The Micro Questions on the SOCHARA CHLP

1. What was the original purpose of CHLP when it was launched?

The **written objectives** of the first phase of the 'Community Health Fellowship and Internship Scheme' (CHFS) developed in 2002-3 were:

"1. To promote life options in community health by offering a semi-structured placement opportunity in CHC, in partnership with selected community health projects.

2. To strengthen the motivation, interest and commitment of persons for community health.

3. To sharpen analytical skills, and to deepen the understanding of the societal paradigm of community health."

Mandate: The 1991 Memorandum of Association mandates us to *"evolve educational strategies that will enhance the knowledge, skills and attitudes of persons involved in community health and development."*

Pre-fellowship training: During the initial ten years team members undertook a lot of training at the request of several partners in different parts of the country. Various topics were covered. Training for non health groups was also done. Local language training was undertaken. The Catholic Health Association of India set up a Dept of Community Health drawing on CHC knowledge and skills. A definition of community health was evolved through a workshop. A women's health empowerment training across five districts in Karnataka, and simultaneously across 16 states was facilitated by the Central Ministry of Health & FW, in which Sochara was involved. A reflection workshop of all training initiatives suggested that we move beyond.

Background to the CHFS/CHLP/MP CHFP: During the 1980s community health and public health were not popular among students and young persons. The academic style of teaching the discipline in medical colleges was archaic, unrelated to societal context, dry and not very inspiring. It was also limited to medical professionals. The live experience of engaging intensely with communities for health in situations such as the Bangladesh refugee camps in 1971 and the Andhra Pradesh cyclone relief camps in 1976-77 provided a very different perspective and approach to those who later set up CHC and SOCHARA. The strength of affected communities, their resilience and contribution to processes, their outstanding ability to rise above themselves and above the circumstances that life threw at them were a huge learning, as well as a motivation and attraction. While we continued for some years in an academic setting within a department of Community Medicine we began with the full support of the Dean and institution to experiment by creating learning opportunities that would be meaningful to the young persons aspiring to be doctors. We were also encouraged by an institutional decision to conduct a community health worker program for adults who were already working in rural areas/ with underprivileged communities. The Alma Ata Declaration in 1978 of Health for All by 2000 AD using primary health care as an approach found a resonance in us. This supportive ecosystem in

an institution mandated to community health had its challenges of university requirements, which took time and effort. A changed institutional leadership also had a different vision and approach.

This experience created a restlessness of being bound down by other academic requirements of exam orientation and professional goals of most doctors who had other desires and interests. We took a year off traveling to remote parts of the country visiting alumni and members of the medico friends circle as well as other health and development projects. Seeing raw reality and the wonderful unbounded work which had results was a huge impetus and further learning. We left the medical college setting but always kept a deep interest in being available to young persons seeking to work with communities for health. While we engaged with other activities, we had a group of young persons including health professionals who spent varying periods of time to explore alternative approaches to community health. Involvement with the medico friend circle, the Indian Social Institute, the Bhopal disaster and a lot of reading sharpened our societal analysis. The social paradigm of health emerged in our first report in 1986-87 and the understanding of the social and underlying determinants of health grew.

This search became crystalized within CHC in developing the first phase of the CHFS when the Tata Trust suggested a partnership in 2001. The CHFS therefore drew upon the collective and individual experiences and understanding of community health within a social context over several decades. The community health movement as we perceived it with a range of diverse community health and development projects in different locations provided a rich base for learning about how concrete change can take place at micro level by being contextually relevant and involving people at all stages.

The Jan Swasthya Abhiyan (JSA) /global Peoples Health Movement (PHM) worked more on macro analysis and leveraging action for larger scale change on underlying issues that was required in this country and elsewhere. There was an urgent need for many more young people to get involved at multiple levels according to their interests and capacities. This would enable the creation of a critical mass through whom change towards health equity could be accelerated.

SOCHARA members with whom this was discussed in detail were supportive, as well as engaged. The purpose was to contribute towards increasing the number of persons committed to community health as an approach to reaching the larger goal of Health for All. Once they found the passion and space they would create their own path. The growing network of like minded groups became partner NGOs and fellow travelers with whom the young persons could engage. The learning process was mutual. Each fellow had a team mentor and a field mentor.

The need to develop this into a learning triad through conscious effort was recognized by the concurrent evaluation.

The first phase had a final evaluation which led to the next phase and further change. The key learnings from phase one included: a) intensity of process which requires considerable time involvement from all concerned; b) need for regular and ongoing interaction with field mentors; need for more detailed semi-structuring during field placements; c) need for specific skill building opportunities; d) need for continuing flexibility to be able to respond to flexi interns who cannot do a whole year due to other commitments; e)need for alumni support in their life journey.

2. How did the purpose evolve over the years? What was retained from the original purpose and why? What was dropped and why?

After the first phase the management of the programme was given over to a younger team with the seniors available as advisors, mentors and learning facilitators. There was therefore a larger team available. The intake of fellows/interns was increased. The name was changed to community health learning programme (CHLP). The objectives were : 1. Community Health learning with the three points as in phase one. 2. Alumni support and extension learning including development of teaching materials and organising small workshops. 3. Developing into a resource centre. 4. Documentation with modularization of the learning material. Development of the website 5. Dissemination, networking and advocacy so that other groups could also consider running fellowships through two national workshops and annual fellows workshops. The intake became more south Indian particularly from Karnataka and Tamilnadu as the young team were not familiar with central, north and north east Indian contextual settings. This phase also had a mid-term and end evaluation. This phase ran simultaneously with a new initiative of a two year community health fellowship in Madhya Pradesh offered to 20 persons per batch. These two programmes learnt from each other. For instance community based enquiries and work on underfive nutrition were common interests.

The profile of participants has changed; the team members who facilitate the programme have changed; and the teaching learning approach too has been varied based on the personal background of the facilitators. However despite the change the focus on community based and community led efforts to improve health and health conditions has remained. So has the commitment to Health for All, health equity and the social determinants of health. The post CHFP/CHLP attrition from community work has been low.

In 2011 during the 20th year of SOCHARA the organization reorganized itself building on the varied experiences with the People's Health Movement; engaging actively with strengthening

and communitising the public health system; and developing the CHFP/CHLP. SOPHEA was launched along with other systems described in another section.

The third phase of CHLP was guided by a Mission to develop a critical mass of community health practitioners cum activists, with scholarship, competence and commitment to work towards Health for All through developing a civil society school of public health, equity and action" The 3 year mission was to strengthen the academic and research framework,; mentoring processes, systems and organizational mechanisms based on principles of social justice, humanitarianism, quality and integrity. The objectives were: 1. to train 60 young professionals over 3 years for the Health for All goal and movement; 2. conduct a one year PG level teaching programme through theoretical and experiential learning; 3. Foster core competencies for community health and public health among the faculty, fellows and interns; 4. Build a community health resource network, and 5. Strengthen the community health learning and information centre.

The methods used retained the person orientation that have been core to the fellowships. This required the team to put in a lot of efforts which was done in an exemplary manner. Team retreats and workshops aimed at personal growth of team members. Being dependent on donor support meant that continuity could not be maintained despite the gains made that were captured in the mid-term and final evaluation reports of phase three. The rise in living costs also placed a challenge as NGO salaries are insufficient to manage families, housing and children's education. Lack of a University affiliation and degree an issue.

External factors had also changed. The number of MPH (Master's in Public Health) programmes grew from 1 in 2000 to 46 in 2016-17. The Public Health Foundation of India established in 2005 as a PPP took place with our active involvement. The National Rural Health Mission in 2005 grew into the National Health Mission in 2013 offering many job opportunities. Public health and community health came onto the public and policy agenda and became much more visible now attracting the best along with others. Health and wellbeing are becoming increasingly important on people's agendas with the government also recognizing this. The private sector has leaped into the process as well. CSR's and Foundations focus on health and its determinants. Consciousness has grown about the consequences of not addressing these issues on scale as well as at individual and community level. These were some of the changes that resulted in phase three being different.

3. Think about significant events across various CHLPs when you were excited and touched. What made each event a great moment? How did you contribute to creating this moment? How did the event enhance meaning for the collectivity?

The energy, enthusiasm, openness and curiosity to learn among the young participants has been a wonderful experience.

The stories of their lives in different parts of the country and from diverse communities shared with authenticity is very touching.

The commitment they demonstrate to become change agents is inspiring.

Listening to them, and journeying with them provides meaning to oneself. Their creativity be it through singing, art, drama to express themselves is amazing and touching. Listening to them in the daily debriefing sessions that start the day, or when they share their learnings after a community placement is a source of new learning of current contextual factors that go much beyond books.

The recognition of the community (rural and urban poor) and of front line community health workers as mentors during their field placements was part of a paradigm shift.

Their recognition of structural inequalities in health through direct contact with such situations never failed to move all of us, and to strengthen our resolve to continue this work.

The sharing of struggles faced in work including of loneliness and a sense of isolation makes one realise that support systems need strengthening and development of small groups in every block of the country is needed, and ideally in every village.

When there were interesting events in the city we changed the programme and encouraged their participation. These opportunities became very important to their growth both personal and professional.

We initiated what is called Inner Learning through small steps for the same purpose. This was appreciated particularly by some.

Each batch became a community of learning and this was consciously created when we talked about different methods of learning that can be used. The batch developed strong bonds between each other.

At an alumni meet they decided to create a Whatsapp group to share and connect. However it is the face to face human interaction that is most meaningful.

The Madhya Pradesh Fellows have created a Fellows Collective which they have recently registered. Many of them come for JSA events at state and national level. These friendships help them in various aspects of their life journey.

4. How did experiences across CHLP batches add to the meaning making and design of the program?

   Having larger numbers of upto 20 in a group is helpful as there is a richer diversity of experience of community health and perceptions that one can draw from for the teaching learning process to retain its person orientation, as well as to develop core competencies in community health.

   The facilitating team need more attention paid to their own feelings as well as of professional growth with regular sharing, workshops, retreats etc. If there is a work overload the approach could be at risk of getting routinized.

   The diversity in the team and among the fellows (linguistic, disciplinary, gender, identities etc) is a challenge that needs to be appreciated and handled in a very positive manner. This is a huge strength and needs to be retained.

   Evaluations of the programme and feedback loops are essential.

   The involvement in small research enquiries with proposals going upto SISEC was stressful to the participants, but in the end was helpful in their learning. SISEC members have been professional and this prepares them for the real world.

   We need to focus more on participant assessment as this is also a method of learning and not of judgement. It is still feared by participants due to their past experiences.

   In conclusion the community health fellows and the CHFP/ CHLP breathes life into the organization and everyone from the support staff, team members, network partners and Sochara members thoroughly enjoy their presence and lively contribution. The number of young persons seeking such an opportunity has grown and hopefully the organization can take this journey forward.

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Organization Processes in SOCHARA

1. How is funding obtained?

    a) **Donor partners approach SOCHARA**

    A1 - Donor partners approached SOCHARA several years ago saying that they would like to partner with us as they had heard about our work. Initially this was the **Sir Ratan Tata Trust (SRTT), Mumbai** in 2001. This was followed by a discussion at an AGBM and a subsequent visit by the Secretary Coordinator to their Mumbai office when she had gone there for another meeting. This resulted in the Community Health Fellowship Scheme (CHFS) which was the first phase. The SRTT supported CHFS from 2003 over three phases up to 2016 which was the maximum they could do. During the second phase the young team changed the name to Community Health Learning Programme (CHLP).

    A2 - Subsequently we received a similar request from the **IDRC (International Development Research Centre), Canada** in 2010-11. We got back to them in 2012 with a proposal for the CHLP as a health equity oriented community health learning programme, as the Tata Trust said it would be good to have a co-funder. This supported the doubling of the CHLP intake from 10 to 20 persons per annum.

    A3 - Similarly the **Ford Foundation, India Office** approached us and through discussions we developed a study into approaches to social justice in health based on the work that we were doing.

    A4 - We have been approached by the **Gates Foundation** for support to the global PHM secretariat hosted by SOCHARA from 2003 to 2006-7, which we did not take up.

    A5 - The **QSI – CSR** team approached us in 2015-16 and we developed and implemented a short term small grant project with them.

    A6 – **Medico International, Germany** approached us after the tsunami in December 2004 and supported work in Tamilnadu leading to establishment of the Community Health Cell Extension Unit (CEU) in Chennai. The CEU was supported later by other partners.

    b) **Proposals are put up to potential donor partners**.

    B1 - One of the oldest partnerships has been with **Misereor, Germany** details of which are given below under question 2 of this section. It has been a partnership in the true sense of the word with mutual learning and shared values that have sustained over more than two

decades. The relationship with mutual respect has grown organically over a long period of time.

B2 - After working together with the SRTT we put up a proposal to the **Sir Dorabji Tata Trust** (SDTT) for support for a two year Community Health Fellowship Programme conducted in Hindi and confined to the state of Madhya Pradesh which had poorer health indicators.

B3 - We have known members of the **Association for India's Development (AID)** since 2000. This is a like minded group of fellow travelers that functions in learning mode. Society members and team members have interacted with them as individuals, as well as in small and large group sessions, to share experiences from the ground with communities, as well as on major health and development related issues of concern. Some of the AID chapters in the USA have financially supported the work of the team in child undernutrition and tobacco control.

B4 – A small grant proposal was successfully put up to **Menzies CSR** funding

B5 - More recently proposals are required to be sent electronically based on certain formats that are developed by the donors, which also have exclusion criteria. This is used by both CSR and other partners. Donors announce that they will be having the next round of selection of grant proposals within a time frame. This information is available on NGO Box which is an e-group available to all.

B6 - Recently in 2018- 19 we successfully put up a proposal electronically to **HCL Foundation – UDAY** which is a sub-programme for urban areas in south India, specifically in Bengaluru. This is followed up by visits by their programme staff to Sochara and a series of email interactions.

B7 - We also had an unsuccessful proposal sent to the Embassy in India of Kingdom of The Netherlands for work by the CEU team in Tamilnadu

B8 – There was an unsuccessful proposal to **Paul Hamlyn Foundation** for work by the MP CPHE team

c) **Discussions are held with individuals** who learn about our work or may know one or some of us and the work that is done. They provide donations which are untied This is very helpful as SOCHARA can utilize it where there is a need.
C1 - One such source is the **Sarathy Foundation, USA** which has supported us for almost ten years.

C2 - Similarly there is a **Friend of SOCHARA, Switzerland** who has contributed to the Endowment Fund. The interest from this helps in meeting core costs.

C3 – Mr. Aroon Raman, India who is known to Dr. Ravi Dsouza has provided support to the work of the MP CPHE in child undernutrition.

C4 – Dr. Joseph Sequeira, USA had likewise provided support earlier

C5 – Dr. Salim Yusuf provided a donation from his organization in Canada which was used for the Endowment Fund

C6 – Ms. Lalitha Krishnan (Late) has made contributions

C7 – Dr. Laila Chandy, USA made a donation

There are several others who have done this over the years and are a community of support

d) **Govt. of India invited a SOCHARA member to join the Advisory Group on Community Action for Health (AGCA) in 2004-5 which was part of the National Rural Health Mission (NRHM) a country-wide initiative.** The scope expanded by covering urban areas as well and NRHM became National Health Mission (NHM) in 2013. The AGCA developed an approach called community based planning and monitoring (CBMP) which was pilot tested in nine states. Sochara took responsibility along with others for this in Tamilnadu and Karnataka. We received funding from the NRHM via the State Health Society for this for a few years. Our work with the Govt. (state and centre) through being invited members on various committees has been pro bono with the government covering travel and incidental costs.

2. What are the sources of funding?

SOCHARA has had multiple sources of funding over the years. These could be classified as:

- International (NGO donors; government related donor partners; academic institutions; individual donors);
- Indian (Trusts and Foundations; government -state and centre; CSR; individuals)

International

(a) **Misereor Germany** has been a partner since almost 25 years. The funding to us comes from **KZE (which is based on the German Government tax based developmental funding)** as we are a secular group working on community health and public health. A few years ago their parliament had requested an external evaluation of Misereor with regard to their funding and its impact. Sochara was selected among their many partners from the Asia Pacific region under the health sector. An organization called EVAPLAN from Germany did the evaluation with a two member team – led by a German lady and with an Indian professional. There was a very positive report. There was one suggestion regarding Programme Management which we found useful. We subsequently set up a Programme Management Unit (PMU).

(b) **Association for India's Development, USA – a registered Charity** or an NGO donor partner; AID Boston, AID South Dakota etc have supported SOCHARA in a spirit of solidarity. AID chapters are run by volunteers who have full time jobs as professionals. They fund raise by organizing events etc.

(c) **Sarathy Foundation, USA**

(d) **Academic links** – for conduct of studies eg University of Ottawa; Fulbright Nehru Fellowships

(e) **Individual donors**

3. What is the ratio of funding from institutions and individuals?
   This will need to be worked out by the accounts and admin section. Guru can kindly keep in touch with Mr. Nagaraj, Mr. Mathew Alex and Mr. Prahlad in this regard. I will inform them of this need. They are presently busy with project audit work and preparation for the AGBM. Hence this may take some time.

4. How does SOCHARA keep in touch with individual donors?

   There is a fair amount of communication through email, phone calls, annual visits by donor partners and participation in meetings for which we invite them. They too invite us for meetings and engage us in some of their work. For example Misereor and the Tata Trusts have used our services to conduct evaluations, in educational activites of the Tata Institute of Social Sciences (TISS Mumbai), review of a partnership between TISS and the London School of Economics, and part of a committee for an academic review of TISS after reforms were made.

5. What marketing related material is available to enable fund raising?
   We have not consciously marketed our work as we feel that health, wholeness, and healing has roots in a domain that should ideally not be monetized or commercialized, even while recognizing that funds are required for carrying out the work. It is important to recognize the distortions that are occurring in the health sector due to corporate interests without adequate checks and balances. Important ethical and moral issues arise that are debated within the relatively small bioethics and public health ethics communities. If the work is important for society the money will come. We have not invested too much time in fund raising. Our first annual budget in 2004 as the Community Health Cell (CHC)was Rs. 60,000/= per annum for a four member team, two of whom were doctors who moved out of medical college faculty positions in response to a deeper calling. This continued with small increments for a decade with annual budgets. Subsequently as mentioned many donor partners sought us and we then developed proposals with them. So fund raising is a relatively new experience about which we are learning fast. New partnerships have also been good such as HCL F with whom there are

shared values. We have learnt that new communities of mutual trust can and should be evolved. Greater communication is needed for this from our part.

From 2012 -13 we initiated the process of sharing our work more widely by developing an organizational brochure; a brochure for CLIC (community health library and information centre); producing more publications including Community Health Dimentions (also called Dimentions with CHLP fellows doing most of the writing) and updating the sochara website (www.sochara.org).

The idea of developing a compelling story about Sochara and its work and values is interesting as it aims to tap more widely into people and organisations with a social conscience who have the ability to contribute financially. If we adopt a whole of society approach then we do need to go down this path, supported by those with greater expertise and experience in undertaking this.

6. How are general public (civil society) made aware of SOCHARA's activities? How does SOCHARA enable them to join in the activities?

Networking with civil society partners has been a core strategy adopted by the Community Health Cell as well as by SOCHARA. Recognising how small we were, we adopted what we call a catalyst approach, sowing the seeds of a community health in different groups/fora. Based on a decade of experience of direct work with communities through the Dept. of Community Health in a medical college we forged broader linkages. Initially this was with community health and development NGOs, and with networks such as the medico friend circle, the voluntary health association of India, the catholic hospital association of India. We were part of the creation of new networks such as the All India Drug Action Network (AIDAN), Drug Action Forum Karnataka (DAFK), Community based rehabilitiation Forum (CBR Forum); Consortium for a Tobacco Free Karnataka (CFTFK) etc. This was largely within the voluntary health and development sector.

Having realized that we as a collective in the NGO or civil society sector were not a counterveiling power to promote health within a sector increasingly dominated by other interests that were more profit oriented rather than being people and person focused we moved beyond. We were proactive co-founders of the Jan Swasthya Abhiyan (JSA) which has many state chapters. The global People's Health Movement now active in several countries worldwide. The 'communitisation' of the public health system has created mechanisms through ASHAs (accredited social health activists) and village health, sanitation, and nutrition committees under the Panchayati Raj Act have enabled possible larger public engagement for health engagement. This is the collective work of very many people, and institutions including the central and state

governments as well as by a host of NGOs. However it is still early days though 14-15 years old (since 2004-5) as there are several challenges.

We have also been a part of the bioethics movement in the country. Which has grown over the past decade. Public health ethics is also gaining salience.

Civil society has a role that is different to that of the public sector and the private sector as well as academia. Asking the larger question and using critical thinking in the larger public interest or public good is important. Using a research approach helps to keep a focus. Developing internal mechanisms of democratic dialogue including dissent are an important part.

We were not interested in Sochara's activities alone but in enabling a larger community health approach. Simultaneously team members being engaged with local community based health activities is necessary as it helps in grounding both ideas and work. The community health fellowships started after many years of work were an approach to harness the energy of youth and share the work with the next generation. The response from them has been greatly energizing and Sochara is known as a groups that mentors young persons in community health. Besides the formal one and two year fellowships and internships we get many students from colleges and occasionally from school who volunteer and support different aspects of the work. All of them get involved directly with underprivileged communities; have a mentor; participate in group discussions and reflections; get exposed to the need for inner learning; write reflective reports; make presentations etc.

7. What are key systems and processes that are present? Why are these key in enabling institutional goals to be achieved?

Collective discussion, reflection leading to decisions and actions have been key principles in organizational functioning. Time is allotted for this particularly in the Bangalore cluster. When this is not done problems arise. Some systems and processes have have been written down and codified to an extent while allowing sufficient space for creativity and in keeping the spirit of community health alive. *Evaluations* of the organization and of the CHLP have also been key in enabling change and growth. *Focus on a community health approach and on the organizational objectives* given in the MoA in our planning and annual reports also helps to keep the diverse multi-disciplinary team together. The adoption of a social paradigm in health is a framework that has been central to strategies used so far.

The **Community Health Cell (CHC)** from **January 1984 till 1991** was a study, reflection, action experiment. *Functioning as a catalyst* the CHC team *networked* with likeminded individuals and

groups. This formed the basis for collective reflection and action on issues critical for health of people in India. Based on an evaluation process a decision was made to register as a society.

Thus **SOCHARA was created in April 1991**. The **Memorandum of Association (MoA)** developed after much thought and consultation has organizational Objectives that have formed the framework for activities and institutional processes that evolved over time. The **General Body** members who are invited to join the Society are decision makers though this is exercised with understanding and care such that the autonomy of the team is not hampered. A seven members **Executive Committee** is responsible for execution of decisions though this is done through enabling the team to function to the best extent. An unwritten approach to being socially inclusive has been sought within the Sochara membership as well as within the team. The annual general body meeting and at least four executive committee meetings are occasions for discussion.

Key decisions such as initiating and supporting the JSA and PHM; initiating the strengthening and communitising the public health system; initiating and managing the community health learning programme have all been discussed at these fora and Sochara members have been a great support in the work. The original members who formed the general body have stuck together over 28 years and stepped in whenever need arose. New members have been invited into the Society, and as time passes some members have passed on.

Team work and democratic functioning was given importance. *Staff rules* were developed by the team including timings and leave policy. A 'green book' on *Financial Management* was written in 2003 on the occasion of the 20th year of CHC. This is always referred to for financial and administrative purposes. An organizational review was done in 2004-5 with important suggestions.

The *salary policy* which is based on an equity principle is always followed. It has been revised and this needs to be done regularly together with fund raising. *Standard Operating Procedures (SOP) for Accounts and Admin* were developed and team training held. A *Finance and Management Committee* was made functional with monthly review and planning meetings. A *Programme or Project Management Unit (PMU)* also began to meet every week. A procurement policy; anti-sexual harassment policy etc were added. These were combined together into a *Governance Manual more recently.* A Child Protection policy has been recently added. A draft environment policy was developed.

A small group set up to review the MoA/Constitution felt that it was broad and very nicely done and could provide the framework for future years.

With the third phase of the CHLP in 2012-13, the institutional processes within the organization received greater attention. A **SOCHARA logo** was developed with *a tag line 'Building Community Health'*. This is now used in all publications, presentations, banners etc. The **School of Public Health, Equity and Action (SOPHEA) was set up in 2012-13,** with an **Academic and Research Council (ARC)** and the **Sochara Institutional Scientific and Ethics Committee (SISEC) established in 2014** for review of research proposals by Fellows, team members and associates. A *52 week teaching learning programme for community health* was evolved by the ARC and senior team through several workshops and meetings. Some modules are on the website. A set of modules on district health management are also on the website. Alumni meetings and mentors workshops were held with important suggestions such focus on the triad of fellow/intern, team mentor and field mentor. There have been eight evaluations of the fellowship programmes since 2003 till 2016 providing direction and food for thought and action.
During this phase **mainstreaming** was a specific focus. Work with the Rajiv Gandhi University of Health Sciences which is the Karnataka State Health University led to the adoption of a three year MPH programme one year of which draws substantially from the CHLP. The Adichunchunagiri University is very recently also in the same process.

The KZE was mandated to do an evaluation and Sochara was selected from the health sector from the Asia Pacific region.

The **Sochara silver jubilee archival unit in 2016**, the **Sochara Sarai**, and the **Health for All Learning Centre** evolved where senior members are available to young persons; to those who want to reflect on their life journey; to team members; interns and volunteers; and to the organization whenever needed.

8. What learning content have we created over the years from our experiences? How do we collate, synthesize and distribute these for usage by various stakeholders.

CHC and SOCHARA team members have written a fair amount based on the work experience and its analysis. Some of these are available as Sochara publications. These are not sold, though contributions are accepted. They are distributed at meetings, and to visitors, fellows and interns. CLIC organizes stalls at larger meetings organized by others and ourselves. They are shared with donor partners. The materials are available under the Publication section of the website www.sochara.org. A few key documents are:

1. Community Health: In Search of Alternate Processes, 1987. Republished 2011.
2. Voluntary Organisations Financial Management : as practiced in Community Health Cell, functional unit of SOCHARA, 2003
3. The report of the Research Circle meeting organized at the second global People's Health Assembly in Cuenca, Ecuador, was published by Sochara in English and Spanish.

4. Learning Programmes for Community Health and Public Health, 2008
5. The SOCHARA Brochure 'Celebrating twenty years of community health journeys and public health action 1991-2011', 2011
6. The CLIC Brochure (Community Health Library and Information Centre), 2014
7. A Journey of a Thousand Lives: Building Community Health through Fellowships, 2011
8. Social Justice in Health: Multiple Pathways towards Health for All: A reflective report. 2014
9. Capacity building for Health Equity in India – A reason to Hope. SOCHARA SOPHEA team 2016
10. Newsletters have been produced called Building Blocks; later Dimentions; subsequently Community Health Dimentions. Fellowship participants contribute articles.
11. Annual Reports, some of which were published are available.

Sochara team members write in several journals, magazines and reports and contribute to the body of knowledge. They are also aware of the politics of knowledge and use alternate methods of dissemination, other than peer reviewed journals. There are publications in local languages Kannada, Tamil, Hindi as there is a great dearth of written material on community health in local languages.

We have a large collection of posters developed and collected over the years. We have had a few cartoonists and artists among the fellows and team. Some work is available under Cartoon Gallery.

A set of Kalajatha songs in Kannada which were developed through a Kalajatha workshop prior to the first National People's Health assembly in 2000. These were later printed. Further songs were developed at the time of the second national health assembly in 2007.

A few videos have also been produced. Two are about the Community Health Learning Programme. There is one produced on Community Health. Video clips are also available from the tenth anniversary of CEU. A video on endosulfan poisoning and its impact on people is available.

The Alumni have a WhatsApp group through which they share experiences. Social media is also utilized with Facebook, twitter etc.

There is a large collection of photographs of work done.

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