The Community Health Cell Journey

Step by Step 1982-2008

Dr Ravi Narayan

1982: The Seed of the Idea

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

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

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

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

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

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

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

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

1983: Evolving a collective definition of Community Health

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

Definition of Community Health

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

Source: CHC Red Book,1986

1984: The Inception of CHC

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

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

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

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

1985: Learning from the Bhopal Disaster

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

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

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

Challenges in responding to Bhopal Disaster

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

Source: mfc bulletin 112, April 1985

1986: The Red Book of CHC

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

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

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

Ten Community Health Axioms

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

Source: CHC Red Book, 1986

1989: Medical Education Re-examined

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

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

The 1980s were a watershed period for reorientation

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

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

The Alternative Medical Curriculum of mfc

(Some Extracts)

Preamble

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

Objectives of education

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

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

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

1990: Towards a Health Policy for Hospitals with a Mission

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

Health Policy of Church in India

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

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

1991: A Community Health Trainers' Dialogue

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

Statement of Shared Concern and Evolving Collectivity, (Extract)

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

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

Source: Community Health Trainers' Dialogue, 1991

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

1992: Predicting Future Health Scenario by Health Policy Delphi

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

Policy Delphi Predictions for 2000 AD and Beyond

Health Problems

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

Health Responses

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

Source: Seeking the signs of the times, CHAI 1992

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

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

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

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

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

Initiatives for Reorientation of Medical Education – I

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

Source : Strategies for Social Relevance, CHC, 1993.

1995: Participation in the Independent Commission on Health in India

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

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

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

Prescription for change in Medical Education

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

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

1996: Building an Appropriate Malaria Control Strategy

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

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

Towards an Appropriate Malaria Control Strategy, (Extracts)

The Public health crisis in India

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

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

Lessons from History

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

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

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

1998: Understanding the Health Policy Process

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

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

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

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

Table: Tuberculosis and Society-Levels of Analysis and Solutions

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

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

1999: Towards a Poverty Agenda for Health and Development

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

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

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

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

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

We are concerned with

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

We recognise

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

We declare our commitment to

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

Finally we conclude that

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

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

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

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

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

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

Indian People's Health Charter- 2000 (Extracts)

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

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

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

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

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

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

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

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

Issues of Concern and an Agenda for Action

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

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

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

2002: Towards an Integrated State Health Policy

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

The Karnataka State Integrated Health Policy (Extracts -I)

Principles

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

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

Perspectives and goals

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

The Karnataka State Integrated Health Policy (Extracts -II)

Public health approach and primary health care strategies

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

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

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

Source: Karnataka State Integrated Health Policy- 1983

2003: Community Health Fellowship Scheme – Building the Next Generation

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

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

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

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

2004: The Mumbai Declaration

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

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

The Mumbai Declaration, 2004 (Extracts)

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

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

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

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

Source: The Mumbai Declaration , PHM , 2004

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

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

The Cuenca Declaration, 2005 (Extracts)

Preamble

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

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

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

For full text, see www.communityhealth.in

2006: Traditional Medicine and Right to Health for All

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

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

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

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

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

Vision

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

Traditional Systems and Health for All

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

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

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

2007 - Promoting the Right to Health

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

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

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

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

Source : HHR section, CHC Annual Report 2007

2008 The Silver Jubilee Year Begins.....

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

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