determinants and train students and professionals to be competent at primary care and skills to stand on the group of people is the aiming to promote health for all.
- There is inadequate coordination between departments within institutions. Humanities and health Division is a part of research institute – which provides an opportunity.

- The speaker mentioned that using qualitative method in the research is important. A participant argued that time constraints during the postgraduate course is reducing the opportunity to explore qualitative research.
- Mechanisms toIt is true, because research influenced policy then into the new programme and so on, yes it takes time that is why we need to keep in mind how to put influences into a speed.

Some challenges identified:

- There is a difference in the language of the doctor/research from the community – this gap has to be bridged for more effective research and translation processes.
- About creating community health nurses, the suggestion given was to balance theory and practical and to focus mainly on the needs of the community and on community processes and realities.
- There is a need to evaluate interventions being made in academic settings against the objectives o the academic programmes. One method of assessment suggested was the community's acceptance of the young doctor, as "our doctor" rather than "your doctor" at the end of her/his posting.

Final session: A consolidation of learning – evolving consensus, issues for further debate, and the way forward

Facilitator: Mr. Sam Joseph; Speakers: Dr. Rakhal Gaitonde, CEU, Chennai; Mr. S J Chander, SOCHARA; Ms. Shani John Sequeira, SOPHEA

Evolving consensus of debate and discussions:

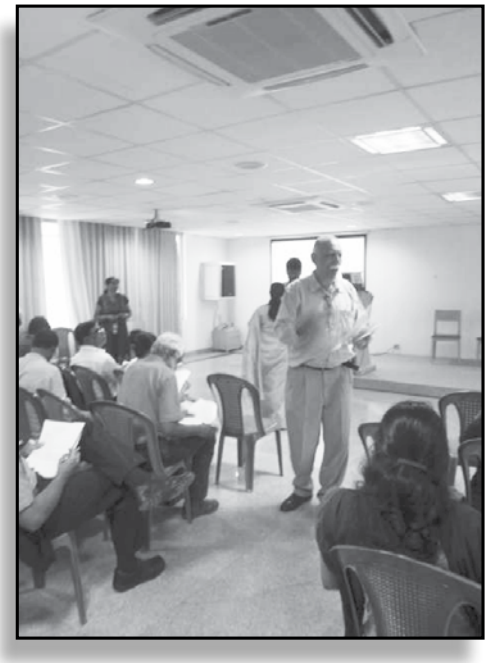
Five key strategies that the people in Community Health or People's Health Movement need to understand and engage such as: Paradigm Shift, Communitization, Social Vaccine, Globalization of Solidarity from below and SEPC analysis. He also mentioned that the concept of social vaccine and SEPC analysis also need deeper understanding. Reflecting on the session on "Pathways, Challenges and Possibilities in the Journey towards Health for All in India" the speaker highlighted that there is a need to broaden our vision to include health care and health in our discussion. There is also the need to fight against the commercialization of the health sector rather than the debate on public vs private. Finally, rather than just being defensive for the system, there needs to be a balance with creating alternative system which the movement is not focusing on adequately at the moment.

From the parallel sessions, several learnings were shared: the issue of urban health is becoming very critical and has received little attention in the government policies and program - National Urban Health Mission is greatly anticipated. On mental health issues, he highlighted issues such as social exclusion, and care's needs. The three models emerged in the discussion – the Basic Needs model, basic mental health, and the integration of mental health in primary health. On privatization of healthcare he highlighted the points such as the unregulated practice leading

to poor quality of service delivery, unethical practice, PPP, the need to strengthening the public health care system and the politics behind the healthcare system. On environmental health he highlighted the importance of creating healthy environment.

The way forward:

- As a health movement we must increase our focus on commercialization and privatisation of health care, and on private sector regulation. But it is also important to move away from the debate of private versus public, and look at it as an opportunity for healthcare for all under a universal umbrella.
- There is a need for interdisciplinary research for social change – studying the impact of social movements to strategise better. There is also a need for more reflections within social movements – on how decisions are made and other dynamics. Awareness and skills of people within the movement should constantly be kept updated. A reflection on how to partner with nursing and other professionals effectively in the health movement and for universal access to health care is needed. There is also a need for encouragement/regulation towards ethical practice by professionals.
- Multiple stakeholders should always be involved in action. Links with academic institutions must be made for the same – forum needs to be created for bringing academics and activists together.
- There is a need to press for rights of urban local community to get involved in governance and for elections to be re-instated similar to what happens in PRIs in rural areas.
- Mental Health must use rights based framework for quality health care and support because of the injustice, large gaps and gross neglect. Also identify ways to deal with social exclusion. The community is to be viewed as a resource rather than consumer of goods and services not just in mental health in other dimensions as well. Other neglected themes such as domestic violence and child sexual abuse that are also intrinsically linked with mental health should be taken into account.



- Environmental health must be closely linked with justice.
- As it is not possible to plan action adequately on the range of topics discussed here, it is recommended that interested groups stay in touch and work together Community based health workers training must be strengthened. Further studies are required to understand the impact of our current strategies and efforts in ASHA training and CAH

Based on individual preferences for topics – privatization, urban health, mental health and environmental health – each individual was asked to reflect on the 5 strategies – communitization, social vaccine, language, SEPCE analysis and solidarity from below and rank them. The groups

for each topic were asked to assess whether they have at least one member who considers each of the listed strategies as a priority for their work approach. Based on deficiencies in each group – some redistribution and negotiations were made to bring balance of interest and skill within each group. These groups were suggested to form action groups among themselves and plan for further action.

Following this reflection a short introduction to systems thinking in health was given – the importance of participatory causal loop diagrams in understanding points of leverage was demonstrated. The use of these methods was encouraged for planning and action in community health.

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Final Editing – Thelma Narayan

National Workshop on "Social Justice in Health and Universal Health Coverage: Challenges, Possibilities and Pathways"		
List of Particpants		
S.No.	**Names**	**Organisaion**
1	**Adithya P**	**SOCHARA**
2	**Amar Jesani**	**CEHAT**
3	**Ameer Khan K**	**SOCHARA**
4	**Anand Kumar**	**CH Fellow**
5	**Anant Bhan**	**Freelancer**
6	**Aravind Kasthuri**	**SJMC**
7	**As Mohammad**	**SOCHARA**
8	**Ashwini.G.S**	**SJMC**
9	**Avitha**	**SJMC**
10	**Banri Kynti Shisha Diengdoh**	**CHLP**
11	**Bhagwan Singh Verma**	**SOCHARA**
12	**Bhimraj**	**CHLP**
13	**Chandra.P**	**D.Arulselvie CBR**
14	**Charishma**	**Head Streams**
15	**Chongneithem Lhouvum**	**CHLP**
16	**Chowdhury Ahshanul Haider**	**SOCHNI**
17	**Deepa Shree**	**Karuna Trust**
18	**Deepthi**	**SJMC**
19	**Devashri Mukherjee**	**Baptist Hospital**
20	**Dhirendra**	**SOCHARA**
21	**Esther Shirley**	**SOCHNI**
22	**Ganesh**	**CHLP**
23	**Ganesh.S**	**CH Fellow**

24	Glory	AVAS
25	Guru	BNI
26	Hari Prasad	SOCHARA
27	Jeyapaul Sunder Singh. S	CH Fellow
28	Joseph	SOCHARA
29	Josephine	AVAS
30	Juned Kamal	SOCHARA
31	K Gopinthan	SOCHARA
32	Kanishka Koshal	CHLP
33	Karen Mathias	EHA
34	Karthikeyan	SOCHARA
35	Kavita S K (KIMS)	KIMS
36	Kishore Murthy	Brickworks
37	Kumar	SOCHARA
38	Lalitha.T	Head Streams
39	Lavanya Devdas	CH Fellow
40	Lekshmy.M	CHLP
41	Madhappan.M	CH Fellow
42	Madhavi Venugopal	CHLP
43	Magimai Prakasam	Chennai
44	Mahadevaswamy	SOCHARA
45	Malatesh Undi	KIMS
46	Mani Kalliath	BNI
47	Manjamma	BNI
48	Manjulika Vaz	SJRI Health and Humanities
49	Manjusha B.Dhiwer	CH Fellow
50	Maria D Stella	SOCHARA
51	Mathew Alex	SOCHARA
52	Mohan Isaac	SOCHARA
53	Nandaris S Marwein	CHLP
54	Naresh Kumar	SOCHARA
55	Naveen Pinto	SOCHARA

56	Naveen Thomas	Head Streams
57	Navya	SJMC
58	Prasanna Saligram	SOCHARA
59	Prem Mony	St John's Research Institute
60	Pushalatha	SOCHARA
61	Rachana A R	KIMS
62	Rakhal Gaitonde	SOCHARA
63	Ravi Narayan	SOCHARA
64	Riaz Basha	Bangalore Medical College
65	S J Chander	SOCHARA
66	Sabeena Lyngdoh	CHLP
67	Sabu K.U	SOCHARA
68	Saharsha	Head Streams
69	Sam Joseph	SOCHARA
70	Samantha Lobbo	CHLP
71	Santosh	SOCHARA
72	Sarah Bhattarcharji	Vellore
73	Sayed Razi	SOCHARA
74	Selvi Thangaraj	BMC
75	Shani J Sequeira	SOCHARA
76	Shanti D"souza	CHLP
77	Sharmila K N	KIMS
78	Shashirekha.P	CHLP
79	Shweta	SJMC
80	Shwetha	Head Streams
81	Sonu G Nair	CHLP
82	Sr Dr. Aquinas	Holy Cross
83	Sudha N	SPAD
84	Suresh D	SOCHARA
85	Suresh Shapeti	PHFI
86	Tanya	IPH, Bangalore
87	Thelma Narayan	SOCHARA

88	**Tulsi Chetry**	**SOCHARA**
89	**Vasundhra.M.K**	**SOCHARA**
90	**Venkatesh**	**CHLP**
91	**Venkateshan.R**	**CHLP**
92	**Victor Fernandes**	**SOCHARA**
93	**Vijayamalar**	**CHN, ANRIN.**
94	**Vinith**	**CHLP**
95	**W. Ernst**	**Oxford, Brookes University**
96	**Yuvaraj**	**SOCHARA**

Part – III

REFLECTIONS ON ISSUES IN SOCIAL JUSTICE AND HEALTH SPECIFIC INITIATIVES AND MOVEMENTS

10.

REACHING THE POOREST AND DISADVANTAGED POPULATIONS*

Thelma Narayan, 2000

10.1 Introduction

The past century has seen an overall decrease in infant and child mortality, increased longevity, the global eradication of smallpox, and the control of major infectious diseases, particularly in some parts of the world and in certain social classes. Improved socio-economic conditions and living standards, including better housing and nutrition; public health measures; education; and increased access to medical and health care, are the major causal factors. Developments in medical science and technology and important social shifts underlie some of the changes. The latter includes participatory democracy which has increased opportunities for previously powerless sections of society and recognition of the basic human right to health and health care based on social justice among others.

However at the start of the new millennium long standing and yet unresolved challenges remain. They include the continuing health divide between the rich and poor; between and within countries; the gap between expected outcomes and reality; implementation gaps in health programmes; and disparities in control over decision making concerning health, between the powerful and powerless.

We need to shift attention from just reaching the poor and disadvantaged, which implies merely an extension of the existing paradigm, to understanding issues of poverty, inequality and health, and to less visible yet strong, underlying societal and behavioral processes, which call for fresh approaches and paradigms, As we '***cease our endeavors for a short while, to reconsider and redefine our goals for the future'*** (MMM, 2000), which is one of the objectives of this conference , we need to re-vision our understanding of 'self' as a profession and our relationship with the 'other', particularly the poor in society, recognizing the deeper oneness

* Paper presented at Medicine Meets Millennium- World Congress on Medicine and Health, Hannover, Germany, 2000; Reprinted in Associazione Italiana Amici di Raoul Follereau AIFO) Health Cooperation Papers N. 17, 2003, Poverty Health & Development, pp133-139

and unity between us and them. In reaching out to the poor, and in addressing poverty, we help ourselves. From a traditionally privileged position, increasingly subject to public scrutiny and debate, the health profession can build on its strengths and knowledge base, especially with insights from the social sciences, to increase its social accountability and work in partnership with others, especially the poor, **towards Health for All, Now!** (Health for All, Now! is the slogan of a people's health campaign underway in many countries, with a **Peoples Health Assembly** (PHA) organised in December 2000)

10.2 Clarifying words, recognizing shifting boundaries.

a) The Poor-Social Minority or Majority?

Critical to the theme of this paper are perceptions of the poor, and their role or agency in transformatory, change process, towards better health and life in all its fullness, as participant key subjects rather than objects. The word 'marginalized' is often used alongside 'poor and disadvantaged'. This suggests small numbers or minorities at the margins of mainstream society, who are left out and need to be reached. Knowledge, gained through research and experience of working outside hospitals, suggests that numbers are much larger, comprising perhaps the social majority. 'Impoverishment', another word, suggests that social and political processes occur, making people poor.

Measuring the magnitude of persons living in poverty through poverty lines, is dependent on how poverty is defined. Income poverty or food poverty lines (measuring purchasing capacity for basic caloric requirements as in India) represent a minimal, static and even arbitrary approach, resulting in lowered estimates (Ghosh,1990). The basic minimum needs approach (including requirements for clothing, shelter, medicine and schooling) and the Physical Quality of Life Index (PQLI) are other instruments. More recently the multi-dimensional Human Poverty Index (HPI) is a composite of longevity (life expectancy), knowledge (literacy), economic provisioning and social inclusion (employment) (UNDP,2000). Distributional disparities occur between gender, rural and urban areas, region, ethnic and language groups. Incidence and intensity of poverty varies. Those just above the poverty line fall below it during of illness, adverse seasons, during natural calamities social and political unrest, conflict etc. The gap between rich and poor is widening in countries where economic liberalization is underway (PHA, 2000). While absolute poverty with a lack of resources necessary for survival, is associated with poor health, evidence from U.S.A and U.K indicate that relative poverty, defined in relation to average resources available in a society, is also a major determinant of health (McCally 1998). While the poor are sub-classified into being destitute, very poor and poor, ill health lowers access to good quality health care. Ill-treatment by health providers, are common experiences for the entire group.

Poverty is also defined in contemporary times "*as the denial of opportunities and choices most basic to human development- to lead a long healthy and creative life, and to enjoy a decent standard of living, freedom, dignity, self-esteem and the respect of others*" (UNDP, 1997)

Given the broadened definitions, which are required when using a value base of social justice, there is evidence that a substantial proportion of the global population live in poverty, with different degrees of deprivation, alienation and social exclusion.

In India, the proportion below a minimal poverty line declined slowly from 50% in 1951 to 35% in 1994, but due to population growth (which is also dependent on social development), the actual number increased from 164 million to 312 million. Recent surveys of rural households show 68% as landless wage earners and 45% of households without anyone literate (cited in Lamba, 1999). In 1998-99 in India, among children under age three, 46.7% were underweight (weight for age), 44.9% stunted (height for age) and 15.7% wasted (weight for height) (NFHS 2, 2000). Among women aged 15-49 years, 51.8% were anemic *ibid)*.

This evidence along with several other studies, indicates that a much larger proportion of people suffer from deprivation, be it food, education or biological poverty, than indicated by income poverty lines, which are now below 30%. Thus it is suggested that the poor in India and globally comprise a social majority (A Pinto, 1998). **Does this make a difference to our strategies*?***

b) What is being reached?

Increased provision of medical care reduces unnecessary pain and suffering, but in itself only marginally improves health status. WHO defines health as a state of physical, mental and social well being, and not merely the absence of disease or infirmity. Attempts to improve health status, towards reaching this ideal, have long recognised the importance of access to basic determinants of health, such as nutrition, safe water, sanitation, clean air, housing, employment, safety at home, in the work place and on the roads. Social inequality deprives the poor of these basics. **Is the medical and health profession interested in just medical care or also better health?**

The WHO-UNICEF Declaration in Alma Ata in 1978, on Health for All (HFA) by 2000 through the Primary Health Care (PHC) approach, used social justice as its basis and explicitly adopted inter-sectoral coordination as a strategy to address the need for access to basic determinants of health. The role and scope of the health profession and health sector was thus even then broadened beyond medical care. This was mandated and accepted by all WHO member countries, and followed up by resolutions, national health policies, plans and programmes. This was seen as an advance in improving the health of the poor. Very soon however this broad based approach was narrowed down, selectivised with vertical single disease programmes, and medicalised with a focus on diagnostics and drugs, not on people, communities and society.

In 2000, while WHO busied itself with Safe Blood as the theme of its WHO Day, on 7th April, impoverished peoples and civic society networks and movements in India pledged, through a national campaign, to continue to work with greater urgency towards Health for All, Now! This is part of a wider international people's health campaign, leading to a Peoples Health Assembly

in Savar in December 2000, which asserts that Peoples Health should be in People's Hands and reaffirms the role of the state in primary health care and public health (PHA, 2000). At the turn of the millennium we need to be analytical and remind ourselves of the reasons that prevented Health for All, through Primary Health Care, from becoming a reality.

10.3 Strategic Approaches to Improved Health For the Poor

a) Promoting Indigenous systems of medicine and healing traditions.

Poor people across the world have developed diverse traditions of healing and systems of medicine. Women are often the carriers of local health traditions and also carer's of people during illness. Modern medicine with scientific arrogance has often labeled traditional knowledge as non-knowledge, and healers as quacks and witches, causing disempowerment and loss of heritage. There is an urgent need for dialogue based on respect, to enable learning, restoration and promotion of these systems and traditions. This needs to be accompanied by safeguarding community and people's rights from the avariciousness of commercial interests and patent rights.

As part of its 5000 year old living civilization, India has evolved several indigenous systems of medicine, such as *Ayurveda* (the science of life) *Siddha, Unani*, and *Yoga*, all with texts, which form part of the world's oldest written medical literature. A wealth of local oral traditions exist, being passed on from generation to generation by folk healers. Similar knowledge bases and caring traditions exist world-wide. There is minimal budgetary, legal and institutional support for the growth and promotion of these systems. They are scarcely involved in health planning and programmes. Some have been pushed into subaltern states by the dominant modern biomedical paradigm. Recognition, legitimization and strengthening of these traditions will enhance the contribution of people themselves to improved health and quality of life. Supported by the philosophical traditions they represent, indigenous systems are less compartmentalized, and deal differently with issues such as the meaning of life, quality of relationships, attitudes, and acceptance of death. In the quest of health we need to include multiple world views, multiple realities, multiple voices. For this we need to listen, to learn, and to allow a questioning of the hegemony of modern medicine.

b) Fostering Community Involvement

Community involvement, a cardinal principle of primary health care, and of community health, has been fragmented by a combination of professional and commercial interests (the doctor-drug producer axis) operating through market forces. It has been declared idealistic, non-workable and immeasurable by experts, who are impatient and focused on specifics.

The potential power of the community as healer, as being able to hold brokenness and restore wholeness, are human and higher dimensions beyond market and biomedical paradigms.

At another level, community involvement in micro-planning, decision making and in running health programmes have made possible more rapid, sustainable health gains at low cost. This is the experience of NGOs globally. Community participation in public sector programmes, through elected representatives and civil society groups, enhance implementation, including quality.

On a larger scale, social movements of the poor raise basic issues, which impact on health. These include movements regarding livelihoods, water, and environment. Socially conscious professionals and other have worked on campaigns for rational therapeutics, which there is an emerging health movement.

However resistance by the medical profession to subject itself, and its technology, to social control, through local committees, consumer and patient groups, ethical committees and elected local bodies, hampers outreach, development and access to the poor, and is one of the barriers between people and the health services.

c) Bridging Implementation Gaps

All aspects of health policy in some countries, including problem identification, policy content, programme planning and implementation, are influenced by dominant interests, in ways such that the needs and interests of powerless and poor come last (Narayan, 1998). This is evident in the poor implementation of tuberculosis programmes with continuing high mortality and poor treatment outcomes, despite effective, low cost treatment.

High rates of child under nutrition and anemia; large proportion of people still lacking access to safe water and sanitation; high maternal, infant and child mortality; are all witness to implementation gaps in public policy.

Political economy factors are evident in the energetic promotion, on the other hand of population programmes, euphemistically given new names, such as family welfare, reproductive and child health, but still driven by demographic determinism. These factors are also evident in the disproportionate leverage in national policy planning that donor agencies expropriate, despite very small proportions of actual aid or more recently even with loans.

Several scholars and agencies recognize the need to improve institutional mechanisms to strengthen implementation and reduce gaps. This includes the need for good governance, leadership at different levels, management and most importantly strengthened capacities and humane attitudes and relationships at the interface between patients, people and providers. Involvement of different stakeholders especially women and NGOs with systems of accountability and transparency, enhance implementation. There is a recognition however that the poor, preoccupied with survival tasks are the least organised and articulate, with less bargaining and negotiating abilities. On the other hand professionals, technocrats, bureaucrats

and industry, form strong alliances. With access to up to date information, good communication and coordination mechanisms the playing fields are very uneven. Thus implementation factors are complex, but need to be given priority and close attention at all levels particularly locally, if better health for the poor is to become a reality now (Narayan 1998)

d) Addressing Political Processes and Power

At the turn of the millennium there is a need for explicit recognition that political structures and processes and issues of power, help determine content, direction and implementation of health policies and programmes. Equally important is the recognition that the medical profession itself is a strong political player, very protective of group interests, well organised, working in alliance with governments, industry and international agencies and often unmindful of the real interests of the poor, despite public statements and individual acts of commitment. Professionals as a group violate the health rights of the citizens, particularly the poor, by non-implementation, non-action, apathy, non-availability, provision of poor quality care, corruption and rude behavior (Narayan 1998). Though occurring to different extents in different parts of the world, this factor needs recognition and redressal.

e) Preventing Distortions due to Privatisation

Another important issue, in the current neoliberal context, that hurts the interests of the poor, is the promotion of privatization in all sectors, particularly in medical and health care, by powerful institutions such as the World Bank and allied bodies. Despite cautions by WHO, these institutions used loan conditions to further this agenda. Thus commercial high tech, secondary and tertiary care was introduced, opening up markets for multinational consumer products, along with stagnation and reduction in real public sector health spending. This worsened pre-existing inequities in health.

Global policy prescriptions for contraction of public sector expenditure, derived in part from over-extended unsustainable health budgets in developed countries, were applied to India in which public health expenditure was far below WHO recommended norms . This makes any contraction of health expenditure counter-productive, leaving money for salaries but not for service or infrastructure maintenance. A public private mix is advocated with a larger role for the private sector in the absence of evidence of significant or sustained private sector participation in health promotion, health prevention, rehabilitation or public health. There is also little evidence of greater cost effectiveness, efficiency or quality of care in the private medical sector, particularly in low-income countries where regulatory mechanisms are least developed. These policy changes have diminished access to care, particularly for the poor, causing shifts to poorer quality care in the informal sector and in households by families, thereby adding to the workload and anxiety, particularly of women. The ethics of introducing major policy changes, without evidence or monitoring need to be addressed.

There is widespread concern about the potential impact of the World Trade Organisation (WTO) agreements on access to health care (PHA 2000, Health Counts 2000). For instance the TRIPS agreement (Trade Related Aspects of intellectual Property Rights), through patents and higher drug prices, prevents access by the poor to the benefits of new science and technology developments in the pharmaceutical industry.

f) Responding to indebtedness and ill health

In low income countries, in the absence of functioning public sector health services, a significant proportion of persons with chronic illness or acute emergencies get indebted while purchasing private medical care (Narayan, 1998). In India, medical expenditure comprises the second most important cause of rural indebtedness. Studies in China show that chronic ill health is a cause for persons and families being pushed below the poverty line. Public sector provision of medical care therefore has a poverty alleviating effect on households.

At global level, NGOs, the Jubilee 2000 coalition, UNICEF and others have documented the adverse effects of international debt on the health of the poor. In 40 heavily indebted poor countries, life expectancy is 12 years lower than other developing countries and 27 years lower than industrialized countries (BMA, 2000). Debt repayments surpass health expenditures by 3-4 times in these countries. The per capita expenditure in health in these countries is less than £6, while it is more than £950 in the U.K.(*ibid*).

With a total debt of $2000 billion (UNICEF, 1999) there is a net transfer of resources from poor to industrialized countries and a continuing of the process of impoverishment, which has a deep structural roots.

Besides indebtedness, conditions linked to structural adjustment programmes result in increased unemployment, a shift to the informal sector where there is no social security, introduction of user charges, reduced access to care, downsizing of the public sector in health, changed nutritional status and increased nutrition, insecurity with withdrawal of food subsidies and currency devaluation. These changes have been documented in Africa, Eastern Europe, Latin America and Asia, with widening gaps between and within countries. Urgent action is required to address this issue.

10.4 Conclusion

Important issues concerning health of the poor and poverty and health linkages, have come to the global policy agenda, during the last few decades of the millennium. They reflect widespread concerns that we, the human race, have not done as much as we had hoped or expected. Valuable lessons have been learned, and insights gained, during the struggle or period of trying to reach Health for All by 2000. This knowledge gained has been both experimental and research based. The challenge before us is how we integrate this knowledge, including the

negatives, into positive, affirmative action for equity in health. Equally important is how we go about the process, moving beyond biomedical and market paradigms, allowing ourselves to be led beyond barriers, especially by the agency of the impoverished.

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11.

PUBLIC MOBILIZATION AND LOBBYING STRATEGIES IN THE SOUTH: THE PEOPLE'S HEALTH MOVEMENT IN INDIA

Thelma Narayan,* 2006

11.1. People's Health Movement – India: Origin and Overview

The *Jan Swasthya Abhiyan* (JSA or People's Health Movement India), a coalition of 22 national networks, alliances, movements, resource groups and federations of NGO's, is the Indian circle of the global People's Health Movement (PHM), working towards equity in health and development with a value base of social justice and health as a fundamental human right.

In 2000, after a year of extensive and intensive community mobilization at village, district and state levels in several parts of the country, a large gathering of over 2000 delegates from 19 states met in Kolkota on November 30th and 1st December, at the first National Health Assembly (*Jan Swasthya Sabha*). The Indian People's Health Charter was adopted, and participants decided to create the *Jan Swasthya Abhiyan* as a broad national platform to continue collective work on health and health care. This was just before the first global People's Health Assembly (PHA I)

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* NCC constituents-Asian Community Health Action Network (ACHAN); All India People's Science Network (AIPSN); All India Democratic Women's Association (AIDWA); All India Drug Action Network (AIDAN); Association for Indian Development, India (AID – India); Bharat Gyan Vigyan Samiti (BGVS); Breast Feeding Promotion Network of India (BFPNI); Catholic Health Association of India (CHAI); Christian Medical Association of India (CMAI); Federation of Medical Representatives and Sales Association of India (FMRAI); Forum for Crèche and Child Care Services (FORCES); Joint Women's Program (JWP); Medico Friends Circle (MFC); National Alliance of People's Movements (NAPM); National Alliance of Women's Organizations (NAWO); National Federation of Indian Women (NFIW); Society for Community Health Awareness, Research and Action (SOCHARA); Voluntary Health Association of India (VHAI).

National Resource Groups in the NCC are: SATHI – CEHAT, Pune; Centre for Social Medicine and Community Health, Jawaharlal Nehru University, Delhi; Community Health Cell (CHC), Bangalore; SAMA, Resource Group for Women and Health, Delhi; Health Watch, UP - Bihar

in Savar, Bangladesh, from 4th to 8th December 2000 which adopted a global People's Charter for Health and launched the Global People's Health Movement. This was a necessary historical step, as with the intensification of corporate led, neo-liberal globalization, liberalization and privatization it is necessary for a global movement to address global determinants of health, which have adverse effects on lives of people across countries. The PHM is a globalization of solidarity from below, which questions, influences and participates in change processes. Both charter's (see www.phmovement.org) form the framework uniting JSA constituents in India. Member organisations of JSA have several decades of prior involvement in people's movements, community based work and progressive thinking. Besides twelve networks/ federations working in health related areas, there is strong participation from the women's movement, science movement and the national alliance of people's movements. The growing *dalit* and environment movements and trade unions participate sporadically during events, though this varies in different regions. The disability movement is marginally involved. In terms of geographic spread, JSA is present in twenty two states with varying levels of activity at district and sub-district levels. There is minimal presence in the North Eastern states, in Jammu and Kashmir, the smaller states and Union Territories. Most national organizations have numerous groups and individuals as members, running into thousands in some cases. It is estimated that over 5,000 small groups would have been associated with some JSA activity at some point of time.

An analytical approach and or a community base or link forms the basis for motivation and understanding. The strength of the coalition is its diversity, spread, experience and willingness to work together. The plurality of perspectives and approaches is both a strength and weakness.

It is significant that a large number of 'non-health or non-medical' large networks with a clearer political stance, associate themselves with the JSA and actively participate in or support several campaigns. However, as would be expected, it is the health groups who maintain the continuity and momentum of work.

11.2 Organizational Structure

A National Coordination Committee (NCC)*, the national decision making body established in 2000 consists of representatives of the 22 national networks and resource groups. It has a Chairperson, a National Convenor and five Joint National Convenors. A national secretariat established in 2003, is currently hosted by one of the resource groups, SATHI – CEHAT in Pune, Maharashtra, supported by two members in Delhi. Frequent communications are maintained through an e-group, telephonic discussions and meetings once or twice a year or more frequently during campaigns and events. The joint convenors form the national working group, along with representatives from the states who jointly take responsibility for facilitating campaigns, events and communications in a given number of states.

Several states have structures such as state coordination committees and working groups. A larger e-forum, the PHA-NCC e-group is a discussion and communication forum. The website www.pha-india.org is one of the country websites linked to the global website www.phmovement.org.

The JSA hosted the global secretariat of the PHM and managed the global website from January 2003 till May 2006. This was based in a constituent organization, the Community Health Cell, Bangalore, a unit of the Society for Community Health Awareness, Research and Action (SOCHARA). A JSA committee supported the secretariat. Thus, JSA is closely linked to the global PHM, with several members actively involved in various initiatives and in expanding and strengthening the PHM in different regions of the world.

The organizational structure and functioning of JSA at national and state levels and links with the global level have been changing and evolving over time. As we cross the honeymoon period of seven years and reflect on the natural history and life cycle of movements, we will need to look at ourselves, our goals and strategize in the context of people's aspirations, widening disparities and global and national dynamics.

11.3 Charter and Background Documents

Five booklets prepared in 2000 for the mobilization prior to the first National Health Assembly continue to be widely used by health activists. They include –

a. What Globalization does to People's Health?

b. Whatever happened to 'Health for All by 2000 AD'?

c. Making Life Worth Living!

d. A World where WE matter!

e. Confronting Commercialization of Health Care.

Dr. Halfdan Mahler, former Director General of the World Health Organization, said ***"These books are the best expressions of the primary health care concept and its politics that I have ever read. They are the bible of primary health care, a glorious milestone on the tortuous road to primary health care".***

Used for popular education, they were translated and printed in 9 Indian languages in 2000. An English reprint in 2004 brought all five booklets together in *"**Health for All Now! - The People's Health Source Book"*** for the International Health Forum and the World Social Forum held in January 2004 in Mumbai. States like Karnataka brought out a sixth booklet and an additional booklet on street plays and health songs. The latter was developed by folk artistes after a three day workshop. Folk media is used in many parts of India for village and community level meetings. Additional documents and reports are produced during specific national advocacy efforts and campaigns.

The Charter available in several Indian languages, and other documents have a clear analysis and political perspective protecting and promoting citizen's rights and entitlements, particularly of impoverished sections of society, comprising the social majority in a globalized world. They address the broader determinants of health such as food security, livelihood, war and conflict, multilateral and bilateral negotiations, trade issues in relation to medicines, tobacco, alcohol and their impact on health of the public, etc and also focus on the need to strengthen primary health care in an era of privatization and commercialization. The analysis links the local and national situation to global events and forces. These documents and an evolving analysis inform the JSA campaigns.

11.4 Campaigns and Strategies

Several campaigns, a few of which are outlined below, have been undertaken by JSA since 2000 to influence health related policies in India using a variety of strategies and addressing different constituencies such as national and state governments, corporations, WHO, and the public themselves in case of socially embedded issues such as gender, caste and communalism.

a) Engagement with National Health Policy and links to Global Health Policy

A **campaign on health as a human right** was launched as one of the earliest collective initiatives on World Health Day, 7th April 2001 which was renamed as People's Health Day. Public rallies and meetings were held in some states.

A **critique of the National Health Policy 2002**, was published and discussed at seminars and in the media and also given to the Ministry of Health.

This led later to a **public dialogue** on health issues **with political parties in 2004** with media presence. A **policy brief** focused on health as a fundamental human right and pressed for the need to increase the budgetary allocations for health.

The new government in 2004 (presently in power) committed to increase the health budget in its **common minimum programme**, and initiated processes to develop a **National Rural Health Mission (NRHM).** The JSA lobbied with the Health Ministry and the Prime Minister's Office during this process and members were invited to join various task groups working on different aspects of the NRHM which was launched in March 2005. A shift was made in the NRHM, through proactive participation and lobbying from an initial demographic focus to decentralized integrated comprehensive primary health care, strengthening community participation and the role of local bodies through institutional mechanisms. JSA subsequently launched a **People's Rural Health Watch,** which has initiated work in 8 states to follow implementation of the NRHM at community level. A secretariat for the Watch is hosted by a JSA member organization, the Christian Medical Association of India in Delhi.

Around the same time a countrywide **Right to Health Care Campaign** was launched by JSA in September 2003 during the 25th Anniversary of the Alma Ata Declaration, for which strategic collaboration was established with the National Human Rights Commission (NHRC). The NHRC is a constitutionally mandated, quasi-judicial body headed by retired Chief Justices of India. The central and state governments have to take note of and respond to guidelines from the NHRC. A series of five regional public hearings were organized in 2004 by the National Human Rights Commission in collaboration with JSA, which documented cases where citizen's health rights were violated. Surveys of primary health care facilities were conducted and several local public hearings held. This culminated in a National Consultation held in Delhi in December 2004 with participative of senior health officials from all the states and JSA members. A National Action Plan was developed by the NHRC with JSA inputs and sent to all state governments. Action on these were reviewed in March 2006 again at a joint meeting. Joint Monitoring Committees were set up, though they are not yet functioning optimally.

In 2003, there was a very large response from India to the **Million Signature Campaign** to place Primary Health Care on the global and national agenda. This helped create a wider discussion and debate about primary health care within the country, at a time when global public private partnerships (GPPP) in health were galloping forward with direct involvement of transnationals with multilaterals, including WHO, in health policy making. There was a tension between different approaches. GPPPs on the one hand create and extend markets for 'global public health goods' and work on developing new technologies with a disease oriented focus. PHM promotes the primary health care approach; decentralized, integrated public health systems, with mechanisms for social control; community involvement in health decision making; and action on poverty and the social determinants of health.

There was strong Indian leadership and participation in **advocacy with WHO for the Primary Health Care approach** to become a priority for the organization. A critique of the report of the WHO Commission on Macroeconomics and Health, led to a PHM demand for a Commission on Poverty and Health articulated at a special technical briefing at the World Health Assembly in May 2002 and at the World Civil Society Forum in July 2002. Subsequent meetings, including one convened by WHO in London in June 2004, led to the launch of the WHO Commission on Social Determinants of Health in Chile in March 2005.

Thus JSA constituents have developed and operationalized multi-level linkages from local to global level, based on the understanding that one should think local and act global, reversing centralized elite and expert driven approaches.

b) Engagement with State Health Policies and Processes

Since health is constitutionally a state subject in India, some JSA constituent groups / members have engaged proactively in their respective states with state governments.

a. Karnataka: In December 1999, the Chief Minister set up a Task Force on Health and Family Welfare with professionals from the Community Health Cell as members. A strong focus on public health and primary health care was developed through a participatory approach and discussions with implementers and officials from several government departments, with social movements, NGOs and the general public. Nine research studies were commissioned. Action was initiated based on an Interim Report submitted in April 2000. A Karnataka integrated state health policy was drafted and the final report submitted in April 2001. The policy was discussed by government at various levels and adopted by the state Cabinet in February 2004 (see www.sochara.org). Some implementation has occurred and is being further pressed for by the state PHM unit, t*he Jana Arogya Andolana – Karnataka.* Resistance by a variety of groups and forces including the medical lobby and functionaries of the Department of Health, changes of government, lack of public awareness, apathy, difficulty in sustaining interest, a growing private health care sector and policy fragmentation have been some of the factors encountered in the implementation process.

b. Chattisgarh: The formation of the new state carved out of Madhya Pradesh in 2000, provided an opportunity for giving a new impetus for action relating to health. The health secretary and a group of NGOs supported by donors set in motion a process that resulted in the development of a strategic plan to strengthen the health system and train a large number of community health workers called *Mitanins*. One of the JSA Joint Convener's took up the challenge and become the Director of the newly created State Health Resource Center (SHRC), which developed an energetic young team who facilitated the training of around 60,000 Mitanins. The SHRC works closely with the government Department of Health and also works in partnership with a number of NGOs in the districts towards strengthening the health system. Support is also provided to other states with poorer health indicators including Madhya Pradesh, Jharkhand and others.

c. Other states:

- **Orissa** state also developed an integrated state health policy, facilitated by another JSA constituent. This was approved by the state Cabinet in 2003.
- In **Rajasthan**, PRAYAS, which is closely linked with the JSA and other organizations are involved in a variety of initiatives using a rights based perspective with communities and with the state and national governments.
- In **Maharashtra,** SATHI – CEHAT, CEHAT and other groups are involved in research based health work including public hearings, regulation of the private nursing homes and hospitals through legislative action and budgetary analysis. They have been a key group in the Right to Health Care Campaign in India and also in taking it forward globally.

Thus in the public health system and primary health care arena, the process of lobbying, engagement, movement building and campaigning are being taken forward proactively by JSA as a collective as well as by its members. In the process, there is grass root community

involvement as well as involvement of a number of young persons often with a professional or academic background, who have an exciting experience of doing something creative and meaningful. Many join the movement through this process.

c) Campaigns on Gender Issues

In early 2001 JSA joined the *campaign against sex selective abortion or female foeticide* by conducting a national public dialogue. Several member organizations and individuals have been the initiators of public action in this regard and continue to work actively on the issue. The most recent example being sting operations conducted with the television media in medical institutions in Rajasthan where medical staff were caught being complicit in this practice. This was followed by protest action and suspension of some staff. There is however still a long way to go in this deeply socially embedded issue, which is worsened by the misuse of medical technology by medical professionals. CEHAT has worked for several years on *Violence against Women as a Public Health Challenge.* A booklet was produced by them for JSA in 2002.

Women's access to primary health care is an important component of the campaign for primary health care and the Right to Health Care. A special campaign was launched on this theme by the Women's Global Network for Reproductive Rights (WGNRR). Some efforts were initiated towards gender sensitization of health staff.

A *People's Tribunal on Population Policies* was organized in 2004 in Delhi by the Human Rights Law Network, Health Watch-UP-Bihar, JSA and SAMA Resource Group for Women and Health, supported by field partners and organizations in different states. Around 120 women and men affected by coercive population (family welfare) policies from 14 states deposed before the panel. The Center for Social Medicine and Community Health has a long track record of researching this issue and pressing for policy change. Pressure from women's groups and several others over the past decade and a half, have helped to reshape policy and practice in this regard to an extent.

Some organizations have worked on *gender and power issues in medical education* taking it to a deemed university, which has launched pilot initiatives in a few medical colleges in the country. Some of the initiatives are not undertaken under the JSA banner, but key persons involved are linked to the movement.

The 10th International Women and Health Meeting (IWHM) on '*Health Rights, Women's Lives: Challenges and Strategies for Movement Building*' was held in Delhi in September 2005. The secretariat was located at and coordinated by SAMA – Resource group of Women and Health, a JSA member. JSA organized a workshop on "Politics and Resurgence of Population Policies: The Global Context". Several JSA members work on women's empowerment on health and a host of related social issues. The women's movement has a long history in India, and is linked globally. The IWHM was an expression of this solidarity and action.

d) Pharmaceutical Policy, IPR and the Campaign for Access to Essential Medicines.

This has been a two decade old campaign with organizations such as the All India Drug Action Network (AIDAN) and other national and state networks (eg, Drug Action Forum Karnataka) actively involved in legal action, public awareness and professional education. AIDAN is a member of JSA, as is the Federation of Medical Representatives Association of India (FMRAI), which is a progressive, proactive player in this area. Over the years, including after 2000, several meetings and initiatives have been undertaken nationally as well as in some states. JSA members have also been involved in developing Essential Drugs Lists and Therapeutic guidelines in some states.

More recently, the Government of India promulgated an Ordinance in December 2004, amending the Indian Patent Act 1970, moving from process to product patents without using the limited safeguards available in the TRIPS (Trade Related Aspects of Intellectual Property Rights) agreement. This was critiqued by JSA and others and public awareness created through pamphlets, seminars and meetings. Social movements including JSA and other organizations lobbied members of parliament and the Prime Minister, resulting in some modifications of the Ordinance, when the final Act was passed. Jointly organizing a national meeting on the Pharmaceutical Policy in 2005 and continued participation and support to specific campaigns regarding Gleevec (an anti-cancer drug) and on anti-retrovirals, spearheaded by HIV-AIDS activists, especially the Lawyer's Collective, has achieved small successes. Currently, there is an active campaign and lobbying regarding data exclusivity.

e) HIV – AIDS

Some JSA members played an active role in developing an **Asian People's Charter on HIV-AIDS**. This followed a major discussion on the issue at the International Health Forum, 2004 and a dialogue with the WHO unit on HIV-AIDS. The People's Charter after discussions in Bangalore, London and Nairobi, was launched at the International AIDS Conference in Bangkok in August 2004 during which people's protests and parallel sessions were organized. It has been translated into Spanish and Kannada. Several JSA members support local action and movements led by people living with HIV-AIDS.

f) Right to Food Campaign

Some JSA members have supported the larger Right to Food Campaign in India, which has been very active with Public Interest Litigations in the Supreme Court and much subsequent action. Material was prepared by the JSA and used for The **Hunger Watch.**

g) WHO Commission on Social Determinants of Health (CSDH)

JSA and a constituent member, the Asian Community Health Action Network were selected as Civil Society Facilitators for the WHO-CSDH for Asia. They organized meetings in several Asian countries with local PHM members and contacts. A representative is a member of the

Measurement and Evidence Knowledge Network of the CSDH. Globally, several PHM members participate as civil society facilitators in different regions as well as in other knowledge networks. Along with an Indian Commissioner, JSA members are lobbying with the government to make India a country partner of the CSDH.

h) Second National Health Assembly

Work is currently under-way for the Second National Health Assembly (NHA 2) to be held from February 23rd to 25th 2007 in central India in Bhopal. (**The city known world-wide for the industrial disaster in a Union Carbide (now Dow Chemicals) factory, that took thousands of lives. It has long term and trans-generational effects on the health of exposed people, besides causing continuing environmental pollution.)** The theme is "***Defending People's Health in an Era of Globalization***". Through this the JSA will continue to demand action on public health, health rights and the determinants of health. Preparatory workshops have taken place in February and July 2006. Another set of eight background booklets are being published. Social mobilization has been intensified, along with training workshops and meetings on critical issues. District and State meetings and conventions are also planned.

i) World Social Forum Process

JSA has organized workshops and participated actively in the Asian Social Forum in January 2003 and the World Social Forum in Mumbai in January 2004. Just prior to this an International Health Forum was organized with 700 participants from 50 countries, during which the Mumbai Declaration was adopted (see website). Members also participated in the World Social Forum at Porto Allegre in Brazil, in the Pakistan Social Forum and most currently with workshops during the India Social Forum, New Delhi in November 2006.

j) Tsunami Response:

Some JSA member, eg., the Community Health Cell, responded actively and immediately to the tsunami with medical relief, network building and longer term community health interventions ensuring community participation, collaboration between NGOs, and accountability of governments. A PHM meeting was organized in Chennai a little over three months after the disaster (8th and 9th April 2005), focusing on Thailand, Sri Lanka and India. A PHM statement "Responding to the Tsunami Crisis – a People's Health Movement Statement" was released, which also focused on the politics of aid and disaster response. Supported by Medico International, a web based Tsunami Response Watch was set up (www.tsunamiresponsewatch.org), which provided people's perspectives and tracked the follow up and implementation of promises made by governments and aid organizations. A CD titled "Living on the Edge" was produced which was used powerfully to change policy regarding temporary shelter and housing particularly of the Dalit communities.

11.5 Conclusion

- For the JSA 'the public' are active participants in a political, social process working towards social justice and equity in health and development, and not passive recipients of information. This is a gradually evolving process during which events, assemblies, and campaigns are methods or strategies to deepen and take forward the discourse, as well as to press for and engage in action. This is one of the strengths of the work of JSA and its constituents. Lobbying activities and engagement with state systems at different levels is a complementary strategy undertaken particularly by organizations and individuals with experience and expertise in health.
- Quite independent of JSA, there are innumerable local as well as large people's campaigns, struggles, movements and protests. Some of these are supported by JSA member organizations and individuals. Identities are not limited to being members of JSA, which is only one platform. Groups and individuals may have multiple associations, besides undertaking independent work.
- Voluntary work has a long history in India. In the absence of effective state functioning particularly in the area of health, humanitarian assistance has been fairly widespread through household level giving and sharing, along with service delivery by faith based and philanthropic organizations which often had a charity approach. A political approach was taken by many NGOs during the freedom struggle, and from the 1970s due to the slow progress towards social justice. However, perhaps as a strategy to stem this tide, NGOs received recognition as alternative service providers by large international donors, multilaterals and bilaterals from the 1980s and large amounts of money became available. This resulted in a mushrooming of NGOs and donor agency driven agendas and a process of de-politicisation. Multilaterals and bilaterals started 'using' pliant NGOs to achieve goals that they could not be achieved through governments, which were in fact mandated to work for development, equity and health. Issue based organizations with a societal or political economy understanding became a smaller voice. Terminology got co-opted and confused. World Bank and other institutions generated new knowledge and the privatization paradigm was promoted diverting attention from growing economic disparities, diminished community control over decision making and weakening of already underfinanced public systems, particularly in health and education. At community level NGOs are busily engaged with projects designed by experts. Large business foundations like the Bill and Melinda Gates Foundation and others have entered the health sector in a very big way influencing policies and attracting highly trained personnel as well as public sector personnel. Global public private partnerships such as the Global Fund (GFATM), GAVI, etc are having the same effect. The NGO sector has been affected. But it has also sharpened the debate which has drawn in academics, civil servants and intellectuals. In India, as in several other countries, movements are not growing weaker, but stronger and more articulate and visible for several reasons. In the JSA, the service oriented, NGO type of donor driven organizations are a minority, and they may decide through their federations not to participate in campaigns. However, a critical mass of NGOs, and individuals even among these groups have decided to be actively engaged. JSA has also dropped some organizations over the years

- JSA work could be viewed as part of the continuing freedom struggle from colonialism / imperialism, with large sections of Indian society still struggling for livelihoods, food security, access to housing, health and education. There are philosophical and other links with the various progressive political movements in the country.
- A coalition of constituents with slightly differing approaches leads to debate and some tensions. For instance, the role of the state may be view differently, with some challenging a coercive state representing elite interests, and others arguing for active engagement with the state so that it is more accountable and responsive to citizens entitlements and demands. However, there is enough space for a variety of approaches from 'Watches' to critical collaboration with the state, and involvement in initiatives to regulate the private sector.
- There may be hidden tensions between academics and activists though this has not surfaced in any major way. JSA has researchers, academics and practitioners working along with activists. The interaction results in a deepening of perspectives on all sides.
- Tensions between local, national and global involvements also occasionally surface. Making the links in the analytical chain is a challenge and is not always obvious. Work on socially embedded inequalities such as gender, caste (racism) etc requires different approaches as against addressing particular macro-policy driven inequalities or policies of the Bretton Wood institutions regarding trade and health.
- JSA works in a multicultural, multilingual context. While language translations are done, and efforts are made to be inclusive, certain sections of society may get left out or be only superficially addressed. Existing social hierarchies may be reproduced. Overcoming this requires constant critical self awareness and effort.
- A large number of complex issues are addressed by JSA, most or all of which find mention in the Charter. While functional leadership and responsibility is taken by different member organizations and individuals for different issues, there are several challenges and risks. There could be gaps between charters, and declarations, and what is pursued rigorously to its logical conclusion or what happens in the field. Overburdening and burnout of individuals and groups could occur. Event orientation may over-ride processes. Collective analysis and strategies can become difficult with a large amorphous group.
- However, we have moved beyond think tanks and geographic or issue focused work to a larger grouping for collective action as the JSA. The past six years have been a creative, constructive period with a lot of positive energies and synergies. Healthy working relationships have developed, which provide the base and a confidence to go forward in the years ahead.

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12.

From Savar to Cuenca via Bangalore - Experience of Sochara's PHM Global Secretariat Team: Reflections on PHM Realities & Future Challenges - 2003-2006

Ravi Narayan and Team, 2005

12.1 Preamble

This background note is based on the experience of the PHM Secretariat team (hosted by the Community Health Cell (CHC), Bangalore, on behalf of the *Jan Swasthya Abhiyan* –PHM India) from January 2003 till December 2005. For three years, we were the coordination, organizational and communication hub of the PHM wheel with spokes spreading out in different directions linking us to the founding networks and institutions; the regional and country level focal points; the conveners of various PHM circles, initiatives and campaigns. We were also in touch with all the individuals, organizations, networks and campaign groups who wished to join or be associated with the PHM or wished to seek PHM's inputs, perspectives or partnership with their specific event, initiative, campaign or document.

This linkage was established primarily by receipt and processing of over 100 emails per day, supplemented by telephone calls, personal visits to the Secretariat, and by discussions with PHM secretariat team members during PHM and other events at country, regional and international levels.

To operationalise the challenges of these evolving linkages with their own agenda's, needs, requests and initiatives, the Secretariat team facilitated processes using governance and decision making structures evolved by the PHM before January 2003. These included the global steering group; geographical and issue based circles; PHM news brief, exchange and website; and an evolving PHM funding group.

In the process of this direct involvement, the secretariat team developed a first hand understanding of the reality of these structures, links, initiatives, campaigns. We also experienced the strengths, weaknesses, opportunities, threats, cross cultural and regional diversities and dynamics of the evolution of PHM globally. This note tries to identify and highlight some of the challenges and

options and was a background contribution to the PHM transition process and strategy meeting held in Frankfurt hosted by Medico International from 6-9th of February 2006.

To stimulate discussion, this note does make some unavoidable generalizations and some provocative judgements – but all these are to be taken as a contribution to our current efforts at strengthening and sustaining the growth and evolution of PHM. We have enjoyed greatly this unique opportunity and responsibility and have appreciated the trust, solidarity and support received from so many from all over the world. However, we also realize how privileged we have been to shoulder this responsibility so early in the evolution of the post PHA-1 movement building process. Recognising the importance of documenting this experience of the early organizational history of this global movement, we have evolved this short paper as a constructive contribution to the further development of PHM.

12.2 PHM AS A MOVEMENT!

a) A movement is not an international NGO or an international health institution or foundation. It is not just a network or coalition; a campaign or issue raising group; an event or project organizer. Neither is it a travel agency for resource persons to move from conferences, seminars or workshops from one region to another; a coordinator of meetings and or field initiatives at local, national, regional or international levels; a community based or community oriented project or organization or just a fraternal group of friendly people and organizations coming together for a good cause. **What is it then?**

b) Our three year experience with PHM helped us to learn, that a movement was more than all these put together, even if some of our time during these years, was spent on activities that fitted into one or more of the above categories.

c) The movement, as we understood it, was a growing and diverse collective process of evolving circles at community, country, regional and international levels of individuals, groups, organizations, networks and campaigns, linked by a commitment to the Health for All strategy, and to addressing the deeper determinants of health with communities and marginalized peoples through health action. The circles were linked by geographical closeness (country and region) or by a common concern leading to action regarding specific issues from the large 'Health for All' agenda.

d) The movement was circles not pyramids of decision making and common action, that were inclusive and not exclusive or ideologically straitjacketed; that built on trust, mutual respect, with an ethos of debate and dialogue; identifying common, shared concerns while accepting diversity and plurality of interpretation and strategy. These intersecting PHM linked country, regional and issue or campaign based circles were further woven together by a series of evolving charters and declarations that symbolized this growing consensus of shared concern and evolving collectivity, particularly focused on impoverished people and communities.

e) If PHM has to grow strong in any region, and develop in a healthy and sustained way, then country focal contact points and their groups or committees need to:

i. be inclusive in their networking;

ii. work with trust, mutual respect and a sense of responsibility for the movement;

iii. appreciate cross cultural diversity;

iv. be non-hierarchical and participatory in decision making ;

v. be patient and constructive in their circle building efforts ;

vi. develop their concerns and activities with people and communities.

Capacity building for the above is a necessary and important challenge for strengthening the movement further.

f) Some problems possibly due to a lack of these approaches were seen in Switzerland (PHM Geneva group), PHM Mauritius, some situations in PHM Latin America and PHM Middle East. The lack of capacity to network was seen in some countries of Africa and Asia, where circle building has sometimes failed to take off. Part of the problem included leadership styles; social skills; sometimes local political or ideological differences; but often members of founding networks were not necessarily inclusive, and had difficulty in donning the more inclusive PHM cap. Being inclusive, without being ideologically vague, is one of the biggest challenges for the PHM.

g) The movement was a new experience with no direct parallel for comparison and hence is a very exciting development.

Internal Audit

If the PHM has to grow in different countries and regions, then selection of contact points and focal points who have these and other skills and capacities are crucial. Alternatively strategies that help chosen contact/focal points at country and regional level to develop these capacities and attitudes may also be necessary. An internal review of existing contact points would be useful

In some countries and regions ad-hoc, hasty selection of contact points without taking some of these capacities into consideration has led to a lot of time wasted, adversely affecting human relationship and bridge building. While the human relations challenge is inevitable in collective efforts, problems are not always unavoidable. A small internal audit cum support group within the evolving PHM global or regional governance system will ensure that these issues can be addressed, without distracting or sidetracking the work of ongoing coordination, planning and movement building.

Auditors could be senior PHM activists or members who have shown these capacities in the past

12.3 PHM VISION AND STRATEGY – WHAT AND HOW?

h) The PHM Vision: The Movement must have a Vision! The People's Charter for Health (PCH) 2000, and its two updates the Mumbai Declaration of January 2004 and the Cuenca Declaration of July 2005 articulate this vision quite comprehensively. The People's Charter for HIV / AIDS released in Bangkok in July 2004; statements on Macro-Economics and Health, Public Private Partnerships, Trade and Health, Primary Health Care, Health Systems Research, Disasters (Tsunami) and the Politics and Power of Aid, the Researchers for Health Statement (PHA 2),; and a series of press statements by the PHM media group articulate evolving perspectives, responding to new international developments and challenges in health.

A ' Vision' Booklet

A small booklet or a section of the PHM website or both Should be planned to increase ready access to PHM vision and perspective statements

A Strategy Review

A small PHM Strategy circle or perhaps the Research Circle should undertake an exercise to review the Charter, declarations, statements and press releases to evolve this booklet and to indentify and respond to dialectics and perhaps inconsistencies if any. Vision clarity and its communication to various constituencies is important, and consensus can be is built up through democratic debate

Strategic Options – what does the Charter offer?

i) The real challenge to PHM is not vision but strategy and action. The challenge is to convert vision into meaningful strategic options at different levels to symbolize the content, direction, role, function and responsiveness of the movement.

An overview of the Charter highlights key strategic directions. In order of their appearance in the body of the Charter these include.

Health for All means*:*

1. "Challenge powerful interests and political and economic priorities of globalisation.

2. Encourage people to develop their own solutions.

3. Hold accountable local authorities, national governments, international organizations and corporations.

4. Demand that governments and international organizations reformulate, implement and enforce policies and practices which respect the right to health.

5. Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.

6. Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
7. Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalized groups.
8. Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
9. Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
10. Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.
11. Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.
12. Oppose international and national politics that privatize health care and turn it into a commodity.
13. Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organizing public health services so as to ensure free and universal access.
14. Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organizations in the World Health Assembly, and ensures independence from corporate interests.
15. Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
16. Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people and public health-oriented, respecting universal ethical principles.
17. Build and strengthen people's organizations to create a basis for analysis and action.
18. Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
19. Demand that people's organizations be represented in local, national and international fora that are relevant to health.

20. Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world".

This list is a selection from a much larger one in the Charters and represents those on which PHM has taken action or needs to do something urgently

12.4 PHM Current Strategies (2003-2006)

By trial and error, through the steering group and in response to situations, PHM has evolved the following major strategic priorities over the last three years. Examples mentioned are those with which the secretariat has been more closely involved. There are other examples at regional and country level which are in the same genre.

1. Building country circles around community and national needs, challenges and opportunities

i. These are ongoing in some countries by proactive country contact / focal points e.g., Bangladesh, India, Italy, Sri Lanka, Philippines, South Africa, Egypt, Palestine, Australia and many countries of Central and South America such as Ecuador, Guatemala, Argentina, etc. This should be enhanced by further recognition, involvement and capacity building of well selected country contact points.

ii. Some country circles have been supported by visits of the global secretariat coordinator, steering group members and resource persons from the PHM who facilitated dialogue and workshops with potential PHM country circle partners, NGOs, academics, researchers and sometimes policy makers. In some countries, there have been more than one such visit – a PHM relay. These PHM relays have been effective in giving a boost or stimulus to country PHM circle mobilization. In USA, Iran and Pakistan, these have been primarily responsible for the establishment of the circle. This approach could continue as capacity building activities in the future. During the past four years visits were made to:

2002 - Kenya, Uganda, Tanzania, UK, Switzerland.

2003 - USA, Sri Lanka, Norway, Sweden, Netherlands, Germany, Iran, Italy.

2004 - Pakistan, Thailand, Mexico, Mauritius, Australia, Lebanon, Germany.

> The outgoing coordinator, some steering group members and resource persons who have shown an aptitude and skill to undertake this inspiration/mobilization task at country and regional capacity building circle, and supported to do the same in coordination with country and regional contact point in the future

2005 - Chile, Ecuador.

iii. PHM India, PHM Bangladesh have very strong, ongoing movement building experiences that need to be more widely shared. The collective effort of over 20 national networks learning to work together as PHM India; people's health tribunals; strong engagement, health policy work and health watch efforts with government health programmes; and

decentralized district level PHM mobilization in Bangladesh are all inspiring examples of relevance to other countries.

2. Building Regional Circles around regional needs, challenges and opportunities

- Some efforts have been made in East Africa; Latin America and Middle East, and in Asia.
- These need to be strengthened and could be an important adjunct to the process of increasing PHM participation in World Social Forum and Regional Social Forum processes. The opportunities to PHM provided by WHO-CSDH for facilitating dialogue with civil society can also be used to strengthen regional circles.

3. Facilitating PHM representation, participation in local, national, regional and international fora and meetings

There is regular input/involvement in the:

- World Social Forum,
- Regional Social Forum,
- World Health Assembly,
- Annual Forum of Global Forum for Health Research,
- Health Promotion conferences at regional / international levels,
- Canadian Society of International Health meetings,
- Meetings of National Public Health Associations,
- National, regional, international HIV-AIDS conferences and meetings.

In many of these conferences PHM resource persons have been on specific panels providing opportunities to raise PHM concerns and perspectives.

In several of these meetings PHM related participants have taken the initiative to organize special lunch time seminars or informal meetings for those interested in PHM so that they get an opportunity to meet the PHM participants, learn about the movement and join the movement if they are interested.

These proactive efforts need to be strengthened and increased so that PHM concerns and perspectives are more widely shared and the movement grows increasing its outreach and impact. Some mechanism and guidelines by which organizers / panelists participating in these events report back to PHM through short reports featured in the PHM exchange and the PHM website are crucial to ensure that the learning experiences are more widely shared. Regular reporting will also inspire more PHM related participants at such meetings to take the initiative to promote PHM concerns and perspectives.

4. Evolving an advocacy strategy to bring WHO back to Health for All perspective and goals and to focus action on health determinants.

The WHO-WHA advocacy circle in close coordination with the Research circle and the Global Health Watch group have very effectively advocated with WHO at different levels and through different strategies making them more open, responsive and keen to engage with Health for All goals and PHM concerns in particular. As of today, this strategy includes:

i. Regular and increasing proactive participation and advocacy in the annual World Health Assembly,

ii. Regular and increasingly proactive participation in the Annual Research Forum of Global Forum for Health Research

iii. Involvement with WHO Commission on Social Determinants on Health at all levels. PHM has a full Commissioner as well.

iv. Informal and formal advocacy including submission of position papers / policy briefs on areas of WHO concern and PHM interest.

v. Participation in WHO meetings including more recently the consultation on WHO General Programme of Work (2006-2015) and the earlier Madrid consultation on Primary Health Care Policy, etc.

vi. Participation by WHO team members at HQ and regional levels in PHM workshops and meetings including the Second People's Health Assembly.

vii. Increasing dialogue by PHM at regional levels with PAHO, EMRO, AFRO, WPRO and SEARO. All are beginning to show interest, with PAHO leading the way with excellent examples of dialogue and partnership.

PHM Advocacy with UNICEF / World Bank/ Global

Similar to the PHM WHO Circle efforts with WHO which are beginning to bear some results – PHM should actively evolve advocacy strategies with UNICEF and World Bank and perhaps the Global fund as well. The Save UNICEF campaign was starting point vis-à-vis UNICEF but this could now be converted to a PHM UNICEF watch. Similarly a group or circle that will monitor, watch and engage if required with World Bank. Health activities and Global Fund as well should be urgently considered.

5. Building Global Solidarity through regular participation in the World Social Forum (WSF) and Regional Social Forums

The WSF processes (both global and regional) provide a unique opportunity for PHM to dialogue with larger global social movements and apart from supporting them also adding or strengthening the health related agenda in their movements. The People's Charter for Health has calls for action that are so comprehensive that they very easily allow this form of linkage or complementary relationship

- PHM participation in the main events with two or three workshops or creative events have become a regular feature of the WSF and regional and country forum's that precede the global event.
- In 2002, 2003 and 2005 PHM also participated in the International Health Forum in Defence of Peoples Health in Porto Alegre, Brazil and in 2004 at Mumbai – it hosted the Third International Health Forum (see Mumbai Declaration, January 2004)
- In 2006, PHM is participating in all the three policy centric WSF in Caracas, Mali and Karachi.

PHM links to the Social Movement

A Circle to enhance this linkage and dialogue of PHM with the events and the culture of the WSF process. Some groups and could be involved to operation-alise the PHM - WSF circle and its activities

6. Global Right to Health Campaign (since 2004)

This has evolved through consultation at various levels, an extensive campaign with People's Tribunals organized by PHM India, and meetings at WHA and other fora with the UN Special Rapporteur on Human Rights. At PHA-2, after extensive discussion the global campaign was launched. Efforts are on now to get around 20 country PHM circles involved, adapting the campaign to local opportunities.

7. Disaster and Humanitarian Responses

- The PHM War, Disaster and Humanitarian Circle has been active raising issues and promoting collective initiatives during the build up to the Iraq war, and during the tsunami (South Asia), earthquake (Iran) and some Latin America disasters.
- The Tsunami statement on the politics and power of aid (April 2005), several press statements, the post BAM earthquake initiative, the Tsunami Watch project etc., are examples of practical initiatives that have greatly helped to enhance the visibility of PHM and also symbolize a responsiveness of the movement.

8. The active participation in the Annual Research Forum organized by Global Forum for Health Research (GFHR)

The WHO-WHA Advocacy Circle and the PHM Research Circle have been very effective in raising the profile of PHM in issues of relevant research important for People's Health in the annual forum's organized by the GFHR.

These have included:

- Presentation and participation in panel discussions at Annual Forum on Research priorities and issues from a PHM point of view.

- Facilitation of a NGO Civil Society Dialogue on Health Systems Research
- Articles and view points in Lancet and BMJ and other key journals.
- Very strong participation and inputs in the Mexico Health Research Summit, November 2004 (18 participants from PHM) which also impacted on the Mexico Declaration and led to PHM now being represented on the GFHR Foundation Council.
- GFHR also supported a Researchers Forum (dialogue with researchers) as a pre PHA2 satellite event which resulted in a small booklet released in Forum

9. The International People's Health University (since 2005)

- From January 2004, PHM has been seriously considering a proposal for regional capacity building and training of younger generations of activists for PHM involvement in the future.
- In 2004, IPHC – one of the founding networks initiated a process towards evolving an International People's Health University Project which will facilitate such perspective/ capacity building processes linked to international and regional events associated with PHM.
- At PHA-2, the IPHC facilitated the first IPHU session from 10-16th July 2005, with 60 participants from around the world (2/3rd from Latin America).
- The Frankfurt meeting will also be an opportunity to review this initiative further and plan its future content and strategy.
- The challenge to the IPHU initiative is to harness and involve all potential academic, research and training centres within the global and regional PHM circles in this international training initiative.

10. Communications and Campaigns

PHM has evolved a communication strategy to keep all its members informed about all that is happening within PHM circles at country, regional and international levels.

This includes:

a) PHM Website;

b) PHM Exchange

c) Regular News-briefs every 3-6 months (we are now moving towards a double bumper issue News-brief 16-17 - which will cover PHA-2 at Cuenca and the transition process),

d) A set of increasing PHM publications at national, regional, and global levels,

e) A set of audio visuals –video cassettes and CDs (see separate list).

It has also evolved campaigns from time to time which include:

a) The Million Signature Campaign (January 2003 Asia Social Forum), Hyderabad

b) No War, No WTO, Health for All Campaign, January 2004, IHF / world Social Forum, Mumbai

c) Save UNICEF campaign – March 2005

d) Women's Access to Health Campaign – Annual campaign of Hesperian, WGNRR of which PHM is a co-sponsor.

(see section on Issue circles as well)

Other campaigns and smaller initiatives have been initiated from time to time because of the enthusiasm of some PHM members but it is necessary to review them and decide on the following as a PHM campaign policy.

12.5 GLOBAL GOVERNANCE AND DECISION MAKING IN PHM

a. The Global governance and decision making process in PHM includes three components:

I. A global steering group which consists of

i. A group of founding networks and organizations

ii. A group of regional focal points

II. A Global Secretariat with a coordinator and a secretariat support group.

I) Global Founding Networks and Organizations

Issues of Governance in the context of Founding Networks and Institutions

1. All founding networks and institutions have played a crucial role in mobilization for and organization of PHA-1, in the formation of the concept of PHM and early governance, structure and initiatives of PHM

2. Now in 6th year of the Movement and based on the experience of 2001-2005, there is need for clarity in each of these eight networks on

a) Areas of support and focus

Technical - What issues of interest

Regional – What regions; Where strong

Membership , Who could be involved

Organisational (support to secretariat function) –

Which function if any of secretariat global/ regional contacts will they support?

b) Need to move beyond individuals/ icons of these networks to more institutional/ network policy linkages

c) Need to build PHM projects/ related initiatives including funding support into their annual/ perspective plans of action and budget of each of these networks

d) Clarity of identity with PHM at all levels- national, regional and global

3. Larger issue for policy review

a) Should founding networks or organizations continue to be represented in the Steering Group separately or should they merge into regional & country level coordination and representation?

If they continue then for how long? Till PHA 3 or permanently

b) What should be the PHM governance response be to inclusion of other global networks like IBFAN, IFMSA, WSHE

ii) Regional Focal Points and Coordination

Apart from the eight member, representatives of the founding networks and organizations the global steering group in the last few years 2002-05 has also consisted of 9-13 additional members who were representing the thirteen regions into which all the original 75 countries (represented at PHA1) were divided. A SWOT of this component of the steering group membership and contribution is as follows:

i. The regions which had a representative (focal point) where South East Asia, India, Southern Africa, East and Central Africa, Middle East, Europe, Central America and Caribbean's, South America and Australia, New Zealand & the Pacific.

ii. North America had two US representatives and PHM USA was facilitated jointly by the Hesperian Foundation and Doctors for Global Health and the absence of a representative from Canada was an additional factor. Further West Africa and China had no representative even though we tried to get WGNRR, (Cameroon) to stand in as a contact point. South Asia had Qasem, even though he was also ex-officio because he was the outgoing coordinator.

iii. Efforts were made to specify the countries allotted to each region and help the focal points initiate regional networking among the contact points of the countries in the region so that they would enhance their representativeness on the Steering Group. This representativeness was enhanced in East and Central Africa, Southern Africa, Europe, India, Australia-New Zealand and the Pacific and Central America and Caribbean's. This was less successful in South Asia, South East Asia, South America and in the absence of focal points not possible in China and West Africa region. However, the efforts in the Middle East region were probably the most effective.

iv. Apart from representativeness, the real problem experienced was responsiveness. In spite of setting up a steering group – yahoo. Group for governance and decision making convenience, that was efficiently moderated by Maria – many SG members neither acknowledged the communication nor provided responses to decision making options or queries on matters of PHM planning and policy. Some complained that the secretariat sent too much mail and too often but any changes in size or number or even labelling them as alerts; needing priority attention; just communication etc., failed to enhance adequate participation. The few who did were mostly representatives of other networks and hence were sympathetic and responsive to the process of communication.

v. We included all the members of the secretariat support group on this yahoo group. They were not steering group members officially but were volunteers who had offered to support the secretariat in specific functional areas and some others who were convenors of issue circles. On the whole, these volunteers were more responsive than most of the steering group and this was very supportive of the secretariat team's morale.

Evolving strategies for organizational communications in concentric circles

There is need to have concentric circles of e-group listing to enhance various levels and degrees of decision making and or enhance internal communication in PHM. This may involve the following circles

- a core for decision making; a core +secretariat support group;
- a core +secretariat support group + country contacts;
- a core + secretariat support group + country contacts + campaign issue circle convenors

vi. Most regional focal points with the exception of Latin America / Australia and North America did not evolve any mechanism to communicate with country contact points in their region so this responsibility became an additional burden on the secretariat team and often we had to send it to everyone directly with no amplification or support from the regional focal point. Hence, potential strengthening of regional level communication strategies did not take place as widely as we had hoped.

vii. Enhancing regional coordination is an important organizational imperative not only to reduce the overall burden on the inevitably small global secretariat team but also to enhance responsiveness, regional decision making, regional capacitation and regional communication. With the exception of Middle East and Central America which were good even before PHA2 and probably North America and Australia and Pacific after PHA2 this capacity will take some time to build in the different regions. Hence, while a collective regional coordination (a horizontal structure of equal regional coordinators) who work complementary to each other such as in HAI or other networks is an excellent proposition and definitely the way ahead, the presence of very unequal regional capacity at present will require some proactive global coordination or convenorship for some time to come. In the absence of such global coordinatorship – often proactive, bridge building, linkage promoting and opportunity exploring, the movement will just disappear or collapse in some regions today.

viii. The choice is not simply global –vs- regional coordination but an active regional capacity building strategy by a global coordination council / secretariat as pro-requisite to a more horizontal governance structure in the future perhaps operationalised before PHA3.

ix. The number of regions (original 13 of November 2001 proposal) has been found to very unrealistic and unwieldy in terms of organizational efficiency and support to decision making processes.

x. Eight or Nine would probably be more feasible and practical especially if we are also going to consider finding more full time regional coordinators who have an NGO in the region backing them up with supportive services as hosts of regional secretariats.

xi. Finally, while deciding on the number of regions and distribution of countries – the transition team must recognize some regional processes that have been strengthened particularly in the mobilization phase towards PHA2. These should be recognized, respected and strengthened further. Key among these ongoing are:

a) **Africa region**: The regional meeting of Civil Society in Health organized in Lusaka, Zambia in February 2005 brought together many Africa based networks including PHM Africa. The group helped the mobilization process for PHA2 and helped evolve the special plenary on Africa at PHA2. A five member group facilitated this and at PHA2 and thereafter two members have continued to support the process including the interaction with WHO-CSDH in the region. It is important to take this process forward after reviewing the experience of 2005. This is particularly important because several efforts in 2002, 2003 and 2004 of PHM resource persons trying to facilitate regional and country level meetings as promoters / visitors from other regions failed to take off. The more local effort in 2005 seemed more feasible.

b) **Middle East in Region** – the region has been mobilizing as a regional group for many years but their efforts got a boost with preparations for PHA2 and the WHO-CSDH process thereafter the proposal for hosting the secretariat that evolved from the region after PHA2 had a very good regional process / movement building plan. While coming to terms with inclusion of Iranian PHM and perhaps people's health group in Israel as well in an inclusive way as also North Africa, the regional process needs to be strengthened with focus on PHM circles at country level. Perhaps hosting the global secretariat will enhance the regional capacity as well. There is a lot of country level potential particularly simultaneously is Egypt and Lebanon that can be tapped.

c) **North America** – PHA2 mobilization and the actual event has led to great strengthening of PHM mobilization in USA and Canada and much greater potential for a North American regional dialogue and joint planning. At Forum 9 in Mumbai –PHM Canada organized an informal meeting as well and PHM USA has also been moving from strength to strength. There is great scope for the North American region of PHM becoming a strong resource group for International Health Advocacy as also a funding support partner for PHM especially supporting regional initiatives.

d) **Europe Region** – the paradox of PHM Europe has been that it is among the strongest resource groups of PHM – the funding operations are facilitated there; the Charter translations are tracked; the Global Health Watch 1 secretariat was based there; the annual Women and Access to Health Care campaigns are facilitated / coordinated from there; the early communication efforts were supported from there; PHM members in Netherlands, Germany, Switzerland and Italy are strong supporters / participants of all PHM events and initiatives etc., etc. But country circles focused on local Health for All challenges are not yet getting established. More recently, the evolving network regarding the movement against privatization of health care with strong trade union roots and European, Social

Forum linkages is a good step to shift focus from international solidarity effort to local country level health action. The discussions among PHM Europe region contacts has also led to the identification of language and cross-cultural challenges in the European region. The North and South of Europe and perhaps East and West have their own challenges and PHM Europe region has to tackle the challenge of bringing together nearly 46 countries with all their diversity. A growing link between international solidarity group and local HFA action groups especially among the trade unions and radical professional groups may be a good way ahead to strengthen further the PHM in the region.

e) **Australia, New Zealand and Pacific** – the Australia PHM has been steadily evolving for the last few years with a boost following the interactions by the PHM resource group from other regions before the Melbourne conference in 2004. The mobilization for PHA2 further strengthened the links with indigenous people and some extension of linkages with New Zealand also took place. Other island country contacts need to be identified and the regional activity further strengthened. The PHM OZ website has been an inspiration. It could be a vehicle for stronger regional networking.

f) **Asia** – originally divided into four regions (South Asia, India, South East Asia and China) Asia has had a mixed regional development. The presence of HAI-AP, ACHAN, CIROAP and TWN and the strong PHM movements in Bangladesh and India have meant that Asian PHM circles have been meeting quite often at various network meetings and regional workshops and at the Asia Social Forum and other key meetings. Country circles have developed to varying extents in Nepal, Pakistan, Sri Lanka, Philippines and are evolving in Malaysia, Indonesia, Cambodia and Thailand. Progress in Vietnam, Myanmar, China and Japan is poor. Regional UN organisations like UNESCAP and WPRO and SEARO have been slowly beginning to recognize the PHM in Asia as a resource. UNESCAP involved PHM in orienting its new health unit team and also in evolving its health policy for Asia.

However, a regional identity of PHM as PHM Asia or even PHM South Asia and PHM South East Asia is yet to emerge. This needs to be constantly worked upon building the resources and opportunities provided by various Asian Networks already interested in and supporting PHM. The enthusiasm of evolving the People's Charter for HIV / AIDS and the evolution of APPACHA was a good initiative but like many others lost some steam along the way. WHO-CSDH-CSO Initiative in India and Bangkok and WSF Karachi (March 2006) offer good opportunities.

ACHAN which has been dormant for a while, but now recently, more involved with Tsunami Watch and also PHA2, should be revived to play a much more significant role with probably younger leadership. A concerted effort by all the five networks in Asia – HAI-AP, CIROAP, ACHAN, TWN, ASF and supported by strong PHM country resources in India and Bangladesh could lead to a region strengthening strategy. This is urgently required. The WSF in Karachi in March 2006 and the next National Health Assemblies in Thailand 2006 and India 2007 may be opportunities for such cross regional efforts.

g) **Latin America** – these includes the PHM regions of Central America and the Caribbean's and South America. The regional mobilization has been historical and strong even before PHA1 and now recently for PHA2. But the region faces some important challenges

- the language diversity – Spanish and Portuguese is a challenge
- the high degree of political awareness and complexity provides a challenge for the issue of PHM inclusiveness and the secretariat has received in the last few years the largest amount of feedback on this matter and has found it not an easy matter to address.
- the region is one of the most inspiring of the PHM regions for the wealth of movement experience including the growing indigenous people's empowerment, and the phenomenally creative culture of protest and celebration, as was evident at PHA2.
- Latin America has so much to offer other regions if some of these complexities could be transcended and the global coordinatorship which was already available for the PHA2 organisation further extended for the next phase.
- The recent political changes with a growing axis of good – Cuba, Venezuela, Bolivia, Chile, Uruguay, Argentina offers a larger regional context of change that makes PHM more meaningful and viable in the region.

In conclusion, there is great potential and possibilities in enhancing regional coordinating both as a concept and thrust of PHM in the next two years building on the ongoing processes discussed above. This should be done however with a specific focus of regional capacity building by a catalyst team which can do it in a participatory, facilitatory way enhancing local effort and local creativity. It will not happen spontaneously so some global planning even to facilitate a group of people who will do this activity in a focused committed way must be operationalized fairly soon.

c) Global / Regional Secretariats and steering group

Guidelines relevant to a PHM global secretariat were evolved in November 2002 at Gonoshasthaya Kendra, Savar – Bangladesh, (PHM steering group) before the shift of PHM secretariat to CHC, Bangalore. These have been circulated (January 2003). Also, how these guidelines were operationalised by the Bangalore has also been circulated (to help Middle East and Latin America understand the dynamics / challenges of global coordination while they were evolving proposals to host the global secretariat.

In this report, we shall not go through these points once again since those documents can be referred to suffice to. A few general points relevant to global or even regional secretariats are included here.

The concept of a global secretariat with a full time coordinator and a small team of communication officer, secretariat assistant etc., was a necessary aspect of the phase 2002-05 because the PHM was an evolving concept and movement. However as the movement has grown rather unexpectedly both in visibility and in terms of demands on global secretariat teams this is not a viable proposition now.

a) A large number of activities / responses / functions presently carried out by the global secretariat and coordinator can be better done perhaps more effectively by regional coordinators if they have the capacity and aptitude to be inclusive, representative and responsive. Funding a larger number of regional NGOs who will support regional secretariats and perhaps even provide a senior team member to do the temporary (part time job) of a regional coordinator may be easier than trying to identify a global coordinator in a region to do the job the Bangalore team did.

b) CHC Bangalore had a rather unique history of networking and movement building in India and later South Asia for over 2 decades, resulting in facilitation of some significant aspects of PHM India mobilization. They also had a senior team member like Ravi Narayan available to be full time on this global assignment. The coordinator of the global secretariat had the full support of CHC team since support to PHM secretariat and process was one of its key initiatives for the phase. So its funding partners were also supportive, as were PHM resource persons from the region. This led to an unusual combination of supportive factors not easy to find in every hosting region willing to host the secretariat.

c) So new approaches may be required. One of this enhancing is regional coordination with supportive NGOs hosting regional secretariats and providing at least part time coordinator who can work together as a global coordination council.

d) Whether global or regional secretariats some factors need to be looked into as we evolve responsive governance structures at all these levels including steering groups or coordination council

e) All global or regional steering groups or coordination groups or coordination councils or (whatever the new nomenclature) must have chairpersons so that coordinators are not expected to do both executive and convening roles, which can be conflicting.

f) As a general rule, steering groups should not consist of icons or very famous or well known resource persons. These should be on advisory groups. Efforts should be made in a concerted way to identify and foster younger leadership in all regions who can be more responsive and creative to the current situations.

g) All councils or steering group members should have limited periods on the group / council – never more than 2 years so that there can be rotation of responsibilities and 'new blood' all the time.

h) Some watch on 'representativeness' and 'responsiveness' of council or steering group members must be maintained to enhance the potential of PHM mobilization at every level.

i) While funds and other forms of resource support may be provided from the global budget of PHM to support, kick start or facilitate regional mobilization and capacity building – regionalisation should also focus on regional capacity building which should ultimately lead to regional capacity to plan, organize, raise own resources and evolve local governance and advisory structures without too much reliance or dependence on global effort / coordination.

12.6. ISSUE CIRCLES

The experience of the secretariat in supporting / facilitating issue based circles and campaigns have been very diverse.

Only three circles the WHO-WHA Advocacy Circle; the Research Circle and the War and Disaster Circle have been consistently active and responding to requests, events and evolving some collective initiatives around World Health

i. Assembly; Global Forums for Health Research and Natural and man-made disasters respectively helping greatly to enhance PHM visibility, relevance, contribution and to some extent impact as well. The membership of these circles has been varying, some events / initiatives linked to the circle activities getting more responses and participation than others. However, even these three circles need to plan their communications on the PHM Exchange and PHM website in a more coordinated way to interest new members in their activities.

ii. Efforts to facilitate a PHM – HIV/AIDS circle after the UNAIDS request for a dialogue in 2002 and the interest shown by WHO with its 3 x 5 initiative to dialogue with PHM around IHF/WSF Mumbai, January 2004 saw some activity leading to the development of the People's Charter for HIV / AIDS before the Bangkok World AIDS Conference. However, this circle has been somewhat dormant since.

iii. A Macro-economics and Health Circle worked on a statement / PHM position on Jeff Sachs report. This was circulated at the WHO regional dialogue with Civil Society in Colombo (SEARO and HQ initiative).

iv. Politics of Health – IPHC had offered to host this circle since it was central to their contribution to HFA before PHA1 and as PHM evolved. But there has been a lack of clarity about this circle and how it differs from IPHC itself.

v. Disability and Economics Circle – a meeting was organized at one of the GFHR fora and there was some interest in many.

vi. **PHA2 – An international organizing committee (IOC**): This was set up to help with PHA2 organisation and mobilization. After an initial well planned meeting between IOC and the local /national committee in September 2004, the PHA2 Organising Circle / IOC failed to work as an effective supportive circle. Hopefully, the PHA2 review that is expected soon will try to explore and establish factors and learning experiences for this inadequacy, which greatly affected the pre PHA2 developments and increased the load on a few people left to handle the responsibility.

vii. More recently, Global Health Watch, Global Right to Health Campaign and WHO-CSDH dialogue with PHM are three PHM related activities which are evolving into relevant and perhaps effective circles of PHM members working together.

The presence of an efficient secretariat team in the GHW1 context; the presence of consistent interest and initiative in GRHC context and the presence of a full time PHM Commissioner on the WHO-CSDH and strong PHM supporters in the CSDH Commission have been responsible for the evolution of effective circle like developments.

PHM Communication Circle: The idea of bringing together PHM resource persons and secretariat support group members who help with communication, Website, News Brief, PHM Exchange, PHM Charters translation and Media have failed consistently in spite of efforts in 2002

viii. through a paper on communications as if people mattered and efforts in January 2004 (IHF) to circulate a paper on communication challenges.

Recently however after Cuenca PHA2 due to the enthusiastic young Bangalore based website volunteers, a website linked communications circle has been established bringing together all the website managers and editors of an increasing number of global and regional and country level websites which have a strong PHM linkage or content.

ix. IPHU at PHA2 has resulted in three potential circles of IPHU student volunteers in the areas of Trade and Health; PHM experiments; and Social Determinants of Health. These are evolving slowly.

Policy on Issue Circles/ Campaigns

- A time has come to move beyond this sort of adhoc circle formations that wax and wane with activities to the evolution of certain guidelines or framework for issue circle convenors in terms of communication/organizations/links to exchange/ web-site and other structural /functional imperatives so that issue circles become a more visible and a more effective form of PHM growth and evolution.
- The website and the PHM Exchange should be the key vehicles through which issue based activities in PHM are communicated and new members are constantly invited/encouraged to join in. This will greatly increase the value and meaning of PHM membership
- Another important policy guideline is to decide when an issue circle becomes a campaign? A campaign must have some core objectives, methodology, an advisory and decision making structure, a time schedule and perhaps some funds of its own

12.7 SOME STRATEGIC THRUSTS

The Bangalore phase of PHM movement evolution has seen six strategic thrusts that go beyond governance, vision, action, funding and communications. These thrusts were seen as crucial to long term sustainability and to the celebration of diversity and plurality of this unique movement.

a) Rebuilding Bridges

The first People's health Assembly had been a great experience of organizing a multi cultural, multi-regional, people's dialogue effort with creativity, competence and a solidarity building ethos. Inevitably however the organizing group and many of the supportive members had experienced the stresses and stains of such a multi dimensional decision making effort leading

to breakdown in some post PHA1 communications, reduction in enthusiasm levels of many participants and supportive networks and NGOs, crossed communication and some degrees of exhaustion, and unmet expectations. As a relatively new member in the global planning group, CHC had the unique experience of not being easily identifiable as linked to these past conflicts and dimensions. As we discovered them along the way, accidentally or through participant feedback and communication, we took very personal and proactive steps to help heal these feelings by encouraging participants of PHA1 with such mixed or negative feelings or experiences to appreciate the larger inspiring reality of the evolving PHM and to get involved with the movement in newer and more creative ways transcending the negative experiences of the past. Without listing such individuals / groups for obvious reasons – one of the nicest experiences of the secretariat team was to see nearly all such people back to work with PHM and strongly involved in PHA2 (healed, enthusiastic and actively contributing at local, national, regional or even global level). We believe that this was a crucial contribution and a lesson for the future as well as we track the post PHA2 scenario which would have had similar experiences.

b) Mobilizing newer and more youthful leadership

Another effort on our part was to identify and support / facilitate newer and often younger leadership in PHM so that the movement was more sustainable and not over dependent on the 'networkers' and 'activists' of the pre 2000 AD era. While respecting the contribution of these elders and their radical perspectives and recognizing the need to keep them involved as advisors, 'perspective builders' and 'inspirers', efforts were made to give newer resource persons (who were less well known globally / regionally but showed great potential capacity and enthusiasm greater opportunity to get more involved with PHM initiatives and take more focused responsibility for management and action. This was not an easy task because many of the 'activists' of the past are not always ready for this shift and have not always been developing younger leadership in their own areas of focus and influence.

However, our experience was very positive and we are very glad that as we transit to the next phase of global coordination, a large number of younger leaders are visible in all aspects of PHM activities. They need to be supported and encouraged in the next phase as well.

The presence of youth in all aspects of PHA2 organization and the effective IPHU experience bringing nearly 60 mostly younger activists were also symbolic of this trend. Efforts were also made to keep in touch with IFMSA, IPSA and other groups focussing on younger potential leadership. This whole process needs to be maintained.

c) Engagement with mainstream not only confrontation

Another major thrust in the PHM Secretariat's efforts since 2003 was to shift the focus of PHM initiatives from only confronting the main stream through protests, street actions and other modes of democratic dissenting – (which are very necessary because of the over dominance

and cancerous spread of neo liberal economic and political determinism) to a more confident and more strategic process of engagement with the mainstream using strategic openings and opportunities (what may be called chinks in the armour) so that we built hope, enthusiasm and 'space for alternative thinking' even within mainstream institutions and the public health system. It was important not to remained confined to pre 2000 AD strategies of 'talking to the converted' or being preoccupied with micro level community based alternatives (the romantics of PHC / HFA) or becoming hopelessly cynical because of our perceived weakness, lack of resources or lack of recognition by the system.

Whether it was the advocacy with WHO, active involvement with WHA or the active participation in the GFHR fora or whether it was the PHM country relays that included meetings in the universities and with policy makers in every country visited, we consciously promoted the presentation PHM concerns, perspectives and Charters in mainstream institution and to policymakers with the confidence that 'evidence' was on our side. It worked to some extent at least especially in events related to WHA, GFHR, GHW releases, WHO-Health Systems Task Force and WHO-CSDH where we saw some results and impact.

d) Inspiring and informing 'evidence gatherers'

During the current phase, we have also attempted to take the PHM Charter to academic and research institutions so that mainstream institutions orient / inform their students about these perspectives and help to build up greater awareness among the future academic and researchers on the social determinants of health and the alternative socio-epidemiological analysis that is central to the People's Charter. Surprisingly, this effort has been more successful than earlier envisaged. The Charter is now recommended to students at the London School of Hygiene and Tropical Medicine, some of the Scandinavian Schools and other institutions. Mainstream journals have run articles by PHM resource persons. The presentations at the Annual Researchers Forum of GFHR and the Research Forum on People's Health preceding PHA2 are good examples of increasing interest in academics and 'evidence gatherers' in PHM concerns and analysis. The Global Health Watch report has been another such linking effort. Over 125 contributors to GHW1 included only 25 with a direct PHM linkage and similarly the Latin American GHW brought together over 30 resource persons from the region in a collective evidence gathering exercise. The IPHU and the WHO-CSDH knowledge hubs in which PHM is very involved are all additional opportunities. If demand creators (activists) and system builders (academics and researchers) can begin to work together with respect and trust and a mutually acceptable alternative perspective, the movement would be strengthened at all levels.

e) PHM as Generic not Brand

This has been the most difficult but challenging proposition. To help PHM recognize all potential partners focusing on PHM as a generic process rather than getting too carried away by

establishing PHM as an overarching brand. This has meant a policy of increasingly recognizing network and campaign groups at local, national, regional and international level as natural partners of PHM and not trying to make them members. This has been done by exploring linkages, common activities, co-sponsorship and collective action. PHM has met and worked with Oxfam, MDM, SCF, IBFAN, Environmental groups, IFMSA, various formations within the WSF arena and other groups at WHA, WSF and other events without too much hassle, encouraging groups to recognize PHM as a partner. This has also helped PHM visibility and outreach. A similar policy could be more actively followed at local, national and even regional levels. The challenge for maintaining this clarity between recognizing lower case – phm as spontaneous movements at every level and higher case PHM, which are initiatives / events sponsored by Global PHM will continue to be a healthy impetus for the growth and evolution of PHM.

f) Some Continuing Challenges

While all the above thrusts began to make some impact and be accepted slowly by the PHM members at different levels, there were some areas in which the secretariat team remained disappointed because not much headway could be made. Perhaps this will continue to remain challenges to be addressed in the next phase.

i. The PHM website, communication and media efforts continue to be dominated by English and the English speaking world continue to be more involved in PHM because of this dominance. While a concerted effort was made to break this language divide by more Spanish-English efforts for PHA2 the language divide remains a challenge. It's not just a matter of communication but much more so the loss to PHM from the absence of cross cultural fertilization of ideas and creativity.

ii. There is much more people/ community level PHM efforts often termed grass roots mobilization taking place at the initiative of local, community, district and sub-national PHM circles and members many parts of the world. However, the communication of these efforts at local / community level are not reflected adequately in our website, publication, reports – these appearing to be thereby focussed only on national and even more so with regional / international events and global levels of activity. Much more effort must be made to record / document the grass roots level of initiative especially by harnessing younger volunteers to document them and perhaps more creative media efforts to focus on reporting them.

iii. Enhancing responsiveness of the PHM participants in governance structures at all levels and enhancing representativeness of those participants will continue to be a great challenge. For PHM to be a more effective movement this internal democracy has to be constantly strengthened at all levels.

12.8 IN CONCLUSION

The next phase of PHM evolution and development post PHA2 will hopefully be a phase marked by greater representativeness and responsiveness of PHM structures, for governance, action and communication

i. A phase of greater rationalization, decentralization and regional and country level capacity building.

ii. A phase of greater maturity and strategy in our PHM initiatives for engagement and confrontation with the mainstream policy and system building efforts.

As Harris and Seid in their latest Book on Perspectives on Global Development and Technology (Bril, 2004) have noted.

"the People's Health Movement (PHM) is clear evidence that the existing linkages between globalization and health are contestable……..

……The People's Health Movent and the People's Charter for Health provide a significant expression of alternatives 'from below' to the present globalization, privatization and commercialization of health among 'from above'.

...The People's Charter for Health lays out a blueprint for the transformation of the existing global circles through democrazation at all levels of the existing system and through what some people in the global social justice movement call 'globalization from below.

...It is based on the assumption that global decisions must be demonstrated and that people's organizations and organized grass roots action can bring about an alternative vision of development – one that promote human and environmental well being. To achieve this vision, the PHM is pursuing the democratization of health decision and outcomes at all levels.

...One of the most strategic assumptions held by the PHM is that it will take organized grassroots action as well as concerted action at the global level to bring about the profound social changes that are needed to achieve the sweeping vision and radical goal of the movement."

The increasing recognition by the non-PHM world of the PHM world is a challenge to us as well as a great responsibility. Are we building the movement adequately to be responsive to such expectations? That is the continuing challenge before us.

13.

Towards a Broader Understanding of Social Vaccine: A Discussion Paper

by Naveen I. Thomas, 2006

Introduction

The search for better strategies for HIV prevention and the long wait for an HIV vaccine or cure for AIDS has led to the popularisation of the 'social vaccine' concept. Though used variably, the concept has gained wide recognition with many agencies and forums working on HIV/AIDS, including UN bodies like UNAIDS [1] and International Labour Organization (ILO)[2], endorsing it.

Origins

Though the origins of the 'social vaccine' concept is not clear, its use can be traced back to the counselling and psychological studies stream. The California Task Force to Promote Self-Esteem (1990) described 'self esteem' as a *social vaccine or a dimension of personality that empowered people and inoculated them against a wide spectrum of self-defeating and socially undesirable behaviour*.[3]

The concept of 'social vaccine' was also used in other areas like de-addiction and control of addictive substances like tobacco and drugs. Here, the use of 'social vaccine' referred to creating an atmosphere where the use of such addictive substances was discouraged and even disparaged. Public opinion was seen as a *powerful social vaccine that effectively precludes certain behaviours*[4] in the fight against tobacco and drugs.

HIV/AIDS

In the field of HIV/AIDS, the 'social vaccine' concept came to be used in the 1990s where it referred to a *comprehensive package of preventive education, promotion of contraceptive use and edification of communities*. This approach was used in Thailand to suppress HIV infection rates and was cited as a model to be emulated.[5]

However, the concept of 'social vaccine' was variably used even in the field of HIV/AIDS. It varied from using it to refer to prominent personalities and traditional leaders interacting with people 'dying of AIDS'[6] to 'prevention and control'[7] to 'sex education'[8] to 'education' in general[9] to 'multi-dimensional response' involving elements such as 'preventing social exclusion, protecting incomes and social security schemes, and promoting solidarity with people with AIDS.' [10]

The varied usage of 'social vaccine' leads to a certain degree of confusion and ambiguity about the concept itself. Does it actually represent any or all of the descriptions mentioned above, or is it actually a 'metaphor'[11]? It is useful to further examine a few of the usages and its origins to answer this question.

Involvement of Traditional Leaders as Social Vaccine

Dr. Donald Ray, a political scientist from the University of Calgary who heads the Traditional Authority Applied Research Network (TAARN) has worked on this concept and done extensive research in Ghana. The idea is to use traditional leaders who historically have 'a special kind of credibility in their communities' to speak to their people about the issue, take part in public education campaigns, and support fund raising events. Dr. Ray even identifies Princess Diana, whose act of shaking hands with an HIV-affected person in 1987 drew public attention to the issue of HIV/AIDS, as 'a traditional leader working outside of the established political structure'. [12]

Education and Social Vaccine

There are two issues here—one is the use of 'education' as social vaccine, and the second is the use of social vaccine in educational settings like the use of school-based risk reduction strategies. The spectrum of use of the former varies from 'sex education'[13] to 'life-skills training'[14] to 'use of education as an empowerment and developmental tool'[15]. The latter has also been studied in detail and various institutions and education systems have come up with packages to deal with the issue.

UNESCO's work in this area is noteworthy, as they broaden the boundaries of education and social vaccine in the context of HIV AIDS. The measures suggested include:

- Policy development on knowledge, behaviours and resources
- School-based strategies including development and use of scientifically accurate, culturally appropriate, good-quality teaching and learning materials
- Teacher's training
- Promotion of participatory and peer education
- Better linkage with health services
- Stronger systems of non-formal and community education

- Greater involvement of people living with or affected by HIV/AIDS. [16]

Social Vaccine as a 'Vaccine'

David J Clarke's paper titled *The Education Response to HIV/AIDS: The 'Social Vaccine' as Metaphor and Reality* (see reference 9) uses the framework of clinical vaccine development, use, effectiveness and evaluation to examine the 'social vaccine' construct. He calls on social sector policy makers and planners to learn from vaccine developers and makes a few recommendations drawn from his observations of vaccine development. They include:

- Increasing investment in good quality social science/education research
- Developing an assessment methodology and a more comprehensive means of reporting on HIV prevention
- Applying cost-effectiveness analysis for social/education HIV/AIDS interventions
- Strengthening the quality and coverage of delivery systems
- Maximising HIV prevention coverage of target populations

The ILO and 'Social Vaccine'

The ILO's work on social vaccine was scaled up after the Regional Tripartite workshop organized by ILO and UNAIDS in Windhoek, Namibia, in October 1999. The workshop gave a call for the 'Platform of Action on HIV/AIDS in the Context of the World of Work in Africa'. The Platform of Action recognised the gravity of the pandemic and categorised HIV/AIDS as:

- The most serious social, labour and humanitarian challenge that is currently threatening every African country's economy
- A developmental crisis, causing discrimination in employment and the social exclusion of People Living With HIV/AIDS (PLWHA)
- A scourge that brings additional distortion to gender inequalities, and increases the numbers of orphans and incidences of child labour

It advocated for a social vaccine that promoted social inclusion, solidarity, and income and job security. [17]

The Future of 'Social Vaccine'

This paper tried to trace the use of the 'social vaccine' concept and its construct in different settings like counselling, control of tobacco and drugs, and more recently in the fight against HIV/AIDS. The wide spectrum of its use and its adoption at the highest levels of social action reflects the potential use of this construct. However, the inability of the social vaccine concept to become more wide-spread in its use and impact points to some basic structural deficiencies in its construct.

Examining the usage of the concept mentioned earlier, we can draw a few observations about the construct of the term 'social vaccine':

- The usage of the term 'social' in almost all the cases mentioned above are limited to the basic understanding of 'social' as 'living together in communities'[18], and tries to make use of that aspect in its intervention.
- The interventions concentrate too much on the behavioural aspects and try to make use of the 'society' in either changing the individual's behaviour, or work towards changing the existing social norms, fighting stigma, etc.
- Interventions like those of UNESCO and ILO try to address the broader issues involved, but they are still limited to interventions in and around the arena of HIV/AIDS. It fails to recognise or tackle the broader social determinants that affect the spread of the disease.
- A major problem in public health responses today is the verticalisation of interventions often to the detriment of other issues being tackled in the health field. The interventions listed above also fall into the same trap by focusing solely on the control of HIV/AIDS while ignoring all other related health issues.

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14.

TOWARDS THE CONCEPT OF A SOCIAL VACCINE

by Ravi Narayan & Team, (2006)*

14.1 Recognizing Social Determinants of health

The People's Charter for Health that emerged at the first People's Health Assembly in Savar, Bangladesh, in December 2000, noted that *'inequality, poverty, exploitation, violence and injustice are at the root of ill health and the deaths of the poor and marginalized'.* It also emphasized that *'health is a social, economic and political issue and above all a fundamental human right*'. In its detailed call for action it suggested a six point programme which included:

- health as a human right;
- tackling the broader determinants of health - economic, social and political challenges;
- environmental challenges
- war, violence, conflict and natural disasters
- a people centred health sector
- people's participation for a healthy world

Very significantly, it is the first comprehensive consensus health document that suggests that action for health has to move beyond the biomedical approach focusing on drugs and vaccines to a more comprehensive social approach (1).

The People's Charter for Health echoed and endorsed the Alma Ata Declaration, an earlier global consensus document which in 1978 had also affirmed that '*health is a fundamental human right and that the attainment of the highest possible level of health is a most important world wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector'(2)* .

The importance of action on the social determinants has been suggested in the past by several health professionals and expert committees.

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* (Background paper for Double Plenary Session on 'Social Vaccine' at Forum 10 Cairo, 30th October, 2006)

In 1981, the Indian Council of Social Science Research and the Indian Council of Medical Research in their Health for All strategy in India, outlined a prescription for Health for All, which included such a broad concept of health action. They emphasized '*the need for a mass movement to reduce poverty and inequality and to spread education, to organize the poor and underprivileged to fight for their basic rights and to move away from the counter productive consumerist western model of health care and replace it by an alternative based in the community'.(3)*

Echoes of this broader social action are seen in the writings of public health professionals and epidemiologists in the late 1980s. In a detailed epidemiological socio cultural and political analysis of Health and Family Planning Services in India,

Professor Banerji noted that: '*Health service development is thus (a) socio-cultural process (b) a political process; and (c) a technological and managerial process, with an epidemiological and sociological perspective'* (4).

Extending this idea further, in 1989, Community Health Cell in India proposed a paradigm shift in health action from a biomedical approach to a social, community approach, which also moved focus from *'drugs and vaccines' to education and social processes* (5) It is important to emphasize that a case was being made not for a biomedical versus a community / social model of public health but for the broadening of the orthodox biomedical approach by the inclusion of a social / community / societal dimension.

The late Professor Rose (1992) after decades of extensive epidemiological research wrote that '*the primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart'* (6).

Many researchers have since explored the social factors as determinants of disease. Studies on mental health have shown associations between risk of mental disorders and poverty and also factors such as experience of insecurity and hopelessness, rapid social change and the risks of violence and physical ill-health. (7). Studies have shown gender disadvantage and reproductive health risk as factors for mental disorders in women (8).

Other studies have shown interconnectedness between women's health and life concerns, including physical fatigue and psychological stresses of living in poverty. The studies have suggested that '*economic, social, psychological, and physical determinants come together in women's bodies'*. This study has recorded that "*Women's evocative words underline emotion and its connection to bodily health, emotions that are a lingering response to the horrors of war and a reaction to the daily degradations of poverty*". (9)

14.2 Recognising social approaches to tackling health challenges and public health problems

In 1998, in a comprehensive public health policy analysis of the problem of tuberculosis and tuberculosis programme in India, Narayan. T, (10-13) suggested different levels of our understanding of the '*determinants of disease*' and hypothesized that '*determinants at different levels needed different levels of solutions and control strategies* (See Table 1).

She emphasized that the recognition of the new and deeper social paradigm would move our understanding of TB beyond vaccine and drug distribution, to include components that enhance awareness, motivation and empowerment of patient through counseling and autonomy building skills. Finally, such a programme would then locate action in a multidimensional and multisectoral mosaic impacting on all aspects of the problem. Without specifically calling it a 'Social Vaccine', it was suggested that the programme would include an increase in health budgets and funds for TB control; poverty alleviation programmes focused on marginalized peoples; housing and planned urbanization programmes; occupational safety focused on high risk individuals and high risk occupations; personal and social support to affected peoples and their families – particularly those from the marginalized sections; and initiatives to address social and economic inequality and injustice. It was emphasized that such a broad based social societal oriented model of a health programme for tuberculosis would then '*strike at the roots of the problem and not fritter away resources in superficial biomedical reductionist strategies that have a limited impact on the disease' (*11).

Table 1

Tuberculosis and Society – Levels of Analysis and Solution

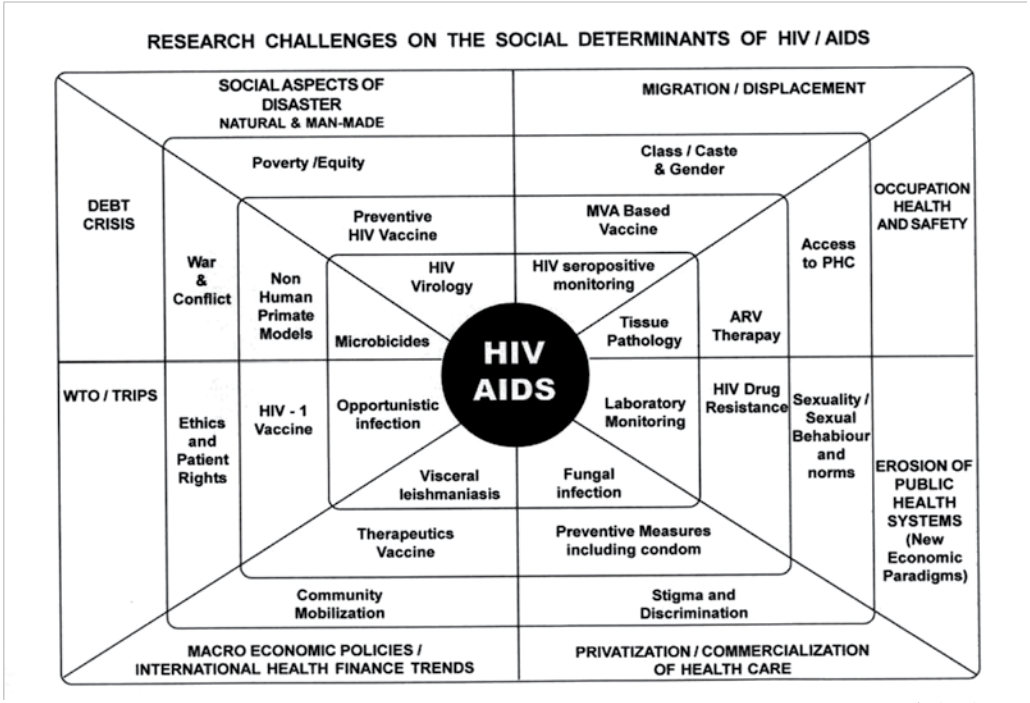
Levels of Analysis of Tuberculosis	Causal understanding	Solutions / Control Strategies
Surface phenomenon (medical and public health problem)	Infectious disease / germ theory	BCG, case-finding and domiciliary chemotherapy
Immediate cause	Under-nutrition / low resistance, poor housing, low income / poor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

Source: Narayan, T. 1998(10)

In a series of annual conferences at Sir Dorabji Tata Centre for Research in Tropical Diseases, Bangalore, researchers have explored the research challenges of social and community determinants of Malaria, Diarrhoea, Acute Respiratory Infections (ARIs) and HIV-AIDS and have recognized that the evidence on these determinants will help to evolve new social and community approaches to tackling these major public health challenges (14-17). In each of these papers, a comprehensive analysis of the social determinants of these diseases has been attempted and it has been suggested that research on these problems should move beyond the biomedical quest of new drugs and vaccines and include social, economic, political and cultural action that may prevent the problem or reduce the incidence. Table 2 summarizes diagrammatically an approach to studying all the determinants at different levels shown in the form of concentric circles, taking the HIV/AIDS paper as the example (17).

Table 2

Research Challenges on the Social Determinants of HIV/AIDS



Source : Narayan, R, et al (17)

In Table 3, three of these papers highlighting the determinants to be researched and the solution and control strategies to be evolved have been summarized. Could some of these strategies constitute a 'Social Vaccine' approach to the problem?

Table 3

Socio-epidemiological analysis of key communicable disease

	Malaria (14)	Diarrhoea (15)	HIV-AIDS (17)
Determinants To be researched	· Malariogenic development Migration patterns · Environmental / Ecological changes · Poverty / inequality community knowledge and attitude · Health care providers (KAP) · 'Resistance' of public health system (system default)	· Poverty, inequality & social marginalisation · Migration / displacement · Ecologically hazardous and unsustainable development · Development strategies without health impact assessment · Economic policies that downside / commercialise public health system. · Commercialization of health care including unethical prescribing	· Poverty / equity class/ caste & gender · Access to Primary Health Care · Stigma & discrimination · Sexual behaviour & norms · Social conflicts · Erosion of public health system · Commercialization of health care · Inadequate occupational health and safety · WTO/TRIPS · Migration & displacement · Natural & man made disasters and debt crisis)
Some solutions / Control strategies **(SOCIAL VACCINES?)**	· Health impact assessment and response · Health care for migrants · Eco-sensitive development · Poverty alleviation · Equity focused health strategies · Health education · Reforms / strengthening of public health system.	· Tackle poverty and marginalisation · Poverty alleviation programmes · Environmental and health campaigns · Health impact assessment of development study · Pro-poor economic policies · Countering commercial of other of health care	· Life skill education for youth as healthy and responsible sexuality · Local level peer education for informed and separate discussion on sexuality. · Strengthening primary health care access for women and marginalized sections of social · Community organization and self-help groups to strengthen access and treatment. · Positive people's network to empower, enable and monitor programme.

Source : Narayan, R (14, 15, & 17)

In the latest paper in this series on HIV/AIDS, Narayan. R has specifically noted that '*there is a paradigm shift required to enhance research towards a 'social vaccine' which will be a much more comprehensive response to HIV/AIDS problem'* (17)

In an earlier paper, at the Mexico Forum 8, there had been a plea for a change in the focus of research from biomedical deterministic research to a more participatory social / community research that would focus on education and social processes rather than only drugs and vaccines (see Table 4). It was concluded that '*A social vaccine for AIDS is closer than the AIDS vaccine*' if such a shift in health research could take place (18).

Table 4: The MDGs and the 10/90 gap : a PHM perspective

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

Source: Narayan. R (15)

It was emphasized that this paradigm shift also require new partnerships between medical / laboratory researcher and public health researcher / activist. The quest for the social vaccine arising out of research activities in this new paradigm is an exciting prospect for the future.

14.3 The concept of a 'Social Vaccine' and its future (19)

Origins: Though the origins of the 'social vaccine' concept is not clear, its use can be traced back to the counselling and psychological studies stream. The California Task Force to Promote Self-Esteem (1990) described 'self esteem' as a *social vaccine or a dimension of personality that empowered people and inoculated them against a wide spectrum of self-defeating and socially undesirable behaviour(20)*.

The concept of 'social vaccine' was also used in other areas like de-addiction and control of addictive substances like tobacco and drugs. Public opinion was seen as a *powerful social vaccine that effectively precludes certain behaviours* in the fight against tobacco and drugs. (21)

(i) HIV/AIDS

In the field of HIV/AIDS, the 'social vaccine' concept came to be used in the 1990s where it referred to a *comprehensive package of preventive education, promotion of contraceptive use and edification of communities*. This approach was used in Thailand to suppress HIV infection rates and was cited as a model to be emulated (22).

However, the concept of 'social vaccine' was variably used even in the field of HIV/AIDS. It varied from using it to refer to prominent personalities and traditional leaders interacting with people 'dying of AIDS' (23) to 'prevention and control' (24) to 'sex education' (25) to 'education' in general (26) to 'multi-dimensional response' involving elements such as 'preventing social exclusion, protecting incomes and social security schemes, and promoting solidarity with people with AIDS.' (27)

(ii) Education and Social Vaccine

There are two issues here—one is the use of 'education' as social vaccine, and the second is the use of social vaccine in educational settings like the use of school-based risk reduction strategies. The spectrum of use of the former varies from 'sex education' (25) to 'life-skills training' (17) to 'use of education as an empowerment and developmental tool' (26). The latter has also been studied in detail and various institutions and education systems have come up with packages to deal with the issue.

(iii) Social Vaccine as a 'Vaccine'

The social vaccine can be both a metaphor and a 'real entity'. This dimension was reviewed in an interesting paper, which uses the framework of clinical vaccine development, use, effectiveness and evaluation to examine the 'social vaccine' construct. The author calls on social sector policy makers and planners to learn from vaccine developers and makes a few recommendations drawn from his observations of vaccine development. They include: increasing investment in good quality social science/education research; developing an assessment methodology and a more comprehensive means of reporting on HIV prevention; applying cost-effectiveness analysis for social/education HIV/AIDS interventions; strengthening the quality and coverage of delivery systems; maximizing HIV prevention coverage of target populations (28).

(iv) The ILO and 'Social Vaccine'

The ILO's work on social vaccine was scaled up after the Regional Tripartite workshop organized by ILO and UNAIDS in Windhoek, Namibia, in October 1999. The workshop noted HIV/AIDS as '*the most serious social, labour and humanitarian challenge that is currently threatening every African country's economy; a developmental crisis, causing discrimination in employment and the social exclusion of People Living With HIV/AIDS (PLWHA); a scourge that brings additional distortion to gender inequalities, and increases the numbers of orphans and*

incidences of child labour'. It advocated for a '*social vaccine*' that promoted social inclusion, solidarity, and income and job security (29).

(v) The Future of 'Social Vaccine'

The wide spectrum of the use of the term 'social vaccine' and its adoption at the highest levels of social action reflects the potential use of this construct. However, the inability of the 'social vaccine' concept to become more wide-spread in its use and impact points to some basic structural deficiencies in its construct as well.

Examining the usage of the concept mentioned earlier, we can draw a few observations about the construct of the term 'social vaccine':

- The usage of the term 'social' in almost all the cases mentioned above are limited to the basic understanding of 'social' as 'living together in communities', and tries to make use of that aspect in its intervention.
- The interventions concentrate too much on the behavioral aspects and try to make use of the 'society' in either changing the individual's behavior, or work towards changing the existing social norms, fighting stigma, etc. Not enough emphasis has been put on health and social policy levels of such change.
- Interventions like those of UNESCO and ILO try to address the broader issues involved, but they are still limited to interventions in and around the arena of HIV/AIDS. It fails to recognize or tackle these broader social determinants as factors that affect the spread of most diseases and are crucial to the continuing ill-health of the poor and marginalized in every community.
- A major problem in public health responses today is the verticalisation of interventions often to the detriment of other issues being tackled in the health field. The interventions listed above also fall into the same trap by focusing solely on the control of one problem while ignoring all other related health issues. Social vaccines need to be constructed as a vaccine for protecting society against a large number of problems simultaneously – a systemic response, not a vertical 'magic bullet' response!
- Many of these interventions also follow the cause-effect model and find an intervention that tackles the immediate cause of the disease or problem, but does not bring about a long-term solution. Social vaccine can be more effective, if they focus on the deeper determinant.

While these are a few challenges that may affect the long-term viability of the social vaccine, the interventions listed above are certainly a vast improvement over the usual interventions that tackle health issues purely from a bio-medical framework.

14.4 The research agenda towards the study of social vaccine

The Special Plenary at Forum 10 will look at the concept and construct of 'social vaccine' beyond the HIV/AIDS focus to other health challenges as well. This includes other communicable diseases like TB & malaria, and social determinants like gender, disability, war & conflict,

mental health, childhood, malnutrition, and social exclusion. The panelists and respondents and contributors from the floor will help to evolve the Research agenda to take this concept of the 'social vaccine' forward. This section of the paper will evolve by the end of the Special Session incorporating all the ideas and suggestions during the presentation of the paper and discussion.

Finally, to summaries this short review on the 'social vaccine' concept, one could conclude with an evolving definition:

> "A social vaccine can be defined as, 'actions that address social determinants and social inequities in society, which act as a precursor to the public health problem being addressed'. While the social vaccine cannot be specific to any disease or problem, it can be adapted as an intervention for any public health response. The aim of the social vaccine is to promote equity and social justice that will inoculate the society through action on social determinants of health"(19).

Two developments in the 21st century are important for further development of a concept of 'social vaccine'. The first is the People's Charter for Health (1) which was a civil society consensus on action towards a series of health and social policy issues, which can be constructed as 'social vaccines'. The second has been the launch of the WHO Commission on Social Determinants on Health (CSDH), which is now bringing together all the evidence that will help us understand the need for 'social vaccines' even more. The commission has to be challenged to move beyond collecting 'evidence for social determinants', which is a very significant and important step itself, but also to use this opportunity of the dialogue between the commissioners, the knowledge networks, the facilitators of the civil society evidence and others, as stimulus for evolving action on these social determinants as a 'social vaccine' construct. As Prof. Fran Baum has noted, '*if the People's Health Movement and the CSDH are successful in picking up the baton from the earlier Health for All 2000 movement they may form the vanguard of a successful movement for a socially just and healthier world in which policy decisions are driven primarily by this vision (Health for All) rather than by decisions that maximize profit for a small elite* (30). The concept of a 'social vaccine' or 'a set of social vaccines' at the core of such a movement may just be the idea which captures the imagination and energy of the World Health Organization and the global network of researchers to make this happen. We hope the Session at Forum 10 helps towards this paradigm shift.

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15.

CHALLENGES FOR HEALTH AS A SOCIAL MOVEMENT : LESSONS FROM THE JAN SWASTHYA ABHIYAN EXPERIENCE AT NATIONAL AND STATE LEVELS IN INDIA – THE PANS PROCESS

by Venkatesan.R and Ravi Narayan, 2012

The context and Frame work of the PANS Process

Some important historical details, organizational objectives and evolving framework of action drawn from the handouts of the JSA and the Indian People Health Charter, particularly from the People's Health Source Book, published in 2004 are enumerated here as background and context for reference for all those at State and National levels involved with evolving PANS project.

1. The Jana Swasthya Abhiyan (PHM India) evolved through a dialogue process that began in November 1999, at the Bangalore dialogue of the International Poverty and Health Network (where members of the organizing committee of the Global People's Health Assembly- including Dr. Zafarullah Chowdhury, Dr. Qasem Chowdhury, Prof. Mathura Shrestha, Dr. Prem John, Dr. Mira Shiva and Dr. Mohan Rao met some public health activists including Prof. D. Banerjee, Dr. B. Ekbal, Dr. Ravi Narayan, Dr. Thelma Narayan, and others to discuss the Indian mobilization for the proposed global People's Health Assembly in Savar, Bangladesh, (Scheduled for December 2000) The statement of the IPHN dialogue which was widely circulated had many elements of the global charter that evolved in 2000AD.

2. Three organizations began to work closely together to evolve a national mobilization response to the proposed PHA. This included the All India People's Science Network,(Dr. Sundararaman, Pondicherry Science Forum and Balaji Sampath of the Tamilnadu Science Forum) and Society for Community Health Awareness, Research and Action, Bangalore (represented by Dr. Ravi Narayan)

3. In January 2000, at a meeting in Chennai, a decision to bring together 18 National Networks of Voluntary organizations to organise a campaign with the slogan Health for All, Now was made and a plan of mobilization towards a people's health assembly in India before the Global assembly in Savar was initiated.

4. These 18 networks included two science movement related (AIPSN and BGVS); the National Alliance of Peoples Movement (NAPM); several health related networks (mfc, VHAI, CHAI, CMAI, AIDAN, ACHAN, SOCHARA); four networks related to the women's movement (AIDWA,JWP, NFIW, NAWO) and four others (FORCES, FMRAI, AID-India and the Ramakrishna Mission).

5. As part of the campaign, 5 cartoon books on five broad themes (What Globalisation does to People's Health; Whatever happened to Health for ALL by 2000AD; Making life worth living; A world where we matter; and Confronting commercialization of Health Care) were evolved through contributions by number of authors to different subsections, which was finally ratified by representatives of 18 national networks in Hyderabad, in April 2000 at a five day workshop in which the draft booklets were considered page by page. For the first time in the country such a wide range of organizations came together to produce these five booklets as a symbol of an emerging consciousness towards the challenges for Health for All.

6. These books were translated into languages – Hindi, Tamil, Kannada, Marathi, Malayalam, Telugu, Bengali, Gujarati, Oriya and copies sold/distributed to health professionals activists and people interested in health issues. Halfdan Mahler the former Director General of WHO and the architect of the Alma Ata Declaration described these books as 'the best expressions of the primary health care concept and its politics that I have ever read. They are the bible of Primary Health Care, a glorious milestone on the tortuous road to primary health care'.

7. Between April - November 2000, the books supported a campaign of public education and mobilization that included village, district, and state level meetings; village based enquires; kalajatha adaptations of the main messages in some states; and dialogue with professionals, health activists and providers / policy makers in the existing health services.

8. After a series of State health assemblies in nearly 17 states (Andhra , Assam, Bihar, Delhi, Gujarat, Haryana, Himchal Pradesh, Jharkhand, Karnataka, Kerala, Maharastra, Orissa, Punjab, Rajasthan, Tamilnadu, Tripura, UP) around 2500 health professionals and activists in 4 peoples health trains, assembled at Kolkatta for the first National Health Assembly (Jan Swasthya Sabha) from 29th Nov till 2nd Dec 2000.

9. An Indian People's Health Charter was adopted at the end of the Assembly and announced at the end of the Assembly, after a march through the streets of Kolkatta. At a rally in the maidan, under the inspiring leadership of Dr. Lakshmi Sehgal (the head of the Rani Jhansi regiment of the INA) a Health for All, now campaign was launched as the second national struggle for independence from ill health and illiteracy

10. The Indian People's Health Charter is an important reference point for this exercise since it lays out the objectives and the demands of the Health for All, Now campaign. It can become the reference points to review our efforts at state level and also at national level. Ultimately our learning review has to help us assess at state and national level, not only what we have done and how, but also where have we reached /not reached in each state and national level vis a vis these goals and demands.

11. The Indian People's Health Charter can be summarized as follows

a) We declare Health as a justciable right and demand the provision of comprehensive health care as a fundamental constitutional right of everyone of us with seven basic concepts.

- Decentralized local governance
- Sustainable agricultural and a decentralized PDS
- Universal access to education, water housing and sanitation facility
- Dignified and sustainable environment
- Clean and sustainable environment
- Drug industry producing epidemiologically essential drugs at affordable cost.
- Health care system that is gender sensitive and responsive to peoples need and not the markets.

b) We oppose

- Market oriented agricultural policies.
- Appropriation of neutral resources livelihood and biodiversity for private profit.
- Conversion of health into mere technology intensive, expensive, and inaccessible,
- medical care for select few, reduction of public sector expenditure on medical care and introduction of user fees in public sector institution.
- Corporatization of medical care and corporate sector health insurance
- Coercive population control and promotion of hazardous contraceptives technology
- Patent regimes that put medical technology and drugs beyond the reach of many.
- Institutionalization of fundamentalism, caste, patriarchy and violence in our society.

c) We demand

1. Comprehensive Primary Health Care – integrates decentralization and with commitments
2. Primary health care under PRI's participation and village level health workers and Urban PHC's.
3. Comprehensive medical care programme financed by government - 5% of GNP- with half disbursed to PRI's.
4. Stop privatization of public institutions through user fees, private practice and contracting out PHC.
5. Comprehensive based human power plan with no further commodification of medical education and promotion of one year compulsory rural posting.
6. Standard treatment guidelines use of diagnostics standard fees structure and regular prescription audit.

7. Rational Drug Policy including banning of irrational and hazardous drugs, introducing essential drugs, promoting generic use, quota's and price ceiling for rational drugs, regulating advertisements, formulating guidelines vaccines, control MNC's, promoting public sector and repealing new patent act,
8. Medical research on priority issues with ethical guidelines.
9. Access to safe and affordable contraceptives and abolishing coercive methods for limiting family size.
10. Support to traditional healing systems including local and home based healing traditions.
11. Transparency and decentralization in decision making process at all levels with Right to information and health policies after wider scientific, public debate.
12. Ecological measures to check communicable diseases including health impact assessment, decentralized surveillance, and gender sensitive services.
13. Facilities for early detection and treatment of non communicable diseases.
14. Women centred health initiatives
15. Child centred health initiatives
16. Measures for occupational and environmental health
17. Measures towards mental health including community support and community based management
18. Measures to promote health of elderly
19. Measures to promote health of physically and mentally disadvantaged
20. Effective restrictions on promotion of tobacco, alcohol, and other addictions (see charter for further details in the context of each demand.)

10. **JSA Aims :**

Since 2000AD the Jana Swasthya Abhiyan at National level has evolved the following:

i) Draw public attention to adverse impact of polices of iniquitous globalization
ii) Campaign to establish Right to Health and Health care as basic human right
iii) Campaign to re-establish Health and equitable development reestablished as priorities at local and national level with PHC as major strategy
iv) Confront commercialization of health care and establish minimum standards and rational treatment guidelines
v) Build integrated comprehensives and participatory approaches to place people health in peoples hands.
vi) Network with all those interested in promoting peoples health to bring together a wide variety of peoples initiatives to organize and access better health care while also contributing to sustainable long term solutions to health problem.

11. **The JSA organization structure** :

This has evolved as follows,

- A national coordination committee with a chairperson, a convenor and a set of joint national convenor (presently nine)
- A JSA national secretariat with a secretary and support team (presently in Bhopal – Dr. Ajay Khare)
- The NCC consists of 17networks and 5 national resource groups presently.
- There are state units /contacts in 21 states- Andhra, Gujarat, Kerala, Rajasthan, Assam, Haryana, Madhya Pradesh, Tamilnadu, Bihar, Himachal Pradesh, Maharastra, Tripura, Chattisgarh, Jharkhand, Orissa, Uttar Pradesh, Delhi, Karnataka, Punjab, Uttaranchal, West Bengal. Each state has its own arrangement for the secretariat and the coordination function.

12. Strategies and Techniques adopted by JSA

- Public information and education on health issues largely through publications, meetings and other events, press conferences and media information
- Social mobilization and protest actions by means of health enquires, public hearings, health diagnosis , seminars and cultural events.
- Representation to decision makers on policy concerns, grievances and gaps in health services, while seeking increased representation for communities in local health related decision making.
- Health surveys and studies to understand and highlight health issues concerning the people
- Organisations of people through community health programmes, to help the poor cope with the burden of disease, gain better access to public health services and monitor health services

13. **JSA activities undertaken so far** :

(The states could reflect on how they have been involved in these. This is just a check list of the key initiatives and opportunities)

i) Critique of National Health Policy 2002

ii) Critique on National Policy on Pharmaceutical

iii) Campaign against the practice of sex selective abortions

iv) Association with Right to Food Campaign

v) Asian Social Forum, Hyderabad,2003

vi) Hunger Watch Group

vii) International Health Forum, Mumbai, 2004 & World Social Forum 2004

viii) Public dialogue on Health with Political parties 2004

ix) Right to Health Campaign- Regional and National Public Hearings

x) People's Tribunal on Population policies.

xi) Campaign towards amending Patent Act

xii) Drug policies seminars at different levels

xiii) People's Rural Health Watch

xiv) Tenth International Women and Health meeting including state and zonal meetings

xv) Engagement with Global People's Health Movement

xvi) Engagement with Global Health Watch

xvii) Engagement with International People's Health University

xviii) Engagement with WHO Commission for Social Determinants of Health

xix) National Health Assembly , Bhopal 2007

xx) Other state level campaigns and initiatives.

14**. Publications of JSA/ PHM**

The JSA has been involved with the following publications at the National level and Global level some of which have been translated by the states into local languages. The following is an incomplete check list.

i) What Globalisation means for People's Health, 2000 (booklet)

ii) Whatever happened to Health For All by 2000AD, 2000 (booklet)

iii) Making Life Worth Living, 2000 (booklet)

iv) A World Where We Matter, 2000 (booklet)

v) Confronting Commercialization in Health Care, 2000 (booklet)

vi) Indian People's Health Charter, 2000

vii) People's Charter for Health , Global, 2000

viii) Health for All Now, The Peoples Health Source Book, 2004

ix) Jan Swasthya Abhiyan – People's Health Movement in India – Pamplets

x) The Mumbai Declaration, 2004

xi) The Cuenca Declaration, 2005

xii) Global Health Watch – I, 2005

xiii) Globalization and Health , 2006 (NHA 2 booklet)

xiv) Health Systems in India, Crises and Alternatives, 2006 (NHA2 booklet)

xv) Women's Health, 2006 (NHA2 booklet)

xvi) Campaign issues in Child Health, 2006 (NHA booklet)

xvii) New Technologies in Public Health – Who pays and who benefits?, 2006 (NHA booklet)

xviii) The impact of the Global Trade Regime on Access to Medicines: A case study of HIV-AIDS treatment access , 2006 (NHA2 booklet)

xix) People's Rural Health Watch, 2008

xx) Global Health Watch –II, 2008

Learnings for the Movement:

THE STRATEGIES AND TECHNIQUES ADOPTED BY JSA:

Public Information and Education on Health Issues:

A. Publications: Documentation of health rights issues in various forms including brochures, films and booklets. JSA has also drafted Policy briefs, memorandums, review papers, advocacy materials etc. There are also several states who have developed publications, articles, fliers, posters and pamphlets in the local languages.

B. Meetings/other Events

C. Press Conferences

D. Media Information: Using mainstream media like newspapers, TV, Magazines, periodicals and journals through Press meets, press statements by introducing health rights issues and articulating Public Health issues.

E. Fellowships/Internships: Organizing fellowships/internship programmes on community health and health rights

F. Mobilizing information through RTI

Social Mobilization (for protest action):

A. Health Enquiries:

B. Public Hearings: Public Hearing a key strategy for mobilizing attention for activists demand from the system and in some cases it has been very successful in seeking a response for the system and the process (by itself) is a high educative exercise for the community

C. Health Watch: Through systematic documentation and analysis of the implementation process of the health system and providing some feedback for improvement

D. Seminars: Organizing Seminars, Conferences, workshops on public health issues

E. Cultural Events: cultural events on public health issues on occasions of public health importance and relevance

F. Developing Alliance with other movements /Campaigns: Developing alliance with likeminded movements/ campaigns and working together strategically to address public health issues.

G. **Networking**: It is a key strategy towards strengthening campaigns and joint action fronts to inform and influence public opinion and policy. (13)

Representation to decision makers:

A. **On Policy concerns:** Gaining a better space and recognition for representation at International, National, state, district and Panchayat level decision making. The process of it is through, engagement with the government as members of task forces, advisory committees and mentoring groups

B. **On grievances and gaps in Health Services:** Through fact finding studies, strengthened grievance redressal strategies, lobbying for legal compensation for health denial cases and so on

C. **Increased representation of communities in local health related decision making:** creating mechanisms for enhanced community participation and empowering the local community on health rights

Health Surveys and Studies: The member organizations/ networks are involved in systematic research, analysis and documentation of public health issues and policies.

Organising people through Community Health Programmes:

A. helping the poor to cope with burden of disease

B. **gaining better Access to Public Health Services:** Training the various committees that are part of the hospital/ health set up on health rights- that will help in identification and fixing of health system problems

C. **Monitoring and Planning of Health Services:** Empowering the community to involve proactively in the monitoring and planning of public Health Services

JSA - Activities Undertaken so far:

1. **Critique on National Health Policy**: Involved in analysis of Policies, legislations, plans such as National Rural Health Mission (NRHM), draft National Health Bill (NHB), Eleventh five year Plan and many other Policy initiatives of national importance (13)
2. **Critique on National Pharmaceutical policy**: The National Policy on Pharmaceuticals was discussed when it was in the draft stage and a JSA critique was evolved which was widely shared. JSA participated in a public campaign concerning the policy. (25)
3. **Campaign against the practice of Sex Selective Abortions**: In response to the Public interest litigation regarding Pre Natal Diagnostic tests and sex selective abortions filed in Supreme Court. JSA initiated a campaign related to constitution of appropriate authorities, registration of ultra sound centers, ban on advertisements, displaying posters in clinics and the issue of son preference. The campaign was taken up intensively in many states. (25)
4. **Involvement in the Right to Food Campaign:** In several states, surveys have been conducted by JSA constituents on the status of mid-day meal and other schemes. A resource material package in the form of a book "if even one person goes hungry…" was brought

out for the Right to food Campaign and it has served to inform the public and keep the issue alive. There is a growing focus on 'children's right to food' and JSA has played a key role in the development of this campaign and issue within the overall campaign for the right to food. (25)

5. **Asian Social Forum**: In January 2003, during the Asian Social Forum at Hyderabad the constituent organizations of JSA conducted several workshops/seminars on key health issues with facilitation by JSA (19)
6. **Hunger Watch**: JSA has set up a 'Hunger Watch' group consisting of public health and nutrition experts which has prepared a draft protocol to investigate hunger related or starvation deaths. A national workshop was conducted for the activists on the method of investing and addressing hunger related deaths. (19.25)
7. **International Health Forum/World Social Forum:** In January 2004, International Health Forum was organized by the Global People Health Movement and locally hosted by JSA in Mumbai. Over 600 health experts and activists from nearly 50 countries attended this 2 day forum, organized in continuity with the World Social Forum.JSA participated in the World Social Forum as a coalition. **(19)**
8. **Public dialogue on Health with Political parties:** Prior to the elections in April 2004, and in May 2009 JSA initiated a dialogue with political parties to encourage them to focus on core Public Health issues. Prior to these meetings a Pamphlet and a policy brief was circulated to the political parties addressing the various issues concerned. It is an appeal to all the political parties that they should incorporate it as a part of their election manifestos. (25)
9. **Right to Health Care campaign/National Public Hearing on Right to Health** : A nationwide campaign by JSA to establish Right to health care as a basic human right for every citizen in India. As part of the campaign, regional and national public hearings in collaboration with the National Human Rights Commission (NHRC) to highlight health care violations and ensure that action is taken to stop such violations and to protect and promote the right to health including women's right to health(13,25)**.** As a part of the process of establishing Health rights, a series of regional public hearings on right to health care were organized by National Human Rights Commission (NHRC). The regional public hearing on health rights for the western region of country was organized in Bhopal in July 2004, followed by the Southern region public hearing at Chennai in August 2004, the Northern region public hearing at Lucknow in September 2004, the Eastern region public hearing at Guwahati November 2004. These major regional hearings each attended by hundreds of delegates and with presentation of dozens of cases of denial of health care were followed by a culminating event, the National Public Hearing on Right to Health Care organized by on December 2004, at New Delhi. Subsequently a National action plan was released by the NHRC with inputs from JSA, towards operationalising the right to health care within the Indian context. **(19)**
10. **People's Tribunal on Population Policies**: The JSA collaborated with Human Rights Law Network and organized the people tribunal on population policies. Nearly 70 women from 15 states assembled in Delhi to depose before a Public Tribunal comprising leading personalities and activists. On the pretext of promoting small family, as many as 4000 men

and women from different states have been disqualified from various Panchayat Positions on the grounds of infringement of the two-child norm. Nearly 120 men and women affected by the coercive policies from 14 states deposed from the panel and expressed the anger, severe pain and humiliation that they experienced in the process. **(19)**

11. **Campaign towards amending Patent Act**: The trips agreement required India to change to a product patent regime in the areas of pharmaceuticals and food, such a move has many negative implications on people's ability to access essential medicines. The JSA has been an active partner in the campaign to pressure the government to make full use of the safeguards available in the TRIPS agreement to safeguard Public Health. (25)
12. **Drug Policies Seminars at different levels**: As a part of National Health Assembly 1 and 2, JSA has organized drug workshops. It has collaborated with partners in organizing drug seminars in Kolkata (2005) and in Delhi (2011)
13. **People's Rural Health Watch:** The idea of a People's Rural Health Watch was conceived of by JSA following its Right to Healthcare Campaign, and after the launch of the NRHM. PRHW was involved in documentation, analysis and assessment of the implementation of NRHM and provided feedback for improvement. This was done by collecting primary information through periodic surveys, as well as looking at relevant policy documents, and preparing reports based on the information (25)
14. **Tenth International Women and Health meeting including state and Zonal meetings:** The process of formulation of "Indian Women's Health Charter" began in 2004-05 through 11 state-level and 6 zonal- level meetings with over 2000 women and some men participants, who identified issues of health concern specific to their states and regions. The ' Zonal process' preceded the 10th International Women and Health meeting in September 2005 at New Delhi, in which 100 grassroots women delegates participated from India.
15. **Engagement with Global People's Health Movement:** With the active participation of 250 Indian delegates from 19 states in the People's Health Assembly (PHM) in Savar, Bangladesh in 2000, the JSA is in continuing its engagement with the Global PHM. (need to expand)
16. **Engagement with Global Health Watch:** The idea of alternative world health report developed into an initiative called Global Health Watch (GHW). The secretariat of the GHW was hosted on the basis of rotation among partner organizations and PHM India is the secretariat for the process of GHW 3.
17. **Engagement with International people's Health University (IPHU)**: JSA in association with People's Health Movement has organized IPHU's Health in Equity course in India on three occasions.
18. **Engagement with WHO Commission for Social Determinants of Health**: JSA has been identified as one of the two organizations in the Asian regions to facilitate civil society participation in the Commission on Social Determinants of Health, constituted by the WHO
19. **National Health Assembly 2, Bhopal-2007:** In March 2007 the JSA organized a three day National Health Assembly, which brought together over 400 organisations and over 2000 participants from across the country.

20. **Campaign against the closure of Public Sector Vaccine Production Units**: The JSA opposed the closure of Public Sector Vaccine Production units. It collaborated with likeminded groups and because of the continuous struggle, now the units are being reopened. **(18)**
21. **Campaign for the release of Dr.Binayak Sen**: The JSA collaborated with the likeminded groups within the country and also with international community and campaigned continuously for the release of Dr. Binayak Sen(13)
22. **Campaign on Universal Access to free OPD Treatement**: A National level campaign on the issue had been initiated by JSA and was also perceived as an important issue at the Delhi level. (9)
23. **Campaign towards ensuring implementation of PCPNDT Act**: JSA is fighting for the effective implementation of the PCPNDT Act to arrest the decline of child sex ratios. (10, 18, 25)
24. **Campaign against violence against women**: violence within home: state violence eg.Gujarat Carnage, which violate women's rights (girl children and adolescent girls); or cause/exacerbate violence against women, monitoring of Laws and acts related to women and ensuring their implementation e.g. Domestic violence Bill (25)
25. **Campaign to ensure that justice for Bhopal survivors**: Efforts are taken to ensure access to various determinants of health-water, food, livelihoods and access to health services and compensation. (25)
26. **Campaign to implement Supreme Court order on sterilizations**: Efforts are taken to ensure compensation in case of failures/violations. Also ensure conditions/quality of care so that failures are prevented.
27. **Boycott Novartis Campaign**: Promotion and intensification of the Boycott Novartis Campaign among medical professionals till Novartis ceases its challenge against the rejection of its patent application on Gleevac
28. **Engagement with NRHM**: The National Rural Health Mission (NRHM) aims to fulfill the United Progressive governments' commitment to meet people's aspirations for better health and access to Health Care.JSA played an important role in the formulation of NRHM. JSA is however of the opinion that the mission must move beyond policy rhetoric and become a part of a bold paradigm shift. Many individual member networks/organizations are directly involved in the implementation process of it. They have signed MOU's with concerned State Governments and are involved in the process of community health building. Some of the major activities include Community Monitoring and Planning, Training of ASHA's and formation of Village Health, Water and Sanitation Committees
29. **Campaigns on issues of mental health, with focus on disability issues and concern of sexual minorities**
30. **Campaign on women's, girl children and adolescent girls nutrition** H,
31. **Response to Tsunami:** The JSA constituents actively responded to the Tsunami disaster that happened in December 2004. A PHM meeting was organized in Chennai a little over

three months after the disaster (in April 2005), focusing on Thailand, Sri Lanka and India. A PHM statement "Responding to the Tsunami Crises- a People's Health Movement statement" was released, which also focused on the politics of aid and disaster response. A Tsunami response watch was also established

State level Campaigns and Initiatives

A. **Gujarat Public Health Act**: JSA drafting group played an important role from the very beginning of drafting the Act. The draft of the PH Act was taken to the National Health Assembly II in Bhopal in 2007 and the process of drafting the Act passed through many stages and JSA group played a vital role in it. (11)

B**. Fact finding of Barwani Maternal deaths:** 9 maternal deaths have been recorded in the Government hospital in a month in 2010. Nearly a thousand people gathered to protest against the extremely negligent treatment of women in pregnancy and labour. Fact finding studies were taken up to address the issue of maternal deaths. (13)

C**. Campaign and lobbying for patients rights/BNHRA rules:** The Bombay Nursing Home Registration Act (BNHRA-1949) was only in papers for 55 years, due to the pressure of civil society groups it was amended in 2005. The JSA has supported the rule making process and effective implementation of the BNHRA Act and has been taken up as a Maharashtra wide demand. Despite the limitations it was decided to make use of whatever space created by this amendment and also to push for Patients rights under the amended BNHRA. (3)

D. **Campaign against the changes in immunization policies of Tamil Nadu Government:** Four children lost their life after being administered measles vaccine, as response the Tamil Nadu government changed the immunization site from the villages to the PHC. The Makkal Nalvazhvu Iyakkam (MNI) and other civil society groups were much more concerned about this issue. As a result of various efforts taken, the Government decided to introduce an outreach programin select areas where PHC's were difficult to access.

E**. Engagement with the State Health Policy Process**: The JAAK actively engaged in the formulation of Karnataka state health policy through the Karnataka task force for the Health and Family Welfare Department. A integrated state health policy was drafted and the final report was submitted in April 2001. The policy was discussed by government at various levels and adopted by the state cabinet in February 2004

F. Roping in Lokayukta for denial and discrimination in Health System: The Jana Arogya Andolana Karnataka (JAAK) has taken efforts for roping in Lokayukta for the denial and discrimination in health system. It has introduced 24*7 helpline of lokayukta and has circulated formal forms on denial of health care and corruption.

G. **Campaign for free treatment (Rajasthan):** The right to free treatment was taken up by JSA in order to make government health services accessible to all. The Rajasthan government, has initiated free medicine scheme at all government facilities and efforts are taken for strict monitoring system through the involvement of civil society organizations and community members (10)

H. **Integrated State Health Policy (Orissa):** Orissa state has developed an integrated state health policy, facilitated by JSA constituent. This was approved by the state cabinet in 2003.

I. **Engagement with the State Health Resource Centre/SHRC (Chattisgarh)**: One of the JSA Joint convener's became the director of SHRC which developed an energetic young team who facilitated the training around 60,000 Mitanins. The SHRC works closely with the government department of Health and also works in partnership with a number of NGO's in the district towards strengthening the health system.

Campaign Areas/Major Themes:

Some of the major campaign areas of the member networks/organizations include

- Policy level interventions for Right to Health and Health care
- Primary Health Care and Health systems that can provide access to health care services for the poor and the marginalized
- Community Health workers Programmes and Community based Monitoring and planning of Health services
- Womens health issues and reproductive rights
- Child Health and Malnutrition
- Right to food and investigation of hunger related deaths
- Violence and Women's Health
- Sex determination and Sex selective abortions
- WTO, Intellectual property rights, patents and Drug Policy
- Medical professional reform and Regulation of Medical Practice
- Privatisation of health services and commercialization of health care
- Health care in conflict situations
- Indigenous medicines and Folk healing traditions
- Rational Drugs and diagnostics
- Drinking water, sanitation, environment & Health
- Health among displaced people, Adivasis and other marginalized sections
- Population control programme and issues of Contraceptive choice
- Trends in Medical and Vaccine Research
- Control of Communicable disease
- Mental Health issues
- Human Resource Development for Health Care
- Tobacco control for better Health

- Child Malnutrition and conflict of interests(16)
- Issues related to unethical clinical trials(14,18)
- Privatization/commercialization of vaccines(18)
- Maternal Health and safe delivery
- Pharmaceutical policy (14)
- Disaster and issues related to Public health

Publications of JSA:

1. What Globalisation means for People's Health, 2000 (booklet)
2. Whatever Happened to Health for All by 2000 AD?, 2000 (booklet)
3. Making life Worth Living, 2000 (booklet)
4. A World Where We Matter, 2000(booklet)
5. Confronting Commercialisation in Health Care, 2000 (booklet)
6. Indian People's Health Charter,2000
7. People's Charter for Health, 2000
8. Health for All Now, The People's Health Source Book, 2004
9. Jan Swasthya Abhiyan- People's Health Movement in India-Pamplets
10 a) The Mumbai Declaration, 2004
10 b)The HIV-AIDS Declaration, 2004
11. The Cuenca Declaration, 2005
12. Global Health Watch-I, 2005
13. Globalization and Health, 2006 (NHA2 booklet)
14. Health Systems in India, Crises and Alternatives, 2006 (NHA2 booklet)
15. Women's Health, 2006 (NHA2 booklet)
16. Campaign Issues in Child Health, 2006
17. New Technologies in Public Health- Who Pays and who benefits, 2006 (NHA 2 booklet)
18. The impact of the Global Trade Regime on Access to Medicines; A Case Study of HIV-AIDS treatment access, 2006 (NHA2 booklet)
19. People's Rural Health Watch, 2008
20. Global Health Watch-II, 2008

Publications in the Local language: The state level member networks/organizations had brought out publications in their local language on health and human rights, health policy briefs and materials on PHM, JSA and so on.

FINDINGS BASED ON SWOC ANALYSIS:

Reflections on strengths:

- Networking Strength -local/ regional, national and international levels /the collective strength
- Collective understanding/facilitation provides space to raise issues and concerns/forum for exchange of learning and analysis
- The diversity of organizations and networks/different movements
- Collegiality of working together successfully
- Documentation and Publication- enabling grassroots activists to access material on issues of health
- Opportunities to build knowledge, capacity and leadership
- The analytical ability of the JSA national group/the e-group discussions which throws light on several issues Enhancing capacity of grass root level activists at district level
- Acts as watch dog/ as a pressure creature and an bring change in the policy
- Runs without funds
- Identity as a health rights movement
- Inclusive work style

Some Reflection on strengths highlighted in the State Process/meetings

- Responded positively to all national level programs
- Suggested number of programs to National JSA
- Quite instrumental in fostering CBM
- Good image of JSA /Government is forced to ask JSA for opinion eg VHSC, PH Act

Reflection on weakness:

- Very little communication reaching the individual networks regarding the activities/stands of JSA/We tend to be linguistically and regionally limited/ the sense of solidarity and communication between and across state units need to be improved.
- Decision making- often arbitrary/ based on individual decisions- not always processes and procedures.
- Non inclusion of many who have significantly contributed to the health movement.
- Need for transparency
- Feed backs from member networks are not taken seriously
- Need to strengthen understanding/perspectives on gender, sexuality, marginalization and other emerging issues for JSA partners

- Conflict of interest and diversity of opinions-therefore inadequate work on common position and common ground of action
- Weakening of the JSA collective leadership over the past few years and inadequate clarity about campaigns and support mechanism in the current global and national context.
- Younger and newer member individuals and organizations need space. Democratic forms of functioning need to be enhanced
- Not in touch adequately with likeminded movements/disability movement and mental health movement
- There is inadequate open reflection in a healthy manner
- Some organizations perceive a domination by certain groups/networks and ideologies and therefore these organizations/networks and individuals who are equity oriented have kept away and withdrawn from active participation
- The background material is produced in 2000 and 2007, the later is inadequately utilized

Some of the Reflection on weaknesses highlighted in the state process

- Not enough regular meetings/lack of coordination
- Engagement with NRHM including CBM has affected organizational work
- Leadership deficit in the network
- Decisions taken regarding organizational issues are yet to be implemented.
- Focus was on provision of primary health care services, hence other issues lagged behind
- Community presence still marginal
- Lack of Publication
- Don't have strong presence in each and every district/not undertaken common activities for campaigns at the village level
- No mechanism to arrive at a common position/We have not communicated our position to the public
- Internal conflicts on rights based versus collaborative initiatives with the government
- Organizations associated with JSA do not have health as a priority focus in their agenda/this makes them dormant and inactive
- Lack of resources for carrying out activities and campaigns
- Less linkages with the other state chapters/national JSA
- Irregular participation of members in meetings and activities
- Lack of participation by government officials

Reflection on opportunities (National)

- **J**SA emerging as a National Level Platform and PHM as a global group
- Engagement with the public health system gained strength

- Through the civil society oriented school of public heath-we look for opportunities in diverse ways that can be discussed if JSA is interested/interested to be involved with research based work of JSA
- Taking forward the campaign of health rights and health for all/designing campaigns and actions
- Has provided opportunities to on build knowledge, capacity and leadership of organizational members
- Opportunities to take up campaigns and advocacy programs
- Collective processes provide opportunity for-
  a) Larger outreach
  b) Larger impact,
  c) Decentralised action
  d) Wider dissemination,
  e) Mobilisation around health issues
  f) Influencing public opinion and policy
- Contribute to JSA analysis/ broadening the understanding
- Collaborative initiatives at all levels
- Community monitoring and Public Trust
- We can use the people's health charter to mobilize people and make right to health a political issue
- Need of E-forum/opportunity for increased networking through internet
- We can combine our vision with the government aims and meet government at one common point of improving health indicators

Reflection on Challenges (From National and State sources)

- If member groups or individuals get limited by their own analysis or develop a rigid approach to diverse ways of engagement it may lead to a weakening of the movement. Our wider social accountability needs to be kept in mind
- We have to improve the current loose coordination and improve the stability of the network
- Mobilization and coordination of organizations remains as a challenge
- Network dynamics and administration- balance needed between democratic processes and formal structures/having full time committed persons
- Community presence- yet to evolve into a larger mass movement
- Evolving more comprehensive strategies to deal with problems in the health system (Keep Charter in mind!)
- Meeting the expectations of member networks which can be varied eg. Technical assistance, training, cultural campaigns, platform for vulnerable groups, financial support etc
- Financial and logistical support expressed by small CBO's

- We have not been able to educate even our friends on health rights issues
- The Gujarat Public trust act will be very restrictive for NGO's
- People in the government don't recognize the suggestions or recommendations made by the JSA
- Monitoring of private health services
- Development of anti-civil society stance among state and towards JSA
- Financial expectation of members
- What will we do with this SWOT analysis?
- Communication and inter-linkages between national and state level activities
- Clarity on "JSA issues and campaigns"
- Mobilisation of partner organisations
- Coordination of the Network

Some suggestions-National level

- Review the decision making process
- Not having involved proactively and benefitted from the tremendous experiences of Dr.Arole Dr.Antia and many others remains a deep regret as they were the pioneers of Comprehensive Primary Health Care in India
- Regular national level programs need to be organised
- Regional convener's have to be established
- Issue based circles be tried out(professional interests/area of expertise)
- Improve communication for sense of inclusion
- Offer Capacity building for state level activists
- Mechanism need to be evolved to circulate JSA stand on many issues (to support state level campaigns/ initiatives)
- Regional level JSA meetings-easy logistics and greater participation
- Mechanism for state units to suggest ideas for campaigns for national level response and support
- There can be collaborative initiatives on drug issues/rational use of drugs

Suggestions –for strengthening state level processes which are also nationally relevant

Strategic issues:

- Membership need to be Strengthened/network has to expanded - identifying and involving organizations that are working in health issues
- Work done by various organizations need to be shared
- Advocacy efforts as JSA need to be undertaken in the state

- Invite new networks involving agricultural issues/ dalit issues/women issues
- Strategies need to be worked out about how CBM process can be strengthened to support movement
- Simplify and popularize the health charter
- Ensure centrality of community by starting at the grass root level
- Redressal strategies to be strengthened: lobbying for legal compensations cases of health denials
- Mobilizing information through RTI/becoming state level pressure group
- Each member networks have specific strengths, these strengths need to be taken into account while planning
- District level JSA chapters and units should be created across the state
- Role of civil society organizations in planning and formulation of schemes need to be recognized by the government
- More visits and interactions with other JSA state chapters should be promoted
- Dialogue with the govt. should be increased/representation of govt. officials in JSA meetings and activities should be enhanced

Form, structure and capacity building:

- Collective leadership: The present structure of a convenor, co-convenor and secretariat needs to be revamped to bring in collective leadership
- There is a need to re-look at the state level structure and explore options/the possibility of a state coordination group that comprises representation from diverse organizations
- Build the capacities of the people involved
- Create forum where the representatives at the zilla level are represented at the state level
- It is necessary to have a proper structure for JSA and an action plan to get things on track
- Have an organisation /office structure and health activists at the zilla level
- Training in using technology for better communication, documentation, research and advocacy
- Immediate helpline for the health workers/activists
- Encourage/ train health activists/JSA members in health action and movements and promote exposure visit/ learning

<u>Building linkages with other movements/campaigns/Individuals</u>:

- Building strategic and working linkages/enhanced support, collective action and improved outcomes of our action using charter as frameworks
- Involve younger activists/PRI/other movements/ likeminded people, intellectuals and other stake holders

Strengthen content of movement initiatives:

- A holistic and comprehensive method to look at the social determinants of health-employment, food security, housing, water, education and other issues as identified in the charter

Human Resources:

- Should we have full time activists at district and state level..?
- Should we set up a media intervention circle for JSA at national and state level..?

From individual reports on state processes:

- Lateral relationships between state JSA's should also be recognized e.g. Gujarat and Maharashtra on the Gujarat Public Health Act etc.
- Need to Share more between states, share resources and exchange visits
- There is a need to involve more women and women groups and women participants in JSA
- There is a need to build the capacities of partner groups/need to build the capacity on larger determinants of health
- There is a need to build second level leadership within the JSA Orissa
- Not every state is equipped rather has the privilege to circulate/share through internet. Hence we need to establish a mechanism for better communication
- We also need to rethink about the role of national convener and joint conveners if they are not contributing to the state processes

Section 3:

Additional Context and Back ground:

1. Some reflections and observations on JSA/PHM from Non PHM Sources:

This compilation of reflections on and relevant to JSA-PHM at the extended JSA -NCC meeting in Nagpur on 12th November 2011, was an effort to keep all of us informed about all the different ways in which the movement is being contextualized, described, thought about and reviewed. The idea was to make us aware that JSA /PHM visibility and credibility has increased over the decade. It is however very important for us to make our own reviews, social audits, and reflections based on praxis and evidence gathered by processes such as PANS so that an overview of the movement and its strengths, weaknesses, opportunities, and challenges emerges as a learning from our own efforts and not only from what others write or surmise about us. These reflections are collated from a wide range of sources which we in SOCHARA have been keeping track of over the years. They provide a very wide range of assessments. What is significant however is that many of these descriptions of the movement now also appear in standard text books of public health in many countries helping to make young public health

professionals more aware of the social movements and determinants of health. These are only extracts. The originals need to be sourced to get the full articles or paragraphs on the movement.

1. Five sources pre-PHM help us to contextualize the evolution of the movement.

   a) H**ealth for All report 1981- The Prescription of ICMR and ICSSR**

   "A Mass movement to

   - Reduce Poverty inequality and spread education.
   - **Organise poor and underprivileged to fight for their basic rights**
   - Move away from the counter productive Western model of health care and replace it by an alternative based in the community ….."

   b) **An Epidemiological, Socio- cultural and political analysis and a perspective (1986) by Prof. D. Baneerji of JNU-CSMCH**

   " ….Health service development is thus

   - A socio cultural process
   - **A political process**
   - A technology and managerial process, with epidemiological and sociological perspective"

   c) **The strategy of Preventive Medicine – 1992, Prof. Geoffery Rose, LSHTM**

   " The primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social … **Medicine and politics cannot and should not be kept apart**."

   d) **People's Health in People's Hands, Dr. N.H. Antia, 1993**

   " This will be the single – most important aspect of this model as the whole concept of the community health care system is based on the community being involved and eventually taking responsibility for its own health care including the health services meant for their welfare……..In the ultimate, the operation of the health system will be determined by the political will either to look after the basic needs of all as decided at Independence or exaggerated needs of a few".

   Agenda for change presented to independent commission on health in India (1998) by CHC SOCHARA in its chapter on Human Resource Development.

   It is time to recognize the role of the community, the consumer, the patient and the people in the health policy debate …..

   What is needed is **a strong countervailing movement initiated by health and development professionals and activists, consumer and people's organizations that will bring health care and medical education and their right orientation high on the political agenda of the country**

   MARKET or PEOPLE ? What will be our choice?"

2. **Comments on the People's Health Resource Books (Five) in India -2000AD** which were used for JSS mobilization, **by** Halfdan Mahler ,DG Emeritus, WHO and Architect of the Alma Ata Declaration.

   "These books are the best expressions of primary health care concepts and its politics that I have ever read. They are the bible of primary health care, a glorious milestone on the tortuous road to primary health care…."

3. **Report on Globalization and Health - Berkeley University, USA, 2004**

   " This movement is engaged in what amounts to 'globalization from below' as it builds support for its global 'Health For All Now' strategy, lobbies at the global level and mobilizes a grassroots based campaign to realize the vision and achieve the goals of the People's Charter for Health."

   "The People's Health Movement is clear evidence that the existing linkages between globalisation and health are contestable. The People's Health Movement and the People's Charter for Health provide a significant expression of alternatives 'from below' to the present globalisation, privatisation and comercialisation of health coming 'from above."

Source : Richard Harris and Melinda Seid, 2004, Perceptions on Global Development and Technology, Vol-3, No.1-2, 2004, Special issue: Globalization and Health, Brill.

4. Public Health Textbook in UK – 2005

"The Peoples Health Movement is an international network of organization and individuals that came together in 2000 to reignite the call for the Health for All, Now. The goal of PHM is to reestablish the health and equitable development as top priorities at local, national and international policy making, with comprehensive primary health care as the strategy to achieve this priorities…….

It is transnational network …… and a good example of an emerging player in global civil society… On a day to day basis the secretariat in Bangalore …… puts forward strategic campaigning priorities…."

Source: Kelley Lee and Jeff Collin (Eds,) Global Change and Health, Understanding Public Health Series, LSHTM, Open University Press.

5. Recognising the Alternative Sector- in a WHO SEARO publication in 2005

"Many alternative institutions, both organized and informal have been actively involved in public health work, as well as public health capacity building. Sometimes they have been termed as alternative sectors…….

….A wave of community health NGO movements has taken place to try alternative experiments and actions, and to build capacity from communities and grass root workers. Unless the national apex institutions or schools of public health recognize these alternative sectors as strong

resources and involve them in training and research , a large portion of creative energy in public health will remain untapped…

….For example, in India, the following organizations, among others have been active in public health education and training- some since the 1980's and others more recently:

- Network of Community Health trainers and voluntary organizations who conduct short courses in community health, development and management
- Peoples Health Movement
- Society for Community Health Awareness, Research and Action (CHC/ CPHE)
- Centre for Enquiry into Health and Allied Themes (CEHAT)

The list can be enriched by examples from other countries as well as with more examples from India. ……"

Source: South East Asia Public Health Initiative -2004-2008, Strategic Framework for Strengthening Public Health Education, SEA-HSD 282, WHO SEARO, New Delhi, 2005

6. Public Health Text Book – Sweden, 2006

"A strong voice in the global health debate for free primary health care is the people's health movement which in 2000, presented the Peoples Health Charter. The charter argues strongly for a publicly financed health services and for development policies that favours health…. This network presently led from Bangalore in India is a leading representative for NGO's in the Global health debate. This global network is itself a new aspect of globalisation"

Source: Ann Lindstrand, Hans Rosling and others, Global Health – An introductory text book (www.studentlitteratur.se)

7. Advocacy with PAHO to renew Primary Health Care and recognize social determinants of health (PAHO primary health care document -2007)

Recognizes the PHM role in evolving the new health and human rights approach to Primary Health Care – with the necessity of tackling the broader social and political determinants of health.

Successful PHC services, encourage (community) participation, are accountable, have appropriate level of investment to guarantee adequate services and ensure services are accessible regardless of person's ability to pay.

Also quotes people's charter for Health.

Source: Promoting Primary Health Care in the America's, PAHO PHC document 2007

8. Globalization of Health, 2007

" History suggests that such changes often demand radical forms of political mobilization and action, although history has not yet encountered such a demand on a global scale. No simple precedents exists but several forms of mobilization are already been pursued…….

The simultaneous rise of a global civil society movement pressing for political actions to shift the rules of contemporary globalization

Source: Ichiro Kawachi, and Sarah Wamala (Eds), Globalization and Health, Oxford University Press, 2007.

9. The New Public Health Paradigm (The First Text Book by a chairperson of the movement steering committee), 2008

The text book covers the following:

1. Approaches
2. Political Economy
3. Research including Qualitative evidence
4. Health Inequalities
5. Unhealthy environment
6. Healthy Societies and healthy environment
7. Health Promotion
8. Public Health in the 21st Century (linking local , National & Global Systems)

" We are challenged to develop a public health approach that responses to the globalised world and its political, social and economic rectifications The challenge is as large as when public health was first developed" . Ilona Kirchbush – 2005

Source: Fran Baum, The New Public Health, Third Edition, Oxford University Press, 2008

10. World Health Report : Primary Health Care : Now more than ever -2008

- **" Where reforms have been successful, the endorsement of PHC by the health sector and by the political world has invariably followed on rising demand and pressure expressed by civil society"**
- Thailand –Thai reformers joined a surge in civil society pressure
- "Mali –sustained extension by local community health associations"
- "Chile - agenda of democratization"
- **"India – Strong pressure from civil society and the political world"**

- "Bangladesh - pressure for PHC from quasi public ngo's"
- "Countries need to demonstrate their ability to transform their health systems in line with changing challenging and rising popular expectations. That is why we need to mobilise for PHC now more than ever"

11. Report of the Commission on Social Determinants of Health, 2008

The process to evolve this report included many PHM links. One of the commissioners was from PHM and in addition dialogue with CSO's in different regions was organized by PHM. Resource persons linked to PHM participated in various knowledge hubs and finally civil society presented a report on SDH to the commission facilitated by PHM. The whole build up has been described in a peer review article mentioned below:

Source :Narayan Ravi, The role of People's Health Movement in putting the social determinants of health on the global agenda, Health Promotion Journal of Australia, December 2006, Vol 17, No.3, Page 186 to 188, Australian Health Promotion Association.

12. Social Vaccine: A new metaphor - 2009

PHM related resource persons have managed to get academia to accept the concept of social vaccines as a new metaphor to describe action on Social and Economic determinants of health.

A paper has been published in Health Promotion International in 2009.

(Fran Baum, Ravi Narayan, David Sanders, Vikram Patel, and Arturo Quizhpe, Social vaccines to resist and change unhealthy social and economic structures: a useful metaphor for health promotion, Health Promotion International,2009 Vol. 24 No. 4, 428-433)

When you google social vaccine you reach this paper on the internet.

13. Expansion of Understanding of Public Health to include the Social Determinants of Health, identified by the People's Charter for Health.

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

Source: Proceedings of SEARO meeting on Application of Epidemiological Principles for Public Health Action WHO – SEARO, Feb 2009

14. A PhD on Social Movements in Health from SOAS used an Anthropological framework and tried to study the movement, 2010

It emphasized the presence of - different narratives – dominant and subaltern; diversity and plurality of networks & members positions on engagement with public health system, varied

approaches to the engagement and convergence and divergence resulting in both clarity and conflict.

15. Recently a Global PHM Evaluation was done by a six member resource team in which a case study on India was prepared after a series of interviews and document review by a member of the team in India, 2011

This case study describes the following aspects of JSA: Evolution, perspective and objectives, structure, coordination within JSA, identity: movement or network, profiles of organisations, mobilizing participation, activities and campaign areas, major coordinated campaigns, intervention by JSA with public health, women's health. medicine's policy, right to food, communications: within and without and funding.

It identified the following achievements- visibility; many activities, campaigns and issues at national/state level; facilitating change in some states; diversity of networks & campaigns; perceived as important entity that needs strengthening,

It also identified the following challenges and recommendations (some)

- PANS process (incomplete); some states and groups unwilling to review organisational issues, and processes; need for national vision and multicentric and multisectoral mobilization; proactive communication at all levels; wider grass root mobilization; and greater transparency and accountability mechanisms

16. The PANS report which is being facilitated by SOCHARA on behalf of the PANS committee and JSA is proposed to be completed by end Dec 2011, giving a little more time for states to complete the process and for national organisations to complete the questionnaire. The report will consists of the following chapters and appendices:

1. Overview of JSA 2000-2011
2. Overview of PANS responses from National organisations.(NCC)
3. Reports of state process and meetings
4. Overview of strengthens, weakness, opportunities, and challenges.
5. The task's ahead
6. Appendices
    a) Current national /state structure/composition
    b) Diary of key events/campaigns 2000-2011
    c) Annotated bibliography of key JSA publications –national / state level
    d) Any others

(Suggestions are welcome and voluntaries to help with the compilation/editorial exercise are also welcome. The draft will be widely circulated before finalization)

17. Some website links to JSA-PHM

For further information visit

www.phmovement.org ; www.ghwatch.org ;www.phmovement.org/iphu; www.phm-india.org; www.communityhealth.in

Compiled by : Ravi Narayan, CPHE SOCHARA, Bangalore. chcravi@gmail.com

16.

COUNTERVAILING POWER IN THE ENVIRONMENT MOVEMENT IN INDIA

by Adithya Pradyumna, SOCHARA team member, Bangalore 2013

Note on solidarity/countervailing power in the environment movement in India

People rising together to protect local environments in India has historical roots. Stories about the *Bhisnoi* community sacrificing their lives for the local forests is stuff of legends (1,2), and from more recently, we have examples such as the *Chipko* Movement which still inspire young activists and are routinely referenced (3).

A 'movement' is the coming together of individuals or "groups to advance their shared political, social, or artistic ideas" (4), especially with respect to creating a countervailing power to existing governance or power structures. "Environmental movement" is often used as a broad umbrella term for various people's movements linked with environmental degradation (5). In reality however, while movements may express solidarity with each other, the level of interaction and synergism has been found to be relatively low, especially from the perspective of creating a countervailing power at the national or international levels. The only major example of a national level integration of scattered environmental campaigns and local movements is through the National Alliance of People's Movements (NAPM) (6). Under this banner, several people's movements have together forged an additional collective identity which has strengthened the position of these groups and has also encouraged sharing of information between them.

It would be useful to understand solidarity and countervailing power within the environmental movement keeping in mind a few case studies and examples. Firstly, we could look at a relatively old and very well known campaign to save Narmada valley – the *Narmada Bachao Andholan* (NBA). This movement was built around people's concerns, and has received wide support from several fronts, including well known celebrities (7). As the Supreme Court has itself admitted, the movement has also contributed towards raising awareness in environmental and developmental issues in the country (8). As a countervailing power, the movement has delayed but not prevented the growth of the Sardar Sarovar Dam and the consequent displacement of thousands of people, predominantly from tribal communities(9). However, the movement broke

into two arms due to discrepancies between impacted communities in two adjacent states. Such incidents have weakened the strength within the movement (9). Divisive powers are sometimes actively employed to reduce the power of people's movements, especially in contexts such as in mining where land acquisition is carried out.

The Bhopal Gas Tragedy, probably the most severe and well known among industrial disasters, and the injustice meted to impacted individuals and communities led to the formation of both a local movement and to solidarity efforts from across the globe (such as the International Campaign for Justice in Bhopal) (10). The campaign for justice has been one of the most inspired and supported efforts in the environmental movement. However, success in the form of environmental cleanup, legal proceedings and medical support has been far from adequate, as expressed by local communities (11). From a historical perspective, several health groups too became actively involved with this campaign. Research initiatives, plea for rational therapy, accountability and transparency were raised, and medical information was demystified for the affected communities (12).

Similarly, there are several local movements all over India. The impact of environmental degradation and pollution from industrial or developmental projects usually is also felt upon traditional livelihoods of communities (especially fishing, forestry and agriculture), and also on their health. Social and cultural disruption due to displacement is also a major concern of affected communities (13). Such common local concerns bring people together to collectively fight for their rights and equalize the power imbalance between the forces supporting the offending project. Local movements have their innovations as well. One such example is from Cuddalore, Tamil Nadu – where an industrial unit (consisting of chemical and pharma plants) located in the midst of populated communities has polluted the local environment. In response, some activists from the community together have formed the SACEM (SIPCOT Area Community Environmental Monitors). These individuals have been trained in systematic documentation of pollution and health impacts, which they have done over the past decade (14). In addition, working local activist health professionals, they have developed methods of documenting levels and types of air pollution in the area based on the nature and intensity of the smell noticed, through what has been termed as a "smell index" (15). Such tools and capacity building has not just empowered the local community, but has made the industries and the local Pollution Control Board officials more responsible to the complaints and demands of the community. Systematically collected pollution and health evidence has served to facilitate CEM's role as a countervailing power in Cuddalore. There is however a lot more to achieve, as levels of pollution continue to be far above acceptable level (12).

SACEM and other similar such groups have networked and interacted under another banner called Community Health Environment Survey Skill-share (CHESS) since 2001. CHESS has evolved as a platform for sharing, networking and capacity building of pollution impacted communities, and was initiated following a request to a community health group, SOCHARA

from environmental activists. Health evidence was seen as crucial in legal strategies in polluted areas, and SOCHARA with its history of people centred approaches to work, has facilitated the empowerment of local communities to document their own pollution and health experiences and also to network with health researchers to facilitate more advanced processes. Four national-level CHESS workshops have been conducted on issues such as industrial pollution, mining and occupational health – each of which was well attended by community based organisations, and movement and trade union representatives alongside health professionals and researchers. Sharing between groups has increased exchange of ideas and greater solidarity between affected communities. In addition, some participating communities and groups have successfully used health as an approach/tool to shift power balances in legal and other negotiation situations. As health impacts are seen in every situation of pollution or environmental degradation, it has been hypothesised that health could be the platform to bring various environmental groups and movements together (12).

Besides environmental campaigns and movements, there exist several independent registered environmental organisations. They broadly work as resource groups working on specific themes (such as biodiversity, forests, wildlife, water, sanitation, energy, toxins, pollution), or through specific approaches (research, advocacy, legal, training, service provision) but with the common aim of mitigation of degradation and promotion of environmental preservation. It has been noted that frictions exist between movement groups and some registered NGOs, which may have resulted due to difference in opinions on how issues are approached, or from broader philosophical and political differences (12).

There is a need for greater solidarity between environmental groups and movements in India, in the context of corporate led globalization and pro-growth agenda of the government which have historically increased economic and health inequities within the Indian population. The coming together of the range of actors is occasionally seen, such as during the Conference of Parties for the Convention of Biological Diversity that was held in Hyderabad a few months ago. Representatives from organisations and movements such as agricultural movements, organic farming groups, wildlife researchers and conservationists, fish-workers unions, and health professionals participated in the discussions and parallel events (16).

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17.

Research for Health for All – Call for Greater Civil Society Engagement

[A Call by twelve organizations who participated actively in the Bamako Global Ministerial Conference on Research for Health, Development and Equity, 17-19th November 2008 organised by COHRED, Global Forum for Health Research, Republic of Mali, UNESCO, The World Bank, WHO]

Preamble

Research for health focuses on better health for all, and calls for a broad involvement of all stakeholders, from different sectors and disciplines. Civil society organisations (CSOs) can play a key role in ensuring the move from health research to research for health. They can:

- bring other views and cultural perspectives to research;
- articulate research agendas and conduct research that goes beyond a narrow focus on health to include the determinants of health and health-related inequities;
- increase local capacity and skills to respond to national and international priorities and demands;
- disseminate research findings to a wider audience using more accessible formats;
- act upon research findings;
- hold all stakeholders accountable.

This blueprint presents key strategies and recommendations to strengthen the role of CSOs in research for health. It was developed by a group of civil society organisations (the undersigned) to:

- clarify the role CSOs can play in research for health;
- define appropriate strategies to increase CSO engagement in research for health;
- inform the discussions at the Bamako Ministerial Forum on Research for Health and participate in developing a post Bamako action plan that will include greater civil society engagement in research for health.

The strategies, based on the perspective of the CSOs, outline what needs to be done for CSOs to make a positive contribution to research for health. The recommendations focus on all stakeholders, that is, Government, academia, funding institutions, development partners and CSOs committed to research for health.

We define CSOs as organisations that are not for profit and operate between the state and the public. Our focus is on those organisations with an interest in research for health. While acknowledging the challenges of representativeness, we believe that CSO's represent community based organisations and community groupings, and that their contribution to research for health can have a positive impact on the population at large.

Strategies for increasing CSO involvement in research for health

1. **Advocate for greater involvement of civil society organizations in research for health**

   CSOs should advocate based on: (a) rational arguments; sound evidence and knowledge; (b) deeper awareness of the values, objectives and motivation of government, academia, funding institutions and development agencies; (c) respectful dialogue and communication about the real needs and concerns of the public in comparison with policies and agendas of government and academia, funding institutions and development agencies;

2. **Establish or strengthen partnerships and networks for civil society engagement in research for health**

   - **Government and Academia**

     Establish or strengthen partnerships between government institutions, academia and civil society organizations based on mutual respect, democratic principles, transparency and inclusiveness

   - **Funding Institutions and Development Agencies**

     Strengthen interactions between funding bodies and between development agencies to support involvement of civil society organizations in research for health

   - **Civil Society Organizations**

     Establish or strengthen linkages between civil society organizations based on common themes.

     Establish or strengthen networks between CSOs, supported by international and global CSOs, to: (a) intensify the voice of the public for influencing policies, strategies and agendas of government, academia, funding institutions and development agencies; and (b) promote collaboration between CSOs on different aspects of research for health.

3. **Strengthen the capacity of civil society organizations to enhance their involvement and credibility in research for health**

   - **Government, Academia, Funding Institutions and Development Agencies**

Support the development of independent institutional and human capacity for civil society organizations to be able to possess an independent voice in research for health and to become a credible partner in the research process.

- **Civil Society Organizations**

  Clarify areas of interest in the research process, identify capacity building needs based on areas of interest and develop capacity building plans based on identified needs

4. Increase civil society organizations' access to research funds

- **Government and Academia**

  Incorporate civil society organizations in research projects, where appropriate

- **Funding Bodies and Development Agencies**

  Harmonise and align funding principles and practices to increase research funds available for civil society organizations

5. Create demand for research for health nationally and internationally

- **Government and Academia**

  Establish systematic mechanisms to make research findings available in language and format that are accessible to the general public on a timely basis.

  Include research component in health-related development projects.

- **Funding Institutions and Development Agencies**

  Provide funds to promote dissemination of research findings in a language and format that is accessible to the general public on a timely basis.

  Encourage the inclusion of a research component in health-related development projects

- **Civil Society Organizations**

  Promote translation of research knowledge to actionable knowledge thereby promoting relevance to day-today living and increasing public trust in research

  Include research component in health-related development projects.

Recommendations from CSOs to all stakeholders in research for health

We call on all stakeholders to:

1. acknowledge the importance of research for improving health for all, and to **recognise the contribution** CSO's can make to support the broad scope of research for health, with a focus on health development and equity.
2. build and nurture **partnerships** with CSO's around common concerns on national and global priorities in research for health, and to base these partnerships on the principles of mutual respect, inclusiveness, multi-disciplinarity, transparency and trust.

3. create environments at national and global levels in which CSO's can excercise their **legitimate roles in research for health,** through providing financial, infrastructural development and institutional capacity building support to CSOs.
4. provide **funding** which is long-term and flexible based on fair-contracting principles, thus strengthening CSOs to engage in participatory processes, build their institutional capacity, and becoming a strong partner in developing and implementing research strategies at local, regional and global levels.
5. value alternative ways of **communicating** research, using a variety of channels and languages, and to acknowledge the role CSOs can play in raising awareness of research, in transforming research findings into action, and in communicating this to the public, thus increasing public trust in research.
6. **jointly identify indicators** and methodologies for measuring the involvement and contribution of all stakeholders, including CSO's, in research for health, equity and development.

SIGNATORIES:

- **Aga Khan University, Pakistan**
- **ANIS, Instituto de Bioética, Direitos Humanos e Gênero, Brazil**
- Centre for Science and Environment (CSE), India
- **Centre for Public Health and Equity, SOCHARA, India**
- Council on Health Research for Development (COHRED), Switzerland
- Centre for Health Research and Development (DBL), Denmark
- **International Centre for Reproductive Health (ICRHK), Kenya**
- **L'Association Tunisienne de Promotion de la Recherche en Santé** (ATUPRES), Tunisia
- Project Africa, Kenya
- Public Health Research and Development Centre (CIAM), Gambia
- Research!America, USA
- Wellcome Trust, UK

18.

A REVIEW OF THEORETICAL FRAMEWORKS OF SOCIAL MOVEMENT IMPACTS: *What can the health movement learn?*

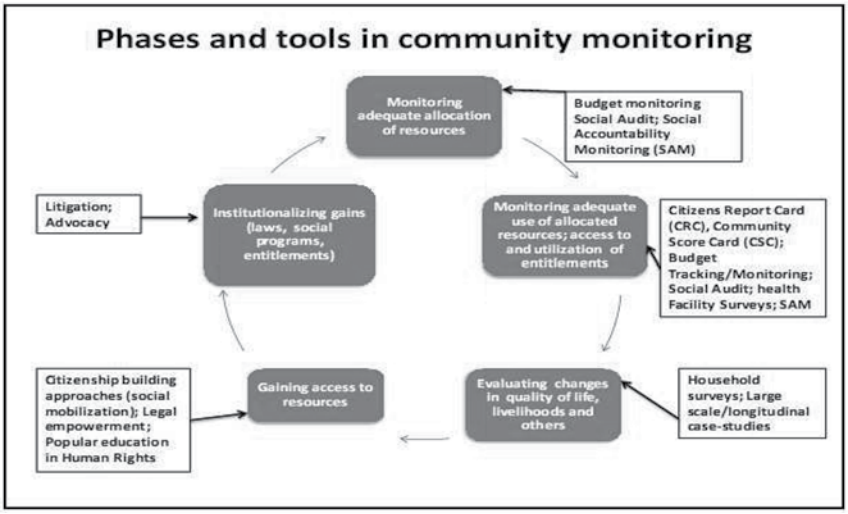
By Rakhal Gaitonde-2013

The world is a very different place from what it was a few decades ago, and indeed quite different from what it was when viewed within longer time frames. Health and social indicators have changed greatly, besides changes in all aspects of life. There are a number of possible reasons for these changes and some of the more commonly quoted reasons include religions and religious movements, social movements and larger movements like the independence movement in India, movements that span across nations and that are woven around common areas of injustice like the women's movement, and so on. While this assumption is perhaps intuitive and highly believable, research linking movements with change, associated in time and space, causally isevolving and members of social movements may not be informed by this literature . Social theory and studies of policy process shed some light. Thus a recent review notes, "*Social movement scholarship is largely built on the assumption that the world we live in today is different and that part of the answer to "why" is that social movements have exerted direct and indirect pressure on key civil and political decision-makers, resulting in cultural and political changes.... In fact, we know too little about what has changed and even less about the causal processes that could tie social movements to those changes*". (Earl, 2004)

Given the increasing appreciation of complexity and the diverse determinants of any pattern of behavior, response and action earlier assumptions of 'impact' and 'success' can be interrogated.. Such reflexivity together with a need for critical analysis of movement claims of impact is not merely a research imperative but is crucial for all movements as they grapple with strategy development to achieve their goals and address bewildering complexity. Thus while huge mobilizations of tens of thousands of people can go completely unnoticed, while the death of one individual can spark a media frenzy, decades of collecting evidence and sustained advocacy brings about no policy changes, and one stray report suddenly sparks of a paradigm shift in policy.

Those of us involved in social mobilization, advocacy, building and supporting movements are often struck by the messiness of the situation. Ideas of a "state captured by the elite" are constantly challenged by remarkable bureaucrats who open doors and create spaces for

the movement; ideas of community mobilization and wisdom are constantly challenged by communities ridden with caste and gendered biases; and lofty ideals within the movement are riddled with factionalism and petty arguments. This is perhaps reflective of the human condition. Experience with a number of movements and advocacy initiatives directly lead one to question the cause and effect that one tends to presume between social movements and social change. Mere association in time and place does not assure causality, and this is crucial as mentioned earlier in planning long term strategies. A deeper understanding of the theories and pathways of change would help movements appreciate other forces that contribute equally to egalitarian social change and thus gain newer partners and allies, it would make movements more self-reflexive and open It would in the ultimate analysis be an ethical imperative. As noted in the literature, " *analysing social movement change requires a causal analysis that not only demonstrates an association between the movement and specific outcomes but also shows that movement processes contribute independently or in addition to other potential causes. Such an analysis also identifies mechanisms involved in bringing about change. The analysis involves placing movements in a broader social context that includes ongoing social changes, the structure of the state, prevailing political alliances, existing ideologies and cultural resources, and the structure of the major social institutions relevant to the change in question*"(Jenkins & Form, 2005).



Source : Walter Flores, CEGSS, Guatemala

This article looks at the question regarding impacts of social movements and reviews some key theories, frameworks and research that address this.

It also suggests elements of an emergent framework emerging from this discussion that can be used in the future. It highlights gaps in research and raises some questions for social movements to think about. The article takes two broad perspectives, that of the social sciences, especially political sociology and systems theory. Both study social change, but from different perspectives. While political sociologists emphasize the multiplicity of players and influences,

systems theorists emphasize the system (and its properties). Both sets of approaches provide insights into the issue.

The Structure

Social movements and social change

While there are a number of definitions of social movements aan essential feature of most of them is the focus on bringing about a change in a given societal situation. Social movements emerge due to dissatisfaction with the status quo by a group that perceives and feels itself at a disadvantage by the status quo. Most social movements aim to bring about changes in either the state (policy, structure, functioning) or at the level of culture. Social movements impact on individuals (especially those involved in them) and also on other social movements and societal relationships.

An important point discussed in the literature and followed here, is the difference suggested between social movement outcomes and social movement change. Jenkins and Form suggest that, "*short term or immediate outcomes of movements, for example life course change, policy enactment and policy implementation*", need to be differentiated from, "*the distinctive contribution of social movements to change net of ongoing changes and social processes* (Jenkins & Form, 2005). Thus while all movements will definitely be able to show 'outcomes' and these are definitely important in themselves, what is of interest to us in this paper is the aspect described as 'movement change' which are probably those aspects of the impact of the movement that are sustained and contribute to structural change.

A useful way of looking at social movements and subsequent action is the cyclical approach proposed by Walter Flores for Community Monitoring (Fig.1) (Accountability and Monitoring in Health Initiative, 2011). In this he suggests that the first step is the recognition of an injustice by a group of people, the framing of that perceived injustice in terms of a demand or a 'right' which basically translates into the demand for more appropriate / just distribution of resources. This is usually addressed to the state. In the literature this is the work of "*critical communities*" (who 'name' issues and problems)(Earl, 2004). It has been noted that, *"Movements take the "conceptual innovations" produced by critical communities and repackage or reframe these ideas for mass appeal*"(Earl, 2004). The next step is to bring the issue on the agenda of discussion and finally into a formal policy / legislation as a formally recognized right. After this there is still the need to continue advocacy and movement activities given that there then needs to be the conversion of the policy / legislation into an implementable program and resources need to be set aside for this and then implementation with all its problems takes place. This movement cycle is a useful descriptive framework for the life and actions of a movement.

Other authors describe a much simpler life cycle as that of (1) emergence; (2) stabilization; (3) institutionalization; and finally (4) dissolution / continuation etc. (Jenkins & Form, 2005).. Both

these approaches are useful in visualizing the long term evolution / changing demands in a path to achieving social justice. Floress' a also lists various tools that may be used in stabilizing / helping communities in achieving the various aims. These two were discussed here to point to the fact that for social movements the journey to achieving social justice goes beyond merely bringing the issue on to the agenda, and at the same time social movements need to realize that they themselves undergo changes that need to be kept in mind for longer term stability and sustainability of the movement.

The early theories and how they handle change

A recent review of social movements and change describes five broadly recognizable groups of theories of social movements. These have been described as – (1) early symbolic interactionist theories of collective behavior, (2) functionalist treatments, (3) resource mobilization, (4) political opportunity, (5) newer ideas about framing and collective identity construction (Jenkins & Form, 2005).

The early symbolic interactionist theories focused on the coming together of groups of people and posited that certain situations and especially those with some amount of unrest / restlessness could lead to "circular reaction processes" and the break down of behavioral norms to lead to crowd action [Blumer 1969]. In theories termed as Functionalist there was a suggestion of 'structural strain' which led to the emergence of alternative generalized beliefs. Theories regarding Resource Mobilization and Political Opportunity focused on the organizational and human resources that a movement was able to mobilize, as well as 'structural' and 'dynamic' opportunities. Dynamic opportunities describe the sudden change in elite motivation (which is is normally in opposition to any social movement) towards social movements creating sudden opening up of spaces. The structural opportunities theories talk about the structures in the system that may impede or facilitate the interaction between the social movements and the state and elites.

Newer theories regarding framing are succinctly described as follows, "*movement leaders and participants construct collective definitions of their immediate environment. They externalize blame by attributing grievances to the mutable policies and practices of institutional elites, and they propose concrete social changes to alleviate these problems* "(Jenkins & Form, 2005).

Synthesising the various theories Jenkins points out, "*In all approaches, it is critical to underscore the societal embeddedness of social movements. The task of accounting for changes brought about by social movements cannot be addressed without explicitly mapping their external organizational environment and testing the various theories of how social movements and other external factors contribute to the process*" (Jenkins & Form, 2005).

Looking at these theories one can notice a gradual move from theories addressing movement emergence, to movement sustainability and functioning to the actual embeddedness of

movements in a complex reality. It is only the later theories that begin addressing issues of movement outcomes / changes and their determinants.

An inter-institutional network approach

In this theory for the sake of simplicity society is divided into four sectors: (1) social movements; (2) governmental institutions, such as legislatures, courts, chief executives, and agencies; (3) political interest organizations, such as political parties and interest groups; and (4) other, social institutions such as those dealing with mass communication, education, economy, welfare and religion. (see Fig. 2)

The authors point out that in an open democratic society, "*these four sectors constitute an interactive system of inter-institutional bargaining, conflict and change. For any given movement, the parent institution and the other three sectors constitute an external organizational environment in which the movement interacts in the process of advancing its aims, goals and values. Our approach treats the macro-societal structure as existing prior to social movements, defining the latter as emerging out of society and responding to groups in this larger structure"* (Jenkins & Form, 2005).

This conceptualization of the field in which the social movements have emerged and act, point to the following main lessons:

- Social movements are embedded in this "inter – institutional field" which defines to a large extent the possible alliances and opponents.
- Sometimes 'other influences' may be un-recognized and thus possibly even neglected, unintended consequences may occur and externalities may change, all of which may have their own impacts on overall movement strategy and outcomes.
- That the ultimate outcome of the movement thus is the 'resultant vector' as it were of multidimensional bargaining groups and influence.

The above sections cover theories that dealt directly with social movements, in the next few sections a few key theories of change are presented that have emerged in the field of policy change (Kingdon 2002); in the health field such as the Transition Theory and Klugmans adaptation of Kingdons streams theory and one that has emerged from the field of systems theory. A careful reading of these is useful as these turn out to be complementary to the theories discussed above.

Kingdons Multiple Streams theory

Among the many influential theories of policy change, the multi-streams theory of Kingdon (Kingdon, 2002) is quite influential. In this the author basically posits that, "*the public policy process has a random character, with problems, policies and politics flowing along in independent streams*".((Kingdon, 2002). Thus the key questions are, "*how a problem gains*

recognition as a problem to be addressed in the political terrain, how specific solutions get onto the political agenda, and why politicians are concerned with certain issues rather than others at a particular moment in time" (Klugman, 2011). Thus windows of opportunity arise at these points of confluence that enable the government (and elites) to act on the basis of the demands from various advocacy efforts.

Transition Theory

A transition in this theory is defined as, "*a gradual process of societal change in which society or an important subsystem of society structurally changes*" (Bunders & Broerse, 2010). The key tenets of system innovation and transition theory are:

1. The multi – level perspective.
2. The multi-phase concept.
3. Transition management.

The multi-level perspective distinguishes three levels of social organization.

- "A Patchwork of 'regimes' at the meso level". These are groups of actors with a shared set of norms and rules by which they solve problems.. Thus the meso level is seen as relatively "resilient"
- At the "niche or micro level" – individual actors act according to various motivations, and include the innovations and alternative approaches to a given problem.
- At the "landscape (macro) level" – This consists of the overall macro picture including issues like the economy, the demography, larger social cultures, the environment etc. This is considered to evolve independently, but has strong influences over the lower levels.

The multi-phase concept – describes a number of stages that a transition can go through that resemble an S shaped curve.

In this model the regime or institutional level initially damps any innovations, however changes in the intensity of the innovations as well as changes at the macro level (in terms of the political and social trends) can enable a situation where the innovations diffuse up to the regime level and induce changes on a more sustainable and wide spread manner. As the authors note, "*Only when experiments at the niche level and wider political and societal trends coincide may changes at the macro level diffuse and scale up"* (Bunders & Broerse, 2010).

The theory basically envisages innovations occurring at the niche level, but being 'damped' by the regimes at the meso level. It is probably changes at the landscape / macro level that weaken 'regimes' that will lead to any change at the meso / institutional levels.

Theory of change framework to assess progress

Building on Kingdons three streams, Klugman adds a fourth, that of bureaucracies and administration, since implementation is as much as site of policy making as is law; and bureaucrats

and administrators, as with policy makers, act on the basis of personal and institutional concerns that may bear no relationship to the problems and desired solutions of those who are most in need or marginalized". Klugman calls the "policy entrepreneurs" of Kingdon as "policy activists", "*to denote their link to social movements, and the recognition that mobilization of those most affected can in itself change the policy environment, in particular the public discourse, to get specific problems and preferred solutions onto public and policy agendas*" (Klugman, 2011).

Panarchy

Panarchy is the term used to describe a concept to explain the evolving nature of complex adaptive systems. "*Panarchy is the hierarchical structure in which systems of nature (for example, forests, grasslands, lakes, rivers, and seas), and humans (for example, structures of governance, settlements, and cultures), as well as combined human–nature systems... are interlinked in never-ending adaptive cycles of growth, accumulation, restructuring, and renewal. These transformational cycles take place in nested sets at scales ranging from a leaf to the biosphere over periods from days to geologic epochs, and from the scales of a family to a socio-political region over periods from years to centuries*" (Holling, 2001).

The idea behind the levels of hierarchies in the theory of Panarchy is that these are some what semi-autonomous levels that emerge from the interaction of various variables (including various types) with similar life times / cycles of change. The two characteristics of these levels are that they interact, and that in fact the higher (and 'slower') level 'dampens' any changes in the lower (and 'faster') levels. This interaction between levels (and the attendant 'control' of lower levels by higher levels) leads to the stability of the system. Thus not only does the system allow innovations and diversity, but also manages to maintain stability.

Holling describes three properties that shape the adaptive cycle and the future state of a system:

- "*The inherent potential of a system that is available for change, since that potential determines the range of future options possible. This property can be thought of, loosely, as the "wealth" of a system.*
- *The internal controllability of a system; that is, the degree of connectedness between internal controlling variables and processes, a measure that reflects the degree of flexibility or rigidity of such controls, such as their sensitivity or not to perturbation.*
- *The adaptive capacity; that is, the resilience of the system, a measure of its vulnerability to unexpected or unpredictable shocks. This property can be thought of as the opposite of the vulnerability of the system*" (Holling, 2001).

The Basic Panarchy model of system change

The trajectory of a system alternates between long periods of slow accumulation and transformation of resources , with shorter periods that create opportunities for innovation

In summary, there are four key features that characterize an adaptive cycle, with its properties of growth and accumulation on the one hand and of novelty and renewal on the other. All of them are measurable in specific situations, again quoting directly from the original:

- An increase in the accumulation of resources parallels an increasing rigidity.
- Increase rigidity leads to a decrease in resilience.
- At this time innovations can occur and there is a phase of reorganization.
- The innovation that survives then starts a new cycle. (Holling, 2001).

Further to this more general description of change within a system, the theory also describes two generic processes of change when systems interact. These are known as the "remember" and "revolt" interactions. Thus when changes in one system are transmitted to the next higher level (which is in a particularly vulnerable state), it can trigger massive change and a small / fast event can impact on the larger level. Similarly even if there is a massive change at one level the ability to be transmitted to the next level will depend on the state it is in.

This theory focuses almost completely on the properties of the system. This is some thing that most social movement activists will be quite uncomfortable with as it reduces considerably the 'agency' of social movements to bring about change and instead focuses on system characteristics and readiness. The primary learning would actually be to force us in the health movement to engage more with the system and its "properties" and understand the multi-factorial nature of change processes.

Overall the theories from different scientific approaches have a number of common themes. One is the embeddedness of the change process in the local context. The second is the multiplicity of players in the change process and the inadequacy of models that envisage a somewhat linear relationship between states and social movements. The other common emerging theme is that of the multiple dimensions or levels or streams of processes that one needs to consider in change processes. Thus while From and Jenkins talk about the number of institutions (each with their motivations), Kingdon talks about the independent streams of events and both in the Transition and Panarchy theories the authors invoke the concept of hierarchies / levels – which while interacting are semi-autonomous.

What is important is that in all the theories from using varied approaches of study, there is a lot of focus on the characteristics of the system. This is very important for us to understand and take into account while planning out movement strategies. Some of these characteristics are 'structural' and some are 'dynamic' (and unpredictable). Thus there is a clear message that movements need to be 'nimble' and open to diverse information sources and influences. It is clear that there is the need for diverse partners and approaches and that a thorough understanding of the context in which the movement demands are made is crucial to planning the strategy.

Studying the effect of social movements on state related factors

As mentioned in earlier sections movements can be visualized as resulting in 'movement outcomes' and 'movement changes'. Methodologically capturing the relationship of movements

to outcomes on their participants like personal changes, changes in ideology, shaping of newer awareness and identities etc. are much easier compared to measuring the impact of movements on 'changes'. Given the complex set of determinants to explain state policy and implementation of various demands on it measuring or even documenting the direct and sole impact (even if partial) of movements on the state is challenging. It has been noted in the literature that, "*Causal arguments in this area can be complicated, making assessing them more difficult. Yet because it is already difficult to study phenomena as evanescent and often poorly recorded as social movements, scholars often engage in case studies that place informational restrictions on the appraisal of their arguments*" (Amenta & Caren, 2004).

Given the understanding from the inter-institutional framework, it is fair to expect that the state and the context of institutional relationships will determine to a large extent the forms of organization and the strategies adopted. In turn social movements attempt to influence the state, competing with some and cooperating with other influences.

There are broadly two types of outcomes following the lead of Gamson (Amenta & Caren, 2004)). The first type of outcome has been described as those leading to "new advantages" which include legislations, policy formulations etc. which basically contribute to a redistribution of resources in favor of the group being represented by the social movements. The second type of outcome are broadly called "acceptance" where the state recognizes the social movements as legitimate. It has been suggested that getting specific policy or legislations based on one's demands may in fact be a minor victory (in a given situation) compared to the movement group being recognized as legitimate and being able to continue to leverage political advantage beyond the immediate demands. This can create positive precedents and can benefit a number of marginalized groups in what are termed as meta-collective benefits (Amenta & Caren, 2004).

Craig Jenkins suggests a three-part scheme based on short-term changes in political decisions, alterations in decision-making elites, and long-term changes in the distribution of goods. The first and third are different forms of new benefits, while the second is connected to the idea of access or acceptance (Jenkins, 1982).

Authors have divided the process of creating new laws into agenda setting, legislative content, passage, and implementation of legislation. This division into various milestones on the way to full realization resembles the life cycle described in the earlier section and enables us to assess the movement in achieving progress towards the ultimate goal rather than seeing the outcome as an all or none phenomenon.

As noted in a recent review "*By gaining representation in legislative offices and bureaucracies, challengers can influence policies for their constituencies throughout the process, including placing programs on the agenda, helping to specify their content, aiding their passage, and supporting their enfor*cement" (Amenta & Caren, 2004).

In the Universal Health Care (UHC) debate presently ongoing in India an interesting phenomenon is being observed. The fact that the Universal Health Care concept has suddenly got ascendance despite the gradual abandonment of Health for ALL concept is very interesting. Yet the reality is that there are two distinct and quite different voices demanding UHC, who despite demanding the same 'right' can hardly be considered allies. Thus the two major voices for UHC are the corporate health sector and the People's Health Movement and its allied networks and social movements. While the People's Health Movement and its allies are demanding UHC from a rights perspective and based on concepts that extend beyond financial arrangements to participatory and communitarian governance, the corporate health sector is probably driven by the fact that it foresees a large part of the investment that the government is promising to make as coming to it and is thus driven by purely commercial interests. Thus the mere demand of UHC coming on to the agenda (which was made by the health movements) is not necessarily as positive as one may feel given that the supporters of the agenda are diverse and the expected outcomes are equally diverse. There is a need for vigilance and constant engagement.

One of the key aspects of the effectiveness of impacting the state is the way the problem is framed by the social movement. Thus the framing may be seen not only in the light of the role of "critical communities" described earlier who bring the issue on to the agenda of discussion, but also in the light of Kingdon and later Klugmans invoking of "Policy entrepreneurs" and "policy activists". Thus one of the crucial roles played by social movements is the way they frame the problem, and thus make it more "acceptable" to the state. The recent advocacy campaign to change the immunization policy of the state of Tamilnadu (which changed its immunization policy from field immunization to institutional immunization) shows the critical role of the way the movement framed the issue. Not only was the way /s this was framed more acceptable, but critically supported by groups within the state bureaucracy who were fighting for this change in side the department (unkown to the movement).

An important point to note is the importance of the concept of political context or ''opportunity structure'' Kriesi et al. (1995) "*take the most systemic view, arguing that the openness and capacity of states largely determines whether a state-related movement will have an impact and whether or not it will be proactive or reactive. When states have both inclusive strategies and strong capacities, challengers are most likely to achieve "proactive" impacts. Under weak states, by contrast, reactive impacts are more probable, as the state lacks the capacity to implement policies*" (Amenta & Caren, 2004).

In short, "*mobilized challengers have impacts largely because they engage in collective action at the right time"* (Amenta & Caren, 2004).

This means that, "*challengers need to engage in collective action that changes the calculations of relevant institutional political actors, such as elected officials and state bureaucrats, and challengers need to adopt organizational forms that fit political circumstances. State actors*

need in turn to see a challenger as potentially facilitating or disrupting their own goals – which might range from augmenting or cementing new electoral coalitions, to gaining in public opinion, to increasing the support for the missions of governmental bureaus" (Amenta & Caren, 2004).

Methodological issues

Based on the above discussions on various frameworks and a review of the studies of the impact of social movements on states, it is clear that the traditional case study approach to study movements is inadequate. While these are easier, they tend to leave out a lot of contextual and more importantly historical data. Thus there is a call for more research based on historical and ecological approaches. There is a need to assess change from a number of perspectives including the anthropological, sociological, political and historical perspectives to appreciate complexity as well as the pathways to change.

Elements of evolving framework

The above discussion of various frameworks of social change, specifically looking at the impact of movements on social change has revealed the complexity and the embeddedness of the situation. Traditional methods based on linear modeling and limited case study based analysis are highly inadequate to study the impact of social movements, and as argued the lack of accurate information on this leads social movement actors to over estimate (or underestimate) the impact of strategies, allies and pathways to change.

- As noted earlier one of the crucial insights especially from the systems studies point of view concerns the characteristics and 'readiness' of the system for change processes.
- The Transition theory and Panarchy discussed show that critical to our understanding of change processes are an appreciatiion of the hierarchical nature of systems (the multidimensional aspect) as well as the influence of multiple dimensions / levels of the hierarchies in maintaining and in setting change processes. These are critical insights for us activists and there is a need to look at our experiences through these lenses to see what these can teach us.

Methodologically there is obviously need for more multi-disciplinary approaches as well as historical, anthropological and sociological approaches.

- One of the key innovations methodologically is the breaking down of the ultimate goal to be reached into various milestones based on insights gained from these frameworks. This has been attempted among others by Klugman when she proposes the theory-of-change based assessment of advocacy initiatives.
- The other is to factor in the motivations of the mulitple and many times unrecognized players in the struggle for redistribution of resources to bring about social justice.
- The third key insight is the crucial role of understanding how to frame a particular problem such that it is not diluted, yet resonates with the largest group as well as the multiple streams of Kingdon.

Social movements need to understand the importance of context and the various institutions (after the inter-institutional framework) that are interacting and influencing each other. In addition there is a need to understand factors at the niche, meso and macro level (following the transition theory) as well as the state of the system in terms of the panarchy theory. It would be best to use some of these insights to interrogate various campaigns and movements to appreciate these issues further and build on them.

Some unanswered questions or questions that can lead to further action are:

- What are implications of this complexity and systems based approaches to the practice of social movements?
- How do these frameworks and approaches help us to understand in greater depth the actual pathways and possibilities of social movements leading to social change?
- How does practice impact on these theoretical frameworks?
- How do we assess the impact of social movements (our work) on the actual realization of the goals of social justice?

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SOCHARA Contact Details

Registered Office

Society for Community Health, Awareness, Research and Action (SOCHARA)
326, 5th Main, 1st Block, Koramangala, Bengaluru, 560034

SOCHARA- SOPHEA

No.359,Srinivasa Nilaya

1st Main, 1st Block, Koramangala,
Bengaluru – 560034, Karnataka State, INDIA
CHC Tel: +91-80-25531518 Telefax: +91-80-25525372
Email: chc@sochara.org; web: www.sochara.org

Community Health Cell, Extension Unit, (CEU) **Chennai,**

SOCHARA
No.31, Prakasam Street, T.Nagar,
Chennai – 600 017, Tamilnadu
Ph: 044-45502438
Email: tnchc@sochara.org

Centre for Public Health and Equity (CPHE), Bangalore

SOCHARA,
No.27, 1st Floor, 6th Cross, 1st Main, 1st Block,
Koramangala, Bangalore – 560 034
Ph: 080- 4128 0009
Email : cphe@sochara.org

Centre for Public Health and Equity (CPHE), **Bhopal**

SOCHARA,
E 8/74, Basant Kunj, Arera Colony
Bhopal – 462 039,
Ph: 0755- 2561511
Email: cphebhopal@sochara.org

SOCHARA AND ITS OBJECTIVES

The Society for Community Health Awareness, Research and Action (SOCHARA) is a professional resource group in community health and public health, rooted in civil society. It has spearheaded community health action; innovative training; and policy action research in community health and public health since its inception in January 1984. The Community Health Cell (CHC) is the functional unit of Society for Community Health Awareness, Research and Action (SOCHARA), which is a registered Society.

(see website www.sochara.org)

The Objectives of SOCHARA are:

- 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 government 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 formulation and community oriented health policies.
- To establish a library, documentation and interactive information centre in community health.

Vision

"Equity, ecologically - sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decision that shape our lives.

There are more than enough resources to achieve this vision"

Source : The People's Charter for Health - The People's Health Movement, Dec. 2000

SOCIETY FOR COMMUNITY HEALTH AWARENESS RESEARCH AND ACTION
359, 1st Main, 1st Block, Koramangala, Bangalore - 560 034
Tel. : +91-80-25531518 | 41280009 | 25630934
email : cphe@sochara.org | Web : www.sochara.org