CHLP National Workshop 2016

Mainstreaming Alternate paradigms: From teaching to learning facilitation in Public Health / Community Health

Background Papers

(Towards a India Relevant Framework and Curriculum)

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1. REPORT OF THE EXPERT COMMITTEE ON PUBLIC HEALTH SYSTEM, (1995)*

- The committee constituted on 8th March 1995, consisted on Prof. **J S Bajaj**, Member, Planning Commission, Chairman, **Dr Jai Prakash Muliyil**, Deptt. of Community Medicine, Christian Medical College, Vellore. Member, **Dr Harcharan Singh**, Ex-Adviser (Health), Planning Commission Member, **Dr N S Deodhar**, Ex-Officer on Special Duty, MOH&FW, Member, **Dr K J Nath**, Director, All India Institute of Hygiene & Public Health, Calcutta. Member, **Dr K K Datta**, Director, NICD, Delhi, Member-Secretary
- The Terms of Reference of the committee were as follows – to comprehensively review:
  a) the **public health system** in general and the quality of epidemic surveillance and control strategies in particular;
  b) the effectiveness of the **existing health schemes, the institutional arrangements** and the role of the States and local authorities in improving the public health system;
  c) the status of the **Primary Health infrastructure** (sub-centres and primary health centres) in rural areas, especially their role in providing intelligence and alerting the system to respond to the signs of outbreak of diseases and effectiveness of the district level administration for timely remedial action; and
  d) the existing **Health Management Information System** and its capability to provide up-to-date intelligence for effective surveillance, prevention and remedial action.

The final report presented on 6th July 1996 was 246 pages. The recommendations of the Expert Committee were as follows (pages : 11-20)

E-I0 RECOMMENDATIONS

E-I0.I Short-term

E-I0.I.I Policy Initiatives

E-I0.I.I.I Review of National Health Policy
The National Health Policy was formulated and adopted in 1983. During the years since then major changes have occurred through continuing population growth, rapid urbanisation, industrial revolution, changing health and demographic scenario, appearance of new, emerging and re-emerging health problems etc. Newer technologies are also available. In view of the same, the National Health Policy needs a careful and critical reappraisal. The committee, therefore, recommends constitution of a Group of Experts to prepare the draft of the new National Health Policy by the end of 1996.

E-I0.I.I.2 Establishment of health impact assessment cell
There is a need to enhance the capacity and capability of the Ministry of Health & F.W. to undertake health impact assessment for major development projects, industrial units etc. so that the project/ industrial authorities could be appropriately advised & guided to incorporate proper intervention measures/ changes as the case may be. All large projects of different ministries should invariably have health component in the proposal itself and this should be examined and approved by the Ministry of Health & Family Welfare. Regular analysis of various public policies and practices of other ministries viz. agriculture, industry, urban development, rural development and environment, which have direct link with the health of the people, must be considered as an essential prerequisite for a meaningful inter-ministerial co-ordination.

E-I0.I.I.3 Surveillance of critically polluted areas
Health impact and environmental epidemiology related to air, water, and soil pollution need to be monitored 'and evaluated particularly in the critically polluted areas in the country. Ministry of Health and Family Welfare should initiate actions in this regard urgently, in co-ordination with the Ministries of Environment, Industry and Urban Development. Measures such as a properly maintained data-base, mapping of the vulnerable areas, immediate intervention where possible and continuing surveillance need to be initiated as a well structured programme of action.

**** Government of India, Ministry of Health & Family Welfare, Nirman Bhavan, New Delhi 110 01***

E-10.1.1.4 Search for alternative Strategy/ strengthening of health services/system research
Uniform health care strategy for the entire country is not likely to succeed because of a variety of reasons: geographic, socio cultural, ethnic, educational, economic etc. The committee recommends that allocation of adequate funds to the Centre, UTs and State Directorate of I Health Services enabling them to undertake or commission Health I Services / System Research and Intervention Studies and to ensure that 4 such research results are utilised to improve the health care delivery I services.

E-10.1.1.5 Uniform adoption of Public Health Act by the local health authorities
Model Public Health Act revised and circulated in 1987 should be examined by all State health authorities, municipalities and local health authorities carefully and adopted/ enacted to suit local and national needs.

E-10.1.1.6 Establishing National Notification System/National Health Regulations
The notification system as it exists today varies widely from ~ state to state and withih the state from area to area. The Committee recommends uniform National Health Regulations for adoption by all states.

E-10.1.1.7 Joint Council of Health, Family Welfare and ISM & Homoeopathy
The existing Joint Council of Health & Family Welfare should ~ be further broad based to make a Joint Council of Health, Family Welfare and Indian Systems of Medicine & Homoeopathy.

E-10.1.1.8 Establishing an Apex Technical Advisory Body
In order to ensure a mechanism of continuing review and appraisal of public health issues, policies, programmes and services, the committee recommends establishment of broad based Apex Technical Advisory Body to advise the Ministry of Health & Family Welfare.

E-10.1.1.9 Constitution of Indian Medical & Health Services
The-Committee reinforces in the strongest terms the need to constitute Indian Medical & Health Services without any further delay.

E-10.1.1.10 Administrative restructuring

E-10.1.1.10.1 Organisational set up of the ministry

E-10.1.1.10.1.1 Most of the functions of the Union Ministry of Health and Family Welfare are highly technical in nature and, therefore, require technical leadership of a high quality. The committee therefore, strongly recommends that the union Ministry of Health & Family Welfare may consider merger of the two departments of Health & Family Welfare and the single department so created benefits from technical leadership as indicated above. The department of ISM and Homeopathy may also have to be similarly restructured.

E-10.1.1.10.1.2 The Department of Health & Family Welfare and DGHS should be restructured and reorganised and while doing so emphasis should be given to strengthen Planning Division of DGHS, Food and Drug Division. New Divisions of Environmental Health & Sanitation, Health impact assessment Cell and Health Manpower Division should also be established.

E-10.1.1.10.1.3 All the major technical divisions under the Union Ministry of Health & Family Welfare "and major institutions/ organisations should have an advisory body to periodically review the functioning of these divisions/ institutions and suggest appropriate corrective step or steps for improving their various activities.

E-10.1.1.11 Health Manpower Planning

E-10.1.1.11.1 The DGHS should have a strong Health Manpower Planning Division; appropriate institutional support mechanism also be established through establishment of a National Institute of Health Manpower Development.

E-10.1.1.11.2 The committee reiterates that recommendations contained in Bajaj committee report of 1987 on health manpower planning production and management should be implemented in right earnestness, which will greatly strengthen public health system in the country.

E-10.1.1.11.3 The committee recommends that positions requiring public health tasks should be filled by appropriate qualified public health I professionals and until these professionals are available, these could be I operated by general category health professionals through appropriate training in health services administration, management and epidemiology.

E-I0.I.I.12 Opening of Regional Schools of Public Health:
The committee recommends that at least four more regional ~ schools of public health are set up in Central, Northern, Western and ~ Southern regions. Duly modernised schools could be in the pattern of 1 All India Institute of Hygiene and Public Health, Calcutta and School I of Tropical Medicine, Calcutta.

E-I0.I.I.13 Strengthening and upgradation of the Departments of Preventive and Social Medicine in identified medical colleges
The committee recommends that some of the existing medical colleges who have very significant expertise in teaching of preventive and social medicine/community medicine be further strengthened by establishing within the department an advanced centre for teaching of public health or through upgrading the existing department so that it can take up additional responsibilities of continuing education in public health subjects for health professionals and can also undertake responsibilities for producing more public health professionals to meet the demands of the country. In this context, it is strongly suggested that a centrally sponsored programme of up gradation of few identified departments of preventive and social medicine in the medical colleges could be taken up during the last financial year of this Plan and during the 9th Plan period at least 25% of existing departments may be similarly upgraded through availability of additional funds by the Planning Commission to the Ministry of Health & F.W. ill this regard. These centres could be linked through a network so that the facilities could be maximally utilised.

E-I0.I.I.14 Reorganised functioning of the Department of PSM in Medical Colleges:
The committee suggests that some of the positions of the Department of Preventive and Social Medicine should be periodically rotated between the State/District National health programme management focal points so that the programme managers get the benefit of updated academic and technical skills and the students are benefited from the practical experience of the programme managers at the field level.

E-I0.I.I.15 Establishing a Centre for Disease Control
The committee is of the view that National Institute of Communicable Diseases, Delhi should be substantially strengthened through capacity building into a National Centre of excellence for Disease Control on the pattern of similar advanced centres such as CDC, Atlanta.

E-I0.I.I.16 Primary Health Care infrastructure in urban areas:
The committee recommends that an Expert Group be constituted to suggest restructuring or even redesigning of health care infrastructure linking existing primary health care infrastructure to secondary and tertiary care in urban areas in a geographically defined area and developing appropriate referral system.

E-I0.I.1.17 State Level:
Creation of several positions of Directors at the State level has led to disintegration of earlier integrated pattern of medical and health administration. Earlier practice needs to be restored. It is also recommended that functioning of the Department of Health being mostly that of technical nature a technical man should be the head of the Department of Health instead of a bureaucrat.

E-I0.I.I.18 District level:
The committee recommends to establish epidemiological unit if not already existing under the National Disease Surveillance Programme.

E-I0.I.I.19 Establishment of a supervisory mechanism at the Sub-district level:
The committee is of the view that there is an ~gent need to institute appropriate supervisory mechanism at the sub district level.

E-I0.I.I.20 Community Health Centres:
Community Health Centre is regarded as the first referral unit. The National Education Policy in Health Sciences as approved by the Central Council of Health & Family Welfare in 1993 has recommended placement of one public health specialist at the community health centre (CHC) level and if this is implemented the same will contribute immensely in strengthening the public health system.

Until such time as a Public health expert is available at CHC level, it is suggested that each of the specialists take up the responsibility of monitoring the public health programme pertaining to 1 their speciality in the population covered by CHC e.g. obstetrician will I supervise collection and reporting of data pertaining to Reproductive Health and Family Planning, Paediatrician for immunization and child survival, physician for communicable and non-communicable disease control programme, surgeon for disability limitation rehabilitation and blindness control programmes.

E-10.1.1.21 PHC/Sub-Centre level
To ensure participatory management by the community the organizational structure of the health services at PHC/Sub-centre / village level should be entrusted to the Panchayati Raj institutions which should decide the nature, structure, and priorities of the organizational of the health care delivery services at the village level depending upon the local situation, resource availability etc.

E-10.1.1.22 Village level
The committee is of the considered opinion that the Village Health Guide in the new envisaged role as Panchayat Swastha Rakshak will provide useful support to the Panchayat system at the village level in enhancing community awareness and participation.

E-10.1.1.23 Prevention of Epidemics:

E-10.1.1.23.1 It may not be possible to completely prevent outbreak of ~ diseases. However, epidemics can be prevented if an appropriate ~ surveillance mechanism is established. In fact price of freedom from disease is appropriate surveillance. The Committee agrees with the recommendations of the Fourth Conference of the Central Council of Health & Family Welfare (1995) proposing initiation of a National Disease Surveillance Programme for strengthening of health surveillance and support services and recommends that this programme should be initiated as a centrally sponsored scheme within the existing health infrastructure with appropriate laboratory support involving already existing expertise in various national institutes, medical colleges, and district public health laboratories.

E-I0.I.I.23.2 With the establishment of National Disease Surveillance Programme, several national institutes at the national, regional and state level along with several medical colleges and important public health laboratories will be appropriately linked so that the response capability becomes faster and expertise available in these institutes promptly could be harnessed by the executive health authorities at the district level to respond to an epidemic situation.

E-I0.I.I.23.3 The committee recommends that National Institute of Communicable Diseases should prepare guidelines for surveillance regularly under the supervision of a National Task Force, update the guidelines at predetermined interval and send to all health implementing agencies. The guidelines should include, details of the mechanism of detection of outbreak and detection of early warning signal.

E-I0.I.I.23.4 The system of civil registration of deaths, Model Registration Scheme, Sample Registration Scheme subsequently renamed as Survey of Causes of Death (Rural), certification of causes of death should be continuously improved by enlarging its scope and coverage so that it gives more relevant data in the context of the entire country.

E-I0.I.I.23.5 The processing of weekly epidemiological statistics being provided by CBHI lacks an appropriate feed back channel to the various peripheral agencies. The same need to be developed in the pattern of MMWR (Morbidity Mortality Weekly Report) published by CDC and National Institute of

Communicable Diseases may take up the responsibility for the same. CBHI may continue to act as a nodal agency for diseases, which are being reported on a monthly basis. The diseases under International Health Regulations and the diseases under National Health Regulations having epidemic potentiality should be the responsibility of NICD, which has the due expertise in appreciating the problem and initiating action accordingly.

With the expansion of HMIS to other states and its establishment on a firm basis the epidemic intelligence component could be appropriately dovetailed within the HMIS and a few districts in some states be taken up where HMIS has been satisfactorily established incorporating the epidemic intelligence component in the light of the experiences of NICD epidemic prone disease surveillance project and NADHI Projects of CMC, Vellore on a pilot basis. If found successful, it will further strengthen the HMIS in its response capability. This could form part of operational research support to the proposed National Disease Surveillance Programme.

E-I0.I.I.23.6 The committee recommends that the Epidemic Diseases Act provisions should be made available to all the health authorities and the provisions under the Act could be continuously reviewed, by a designated group to make it more comprehensive in the light of the latest scientific information available. .

E-I0.I.I.24 Upgradation of Infectious Diseases Hospitals

Every State has got one or more ID Hospitals. Most of these hospitals are inadequately staffed with poor maintenance. Many of them lack the basic diagnostic support services. There is an urgent need that facilities in these hospitals are appropriately reviewed and modernised to meet the requirements of infectious diseases management.

E-I0.I.1.25 Water quality monitoring

Ministry of Health & Family Welfare should take up the issue of water quality monitoring with the Ministries of Rural Areas and Employment and Urban Affairs and Employment and initiate a few pilot studies in different locations in the country to examine the feasibility of implementing a community based and affordable model of water quality monitoring and develop National Action Plan in this regard based on pilot study results.

E-I0.I.I.26 Urban Solid Waste

The committee endorses the recommendations of the 1995 Bajaj Committee Report of the High Power Committee on Urban Solid, Waste Management in India, constituted by the Planning Commission with regard to collection, transportation and safe disposal of municipal wastes including industrial and hospital wastes etc. The committee also endorses the suggestion of the Bajaj Committee, that it is essential ~ to evolve a National Policy as well as an action plan for management of ~ solid waste.

E-I0.1.1.27 Inter-sectoral Co-operation:

E-I0.I.1.27.1 Large number of health schemes are implemented through the A Ministry of Health & Family Welfare. In addition, there are large number of schemes having tremendous impact on human health and quality of life. These schemes are being implemented through several "other ministries. But as different agencies are involved and co- ordination between these agencies is not so easily achieved, the Committee is of the opinion that until and unless a formal mechanism of co-ordination and co-operation is established involving all concerned and guidelines indicating detailed responsibilities in respect of all participating units precisely defined, even in spite of individual schemes appearing to be technically sound, the same will not be able to deliver what is expected of them in terms of effective improvement in the Public Health System.

E-I0.I.I.28 Non-Governmental organizations (NGOs):

The committee recommends that the NGOs should be increasingly involved through an appropriately developed action plan with suitable funding.

E-I0.I.I.29 Involvement of ISM & Homoeopathy:

The practitioners of Indian System of Medicine can be gainfully employed in the area of National Health Programmes like the National Malaria Eradication Programme, National Leprosy Eradication Programme, Blindness Control Programme, Family Welfare and universal immunisation, nutrition

programme etc. Within the health care system, these practitioners can strengthen the components of (i) health education, (ii) drug distribution for national disease control programmes, (iii) motivation for family welfare, and (vi) motivation for immunisation, control of environment etc.

E-I0.2 Long-term

Broad set up of Ministry:
The recommendations of the Bhore Committee that the Ministry of Health should be under the charge of a separate Minister is being followed and is currently in practice. However, the members of the committee are of the opinion that the several activities linked with the human health are presently undertaken by Ministry of Welfare, Ministry of Human Resource Development, Ministry of Urban Development, Ministry of Environment, Ministry of Rural Development etc. The work of sanitation and environmental health was earlier with the Ministry of Health but now it is being undertaken by several ministries viz. Ministry of Environment and Forests, Ministry of Rural Areas and Employment, Ministry of Urban Affairs and Employment and Ministry of Chemicals. It has been further seen that the inter-sectoral co-ordination which is very vital in successful implementation of various programmes is not readily available through a formalised mechanism resulting in poor achievements under various programmes. Therefore, involving all the activities pertaining to human health, creation of a new ministry such as Human Welfare may require serious consideration. Alternatively a National Council of Human Welfare be constituted under the chairmanship of Prime Minister of India, and other members being Deputy Chairman, Planning Commission, Ministers of Concerned Ministers, eminent medical and health professionals and representatives of professional organizations and NGOs etc.

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2. CAPACITY BUILDING FOR PUBLIC HEALTH IN THE ASIA PACIFIC REGION* (2004)

Introduction

1. The historic sixtieth session of UNESCAP held in Shanghai, through its resolution 60/2 on 28th April 2004 gave a "Regional Call for Action to enhance capacity building in public health". It recalled the Millennium Development Goals, especially those that were health related, and the UN General Assembly resolution 58/3 of 2003 to enhance capacity building in global public health. In a significant step it has mandated the formation of a Health and Development subcommittee which is scheduled to have its first meeting in December 2004.

2. The Asia Pacific region, with 62% of the global population, has several strengths. The region has shown consistent economic progress and dynamism over the past few decades, which in turn has contributed to improved living conditions and health of people. It also has a wealth of rich cultural, spiritual, health and healing traditions. However poverty, hunger, disease and disability continue to afflict significant proportions of the population, with growing intra and inter-country inequities in income levels. Current global macro-economic policies and trends have also affected the region, resulting in loss of livelihoods, increased rural distress and migration, environmental pollution and destruction, and an increase in conflicts. These deeper socio-economic and environmental determinants have a major impact on the health of people and enhance the transmission and incidence of disease.

3. The cost of diagnostics, drugs, and of health care in general, are increasing, while public expenditure on health and health care is declining. Health gains achieved over five decades are beginning to reverse in some population groups and countries. Inequities in health status and access to health care are growing.

4. In more recent times HIV/AIDS, SARS and avian flu provide a wake up call and a challenge to the health systems of countries in the Region. Older, long standing problems such as tuberculosis, malaria, diarrhea, anemia and under-nutrition take a heavier toll in suffering and death but do not attract media or political attention. There is therefore an urgent need, and an opportunity to revitalize public health and its practice, and strengthen health systems, building on the infrastructure, experience and expertise, developed over the decades.

5. Capacity building for public health and strengthening of health systems in response to the emerging problems and social context will need to be done through a process of dialogue, consultation and international cooperation. This will be undertaken within the region, with public health professionals in the region and with community participation. Collaboration with WHO, UNICEF, FAO,UNDP, ILO and other international and bilateral agencies will be explored with a strong focus on building local capacity and self reliance, rather than being dependant on external experts and consultants. Special focus will be given to the needs of least developed economies, landlocked and island developing economics and economies in transition. Sharing of human, technical, knowledge-based and financial resources within the Region will be encouraged through institutional mechanisms. Given the mandate and traditions of ESCAP multi-ministerial support and involvement will be sought for capacity building in public health. Reviews using participatory, qualitative and quantitative methods will be undertaken with strengthened monitoring and evaluation systems, in order to assess the health, social and economic impact of the strategy an to learn from innovative approaches and processes that may be used. ESCAP and its member countries will work in close partnership with the World Health Organization, including its regional and country offices. The public health expertise of the WHO is a valued asset. It will be drawn upon extensively for strengthening public health capacity in the Asia Pacific Region. ESCAP in turn will

* *A Policy Document prepared for UNESCAP Health Unit by Dr. Thelma Narayan, CHC, Bangalore*

contribute through its mandate of working on the economic, social and environmental determinants of health. It can assist capacity building of public health systems in the region by expanding horizons beyond a disease focused approach, to include policy action directed at the broader determinants.

Evolving Definitions of Public Health and Primary HealthCare

6. Public heath is an evolving, dynamic concept. The practice of public health, together with improved economic and living conditions, have resulted in major health gains for populations in several countries around the world since the early nineteenth century. This took place through social policies introduced even before the development of vaccines and antibiotics. They included measures to improve sanitation, hygiene, water supply, housing, nutrition, social security etc.

7. The Primary Health Care (PHC) approach as a strategy to attain the international social goal of Health for All by 2000 was articulated at the landmark Alma Ata Conference organized by WHO and UNICEF in 1978. It drew on community level experience sand challenges from countries in different continents including the Asia Pacific. It received a mandate from 134 member countries. PHC expanded the scope and strategies for public health through increasing social control and democratic political processes over health and related services. It attempted to give communities greater voice in health systems through decentralization and institutional mechanisms for participation in health decision making. Moving beyond bio-medicine PHC stressed inter-sectoral collaboration to address the deeper determinants of health. It was rooted in principles of equity and social justice in health and health care. In order to reach the social goal of health for all, PHC emphasized self-reliance at individual, community and national level, and recommended the use of appropriate technology to serve peoples needs. It promoted social means to reach these goals. Primary health care not unsurprisingly met with resistance early on.

8. The International Association of Epidemiologists also defines public health with a broad perspective "Public health is one of the efforts organized by society to protect, promote and restore people's health. It is the combination of services, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective or social action. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same; to reduce the amount of disease, premature death and disease produced discomfort and disability in the population" (JM Last, 1995).

9. More recently the Oxford Textbook of Public Health (2002) describes public health as "the process of mobilizing and engaging local, state, national and international resources to assure the conditions in which people can be healthy." It recognizes that public health is only one of the major influences on the health of communities and that basic economic and social conditions impact directly on people's health and wellbeing.

10. The initiative for public health capacity building can experiment with social arrangements for greater involvement of people, particularly the poor and vulnerable, in the development of their own health services. Thus the public can be brought back into public health. Public health has focused on improving the health of communities and individual persons through comprehensive preventive, promotive, curative and rehabilitative interventions addressing risk factors that could be social or behavioral. The present challenge is to include the deeper layer of social, economic and environmental or developmental determinants of health. The way has already been shown by some communities and countries. The need and challenges have been articulated in the Peoples Charter for Health of the Peoples Health Movement. The World Health Organization is making initiatives to set up a commission for social and environmental determinants of health. The contribution of UNESCAP and its member countries in this regard would be pioneering and would help the achievement of the millennium Development Goals. The current initiative offers an opportunity to further build the concept, principles, and practice of public health in relation to the current times and challenges in the regional context.

Strategies for capacity building in Public Health

11. Human resource development- Developing a pool of well-trained, competent, highly motivated professionals and workers in public health is a priority for all countries in the region. There is an urgent requirement for a range of public health skills and competencies – including specialist epidemiologists, policy analysts, health administrators, program managers, trainers, health economists demographers, statisticians, researchers, social and behavioral scientists, public health nurses, health promoters/educators, laboratory technicians, social workers, multipurpose workers, health assistants, community health workers, health animators and others. While specialization in sub-sections of public health will be inevitable, the key focus should be on training more multi purpose, integrated, socially relevant, public health generalists at different levels.
12. Planning and forecasting the numbers of trained staff in public health required at different levels of the health system is a task to be undertaken by each country. Based on a needs assessment, numbers retiring per year, and overall attrition rates, the numbers to be trained every year can be calculated, keeping in hand a reserve stock of personnel who can manage leave vacancies, respond to emergencies, undertake consultancies etc. Most important is the policy recognition that in order to achieve effectiveness, relevance and quality, some positions at specific levels in the health system will necessarily need professionals with competency and training in public health. The tendency to appoint clinicians to public health positions, and to be susceptible to political compulsions, needs to be avoided if public health objectives are to be met.

13. Public health staffs are often given a lower social status as compared to clinicians, though their jobs may be more complex and thankless. This results in lower morale and self-esteem and needs to be rectified through an enabling environment with adequate recognition, remuneration, and encouragement. Considering the complexity of their tasks and the multidisciplinary multi-tasking nature of their activities, they should be given opportunities for professional growth. Along with these reforms a realistic focus on outcomes, impact, quality, integrity, and responsiveness to feedback from the community, is required.

14. Team work in public health is crucial for it success. Adequate training is needed in team functioning with clarity about roles and responsibilities and lines of communication. Supportive supervision, trust building and problem solving exercises are essential. Public health professionals can be drawn from both medical and social sciences streams and should not become doctor dominated.

15. Continuing education of staff is essential, given the rapid growth in knowledge and the contextual changes that are occurring. Distance education courses, workshops, seminars, newsletters and access to electronic means of updation need to be well developed. Accreditation systems at district or state levels for public health staff will help to ensure basic standards with mandatory requirements for attending a certain number of courses and achieving competencies required for different levels.

16. Ability to work with communities and local government functionaries, with community organizations, and community leaders both informal and formal, is an important skill for public health professionals. This is best developed through experiential learning and in-service training.

17. There is an urgent need to build capacity in developing an evidence based approach for public health interventions. Investment is required in training and retaining research professionals competent in qualitative and quantitative methods. Their findings would be used by a multidisciplinary policy team for developing, reviewing and evolving public health interventions. Skill development is required for recording and reporting systems to be strengthened, with adequately disaggregated data collection to measure differences in social groupings. Analysis and utilization of data for decision making should be done as close to the point of data collection as possible. This in itself will enable capacity development closer to the community.

18. Capacity needs to be developed across sectors to deepen the understanding of the inter-sectoral dimension of health and health action. We need to strengthen the ability to dialogue and involve counterparts in other departments of development, be it food, water, sanitation, environment, women and children's welfare, education, agriculture, labour, and other departments.

19. An alternative pedagogical method that is participatory, reflective, transforming and located in a socio-cultural paradigm, should be sued in teaching public health workers and professionals.

20. It is important for countries in the region to consider the underlying philosophy, educational methods and processes of learning, adopted in the higher education of public health professionals. Two foundational premises that continue to have a major influence have been the biomedical scientific roots of public health and its proximity with state power. These developed historically within the then dominant social context often linked with the industrial revolution, capitalism and colonialism. At the interface with people in the Asia Pacific region, who have their won culture and knowledge base, there is often an alienation of philosophy, concept and praxis. Public health practice is often perceived to be an expert driven, top-down, centralized, prescriptive approach, implemented in a heavy handed manner by the government bureaucracy. This does not win the hearts and minds of people and is often met with scopticism if not with resistance, non-action and non-adherence. Development of pedagogical methods, and the learning environment and process, will need careful thought in order for students of public health to identify and retain the core principles and elements of the discipline, to be sensitive to the cultural and social context of communities with whom they work and to best utilize the right knowledge base and traditional health and healing practices in the region. Since the 1970s much experience has been gained, particularly through community health and development projects in the voluntary sector, in the use of participatory, experiential, reflective and transformatory learning processes. While these methods initially evolved through working with communities, they have also been used in the education of professionals who find it a more liberating, meaningful and motivating process of learning and personal growth. Besides theoretical content and competencies, it includes experiential learning in community based programmes, self awareness and reflection, teamwork, social skills, understanding culture and community dynamics, spiritual and ethical dimensions of health and public ethics, among others. This qualitative change in the method of teaching-learning, enhances social effectiveness and community support increases personal motivation, prevents burnout and helps the creation of a social network among public health workers.

21. These aspects have not been adequately stressed or integrated in public health training programmes in the West. While international collaborative efforts to strengthen public health capacity in the ESCAP region will involve linkages with training centres in the west based on a different history and paradigm, a creative contextual local adaptation of theory and practice of public health is a necessary.

Training Approaches

22. Medical officers of Primary Health Centres and other levels of government health centres play an important role as leaders of health teams. They need to be adequately trained in public health and health management. In practice in several countries a large proportion do not have a post-graduate qualification in the subject and are more clinically oriented. They will need an in-service public health training for at least 6 months which would include the basic theoretical concepts and a period of experiential training under guidance. A mentorship programme could be considered. Exercises in leadership training, communication, team-work, gender sensitization, social analysis, understanding community dynamics and community organization, and public health ethics are important to supplement the traditional public health components.

23. Participatory training methods that are learner – centered, using principles of adult learning, and problem solving and experiential innovative approaches are very helpful. Use of role plays, simulation games, case-studies, films and field visits help the learning process. Debriefing, with analytical reflections of different experiences and method help in the personal growth and motivation of participants besides enabling a deeper understanding of the issue.

24. Team training of primary health care teams for up to 5 -7 days is also a useful method to enhance the quality of public health work. Training is undertaken together as a team to understand each other and internalize the goals and objectives of their collective endeavors. Their different roles and responsibilities are clarified. Systems for communication, recording and reporting, measuring indicators of progress, getting community feedback and of participatory reviews can be discussed. This process helps in bonding together and creating better working relationships. Efficacy of public health work depends to a large extent on the cohesiveness of the teams, their conflict resolution mechanisms, and the feeling of community among themselves, which need to be constantly developed and nurtured.

25. In several countries there has been good inter-action between health systems, and integration of indigenous systems of health and healing into the national health system. Indigenous systems and practices that are beneficial to health cold find an explicit place in national health policies and systems, rather than being a parallel system that is under resourced and sometimes subaltern. This spirit of mutual cooperation between systems needs to be reflected in the training of health workers and health professionals.

Training Content

26. Both traditional public health, as well as the new public health, recognize the close links between the underlying determinants of health and the health status of populations. Teaching curricula for public health however are still dominated by biomedical components, based on a reductionist paradigm. Consequently public health interventions tend to be narrowly focused, vertical programmes; lacking a societal process element. For instance the delivery or social marketing of public goods such as diagnostics, drugs vaccines, condoms etc are given much greater importance than social relationships and processes through which change can occur and where people have a voice. The contextual complexities of social, economic and environmental determinants of health are discussed and researched in very few schools of public health across the world. The Asia Pacific region could be a potential leader in introducing systematic teaching and research into these issues with a public health perspective in order to protect public interest and human rights and to reduce social inequality, with resultant benefits to the health, and wellbeing of people.

27. Content areas to be covered in the training would include
    - Guiding principles and values of public health, which include social justice and equity in health and health care; health and access to health care as a fundamental human right; health as central to sustainable development; community participation and self-reliance; good governance, oversight and accountability.
    - Public health ethics and law
    - Food security and nutrition
    - Poverty and health inter linkages
    - Gender perspectives on health
    - Macro-economic and trade policies and health.
    - TRIPS, GATS and implications for access to medicines and to health care
    - Conflict, violence, disasters and health
    - Environmental health issues with corporate and government accountability
    - Peoples social movements, peoples health movement
    - Environmental health movement
    - Population movement; migration, urbanization.

28. Preparation of learner friendly teaching material and modules; developing a critical mass of teaching staff in the region; and establishing centres that research and intervene in these areas, will need to be undertaken in a systematic manner. Enhancing and disseminating databases on these complex subjects will also need to be undertaken.

Developing Centres of Excellence for Teaching and Research

29. **There is a need for a number of centres of excellence for teaching and research in public health and community health in the Asia Pacific region. While countries with large populations may have more than one centre, smaller countries could share a centre or send their professionals to recognized centres. Mechanisms for generation of financial and technical resources could be developed. Regular exchange and electronic networking between academic and research centres in the region, and close collaboration with WHO regional and country offices would be beneficial. Mapping of existing centres and resource groups in the region could be initiated by the secretariat. Scholarships could be established for least developed economies. Electronic methods of communication could be institutionalized so that whenever required rapid mobilization of expertise and quick sharing of information is facilitated. These centres will be the nerve centers for knowledge generation and application, and will need to be very dynamic and alive. Countries are advised that the leadership, management systems, library and information centres and financial security of these centres are critical areas for development. Their purpose would be to be socially relevant to the public heath related issues and concerns in their countries and neighboring areas. Interaction and alliance building with the local health services, NGOs and social movements would enable them as a group to impact on the determinants of health.**

Strengthening Health Systems Financially

30. Health systems form the basic skeletal framework for public health action. Over the past century public sector health systems in the region have undertaken preventive health work, health promotion, communicable disease and outbreak control, and other measures on a countrywide basis with resultant public health gains. However over the past decade a weakening of the public health system has taken place in some countries where decision makers have uncritically supported and promoted the privatization of the health services. In other countries investment in public health systems has been consistently low and unproductive. In these cases there is a need for strengthening of public health systems to meet public health goals, and to privatize further. The Commission on Microeconomics and Health has pointed out the critical importance of adequate investments in health in the public sector and the economic and social benefits of these investments. Countries have been strongly encouraged to increase their public health expenditure up to the minimum norms.

31. There I an urgent need for countries in the region to build national and local capacity in health financing and in establishing and running National Health Accounts Systems. Capacity building in financial management with accountability and transparency for health institutions at sub-district and district levels and for primary health care is also required.

Capacity Building for Priority Public Health Problems

Environmental health, water, sanitation and waste disposal

32. Despite significant improvements, there is a long standing lack of access to water and sanitation facilities for a significant section of the population particularly the poor in some countries of the region. This is compounded by new challenges. Groundwater is being used faster than it is being recharged. If water conservation strategies are ineffectively implemented, drinking water shortages are predicted to occur. Contaminated water is a vehicle for disease transmission. Poor quality and inadequate quantities of water are estimated to account for about 10% of the total disease burden in developing countries. Privatization of water is reducing access for the poorer sections of society. Industrial and chemical pollution of rivers, groundwater and water bodies and agricultural runoffs contaminated by fertilizers and pesticides are rapidly growing areas of concern.

33. Countries are encouraged to ensure universal access to safe, potable water supply by 2010. Inter-sectoral action between water supply and sanitation boards pollution control boards, departments of health, local government bodies communities and consumer groups is essential to ensure adequate provision and utilization of water, without wastage, and to undertake health

promotion and public awareness campaigns so as to reduce prevalence of water and sanitation related diseases.

34. There is a need for adequate technical capacity in the region to work effectively and efficiently on this issue. Time bound goals and indicators could be set to reduce mortality and morbidity due to the following conditions:
    a) water washed disease – scabies, trachoma
    b) water based diseases – schistosomiosis and dracunculiasis (guinea worm disease)
    c) water related diseases – malaria, filariasis, dengue fever.
    d) Waterborne disease – diarrhea, dysentery, cholera, typhoid, hepatitis A, amoebiasis, giardiasis, helminthic infestation / intestinal worms, camphlobacter etc.
    Prevalence and incidence rates will be collected and analyzed through the disease surveillance system / health information system, for which capacity is also being developed.

35. Capacities need to be strengthened for accelerated interventions to ensure access to household and environmental sanitation facilities (toilets, drainage systems, sanitary waste disposal). This will help minimize disease spread by the faecal-oral route of transmission, which continues to be widespread. Control of these diseases requires a combination of interventions including improved water quantity and quality, sanitation systems but also food hygiene and good personal hygiene. This requires health promotion, advocacy, social mobilization in addition to infrastructure development and regulation. A multi-sectoral approach involving public health engineers, sewage boards, and departments of urban and rural development, water supply and elected representative and community members is critical.

36. Capacities to handle waste management in a professional, toxic free manner are also urgently required to be developed. This area has become very complex over the past few decades and encompassed household waste; solid waste at village, town and city level, non-biodegradable waste; hospital and health care waste; hazardous industrial and chemical wastes; nuclear waste; agricultural wastes etc. Some waste disposal methods, such as incineration are themselves toxic. Short and long term consequences on public health and the environment are significant.

37. In addressing issues of water, sanitation and waste disposal, the role of the state is important. Public health specialists need to work in collaboration with public health engineers and a host of stakeholders, including the environmental justice movement and legal advisors. Adequate sensitization and awareness regarding the issues need to be ensured in the training and continuing education of all public health workers. A few would opt for more specialized training in this area. This stream would need to have an institutional base wherein their higher education, job opportunities and career planning would be considered.

38. The public health system would required the skills and capacity to pick up instances of impact on human health following environmental pollution from industry, including the chemical industry, agriculture (pesticides, fertilizers etc) and the dumping of toxic waste. This is a major emerging social and health problem in the region, which has become the global manufacturing base at low economic cost. Health and safety of workers and communities need to be safeguarded. Other major environmental, issues affecting human life, health and wellbeing including climate change, global warming, ozone layer depletion etc, need urgent research and action. Health impact assessments of new technologies, industries and development projects need to be undertaken. Environmental epidemiologists and occupational health specialists are still scarce in the region and need to be trained in larger numbers. They would need to work closely with government policy makers, health providers, NGOs, the environmental movement and communities.

Nutrition

39. The public health systems of many countries in the region are inadequately equipped to address the challenges of nutritional deficiencies and under nutrition, or the emerging challenge of non-communicable disease which have a food, diet and lifestyle component to their causation. The magnitude of nutrition related health disorders in the Asia Pacific region is large. The impact on mortality, morbidity, vulnerability to other infections and disease, disability and economic productivity is enormous. However the significance and potential for positive health and development impacts through policy measures has often not been adequately understood or

acted upon by policy makers and public health practitioners. Advocacy, sensitization, capacity building and effective action on nutrition deserve the highest priority.

40. Practical training on nutrition needs to be mandatory for all levels of health workers and professionals. The teaching content will need to be relevant to the nutrition problems and issues obtaining in a country or area, keeping in mind the dynamic changes that keep occurring. District-wise nutrition mapping would provide an information base. Centers for nutrition research need support and the findings and recommendations from their work need to be acted upon and also introduced into training programmes, public education and policy interventions.

41. Broader issues of agricultural policy, food diversity, food security, international trade and pricing of agricultural products are issues of national and regional priority. Public health policy workers and practitioners need to have a general awareness about these issues. They need to understand their specific roles and responsibilities in regard to nutrition security, and in improving the nutrition status of people of different age groups, at individual and community levels and through integrated health and nutrition interventions.

Disability

42. The Asian and Pacific is home to an estimated 400 million persons with disability, the biggest number in the world. A large majority are poor, and lack social opportunities and access to good rehabilitative care, that can enable and assure a meaningful productive life. Many disabilities are also preventable.

43. The first Asian and Pacific Decade of Disabled Persons (1993 to 2002), and the recently launched second decade (2003 – 2012), have facilitated many positive regional and country level initiatives. These include a comprehensive and integral approach to the protection of promotion of the rights and dignity of persons with disabilities; improving disability measures for policy use, promoting active participation of women with disabilities; poverty alleviation among people with disabilities; among others.

44. The public health community in the Region needs to be capacitated and encouraged to join, support and expand these initiatives. Multi-ministerial and inter- country cooperation, already initiated, will be further strengthened. Active participation of persons with disability in planning oversight and reviews will be ensured. There will be a special focus on children with disability.

Promoting Mental Health

45. Mental illness takes a heavy toll through the long-term suffering of affected persons and their families. Patients continue to experience stigma and discrimination, and the treatment and care of the mentally ill persons is still an orphan area in most health systems. Mental and emotional ill health, tobacco and alcohol related problems and violence have been widely recognized during the past decade, as major public health issues. The time now is to act. This is a complex issue of human behaviour and social relations in an increasingly stressful environment. Health personnel working in primary care settings in both the public and private sector need to be trained adequately to recognize and diagnose mental health problems. Treatment options that are currently available should be widely accessible. In order to make this a reality there is a need to enhance the number of psychiatrists, clinical psychologists, counselors and social workers, and also to take appropriate measures to reduce their migration. Drug patenting issues will need to be considered to ensure availability of newer drugs at affordable prices. More importantly initiatives to promote positive mental health and to build caring, supportive communities need to be expanded through training of trainers and other methods. These include parenting skills, life skills education, meditation and yoga. Parents, school teachers, religious bodies, and community leaders all have an important role. Legal, regulatory and related capacities will need to be strengthened to dealt with control of tobacco, alcohol and substance abuse.

Infectious Disease Control

46. Old and new infectious diseases take a heavy toll in terms of disease burden and mortality in the region. The risk of transmission within and between countries has become higher with

social instability, conflict displacement, migration and increased mobility. Capacity building for control of infectious diseases is one of the highest priorities in the region. This needs to be implemented with a sense of urgency in a time bound manner. Infectious disease control requires widespread public education and awareness, sharing the known scientific features of the diseases, stressing preventive and control measures at individual and community level, and minimizing misinformation which results in fear and panic. Government departments of health education and health promotion need to be alert, up-do-date, pro-active and creative, using a mix of communication methods and interacting with mass media groups. Health systems need strengthening with adequate budgets, trained health personnel, good laboratory facilities, supply systems for drugs and consumables, communication systems and disease surveillance systems/health information systems. Inter-country collaboration needs improvement. However, most importantly there is a need to focus on the developmental determinants of these diseases through intersectoral, multiministerial interventions, as many of these diseases thrive in conditions of poverty. There is a need to ensure that dominant paradigms eg the bio-medical approach, and dominant institutions do not monopolise policy making. Independent implementation audits and public hearings can be utilized to elicit peoples perspectives on how effective and accessible infectious disease control efforts are. Capacity building is required for all these components.

47. Tuberculosis, malaria, filariasis, dengue hemorrhagic fever and vector borne diseases need special attention, and close collaboration with WHO control programmes. However, rather than managing a multitude of vertical, single disease focused programmes, countries in the region could adopt an integrated primary health care approach wherein early detection, complete treatment, recording and reporting systems function through comprehensions primary health care centres dispersed in the community. Health promotion and community participation are integral components of the approach. Most countries have over the past 3 – 4 decades established a primary health care infrastructure. This needs to be strengthened, guarding against policy advice from international financial agencies and others who suggest a targeted approach with enhanced privatization. The international community and public health experts have universally recognized the important role of the state in infectious disease control through public health systems, popular education and people's participation. In the current neo-liberal context this role needs to be re-inforced.

48. Newer problems of HIV/AIDS, SARS AND Avian flu have been addressed by the UNESCAP over the past few years in its resolutions. The recent 3x5 initiative of the WHO, which aims to increase access to treatment is welcome as a timely response to the severity and magnitude of the disease and to the treatment access campaign. Dialogue between UNESCAP and WHO will help to enhance coverage and capacity building in Asia as early as possible. Newer treatment protocols, simplified procedures, etc will be adopted, monitored and constantly updated as new knowledge becomes available, after reviewing its social applicability. Most importantly countries could use the existing provisions in the WTO clauses to ensure adequate supply of good quality, generic drugs at affordable prices. Lessons could be learnt from Thailand, Cambodia, India and other countries. Health education efforts regarding these diseases should not generate fear but spread positive messages. Methods of positive living for persons already infected could been encouraged. Use of adjunct therapies such as herbal remedies, massage and other forms of healing that recognized not to cause harm will be encouraged. Life skills education and women's health empowerment that has already been initiated in most countries will be expanded through widespread capacity building.

49. The region is faced with a double burden of diseases with non-communicable diseases (NCD) and traffic accidents taking a heavy toll. The Pacific island countries, Japan, China, Australia and New Zealand have already initiated health promotion campaigns through the government, voluntary sector, private sector and professional associations to bring about lifestyle changes such as adequate exercise, healthy diets, stress management, compulsory use of helmets and seat belts, rules about drinking and driving etc. With an ageing population these measures are necessary to reduce the burden of cardiovascular diseases, hypertension, stroke, diabetes and other NCDs. Abuild up of capacity in the public and private sector for management of these disorders is necessary. Ratification of the

Framework Convention for Tobacco Control (FCTC) and implementation of bans on advertising and sponsorship of tobacco products, smoking in public places and stringent curbs on smuggling, would help control the epidemic of tobacco related diseases, including cancers in the Region. Other measures for prevention, control and care of cancer also need to be instituted.

50. The health internet work project of the WHO has piloted the use of the internet and information and communication technology (ICT) for providing easy access to research information on important public health problems to health providers and citizens. ICT offers great potential and needs to be widely used. Internet based public health training programmes are being designed. The use of hand held computers by health workers in the field for recording and reporting will greatly reduce their burden of work.

Community capacity building for public health

51. Traditional public health has been critiques for being rigid, with a techno-managerial, bureaucratic approach which leaves little scope for the creative, empowering and enabling involvement of communities to collectively address the deeper determinants of disease. There is an opportunity now for a change in paradigm based on greater community participation and control, with mechanisms for social accountability and measurement of progress in achieving goals. We could move forward towards achieving the global vision of better health for all, based on the universally accepted premise that the Right to Health and Health care is a basic human right.

52. Capacity building for public health is therefore understood in its broadest sense. This will involve representation from all sections of communities including women, children, persons with disabilities, disadvantaged section of society, the elderly, and persons with HIV/AIDS and other illnesses, so that their perspectives, concerns, and valuable suggestions based on lived experience, will help to evolve the strategies.

53. Where elected representatives function at the level of local bodies and have responsibilities for health, there is a need for innovative training to enable them to improve the governance of the public health system. This exercise may take a few years, but has proved to be effective in several places such as Kerala state in South India.

54. Formation of self-help groups of women is widespread in the region. The value of adding a health and social dimension to their economic activities has been shown to be effective in Bangladesh, Nepal and several countries. This approach could be more widely used. Care needs to be taken that methods used are empowering and liberating without adding additional responsibilities and burdens to women who are already overworked and fatigued.

55. Self-help groups of persons living with particular illnesses who also become advocates for preventive and promotive action play an important role. Involvement of persons living with HIV/AIDS at all levels of health decision making has significantly altered the public health discourse. Shifting the balance between experts, health providers and patients from one of dependency to one of greater autonomy and equality has been an important step forward.

56. Involvement of school teachers and parent sis critical to health promotion. It is important for young people to be touched or moved at a personal level, for personal motivation for positive health to be ignited. Training of trainers for parenting education, life skills education, counseling and health promotion on the basis of the Ottawa charter and subsequent charters would bear great fruit.

57. Politicians and bureaucrats are often placed in positions where they make major decisions that impact on health and health care. They may not have the requisite information and knowledge easily available to weigh the matter objectively. Various lobbies and interest groups present them with sophisticated material favoring their position. Public health groups need to prepare well-researched, objective policy briefs that protect and promote public interest.

58. Experience across the region has shown the great value addition of involving communities with health institutions through a variety of institutional mechanisms that include:
   a) Setting up health communities at health centre and sub-centre level.
   b) Establishing boards of visitors, help-desks and help-lines run by volunteers in hospitals and elsewhere.
   c) Mandating local bodies or elected representatives with specific constitutional responsibilities for the governance of health institutions and programmes
   d) Making adequate provisions for the citizen's right to information to include the heath sector as well.
   e) Establishing mechanisms for participatory management of health institutions, making space for community voice to be heard and responded to.

   All these efforts help to increase community ownership and management of health institutions.

59. Information and communication technology (ICT) could be used proactively by governments to overcome the digital and knowledge divide in health. The necessary infrastructure will need to be established and skill training undertaken. A community participatory model to the Health Inter-network project being piloted by WHO has shown that the sharing of health information with communities, health workers and staff from health related departments using a mix of communication methods including ICT served an unmet information need.

60. Communities have also participated actively and effectively in participatory action research that study some of the developmental determinate of health such as environmental an health consequences resulting from industrial pollution, use of pesticides, mining etc. Community involvement in the research as river-keepers measuring water quality, as community patrols measuring air quality or as bucket brigades has enabled them to gather evidence and become agents for change in a positive manner.

61. Public campaigns on health related issues have become increasingly common in the region as well as globally. The women's movement has been effective in increasing gender sensitization of health policies, in promoting reproductive rights, and in raising gender concerns in health research and in medical education. One of the current campaigns is to increase women's access to primary health care and to reduce violence against women. The people's health movement has been campaigning for a revitalization of the spirit and principles of primary healthcare. The Peoples Charter for HIV/AIDS has resulted in formation of the Asian Peoples Alliance for Combating HIV/AIDS (APACHA). The Peoples Charter for Health of the PHM has also become a rallying point for a campaign to reduce wars, conflicts and violence. The pulse of people can be felt and responded to by listening to the issues raised by people's campaigns and movements. This is an important third fore that is countering the threats to peoples health caused by corporate globalization, liberalization and the commercialization of health care.

62. Use of the principle of subsidiarity in decentralization of health care services, with appropriate training, management and preparation of people, helps to bring services closer to people. However it is necessary to take adequate measures to ensure a focus on primary health care and public health.

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3. POLICY, ACADEMIC AND RESEARCH AGENDA FOR PUBLIC HEALTH IN INDIA (2006)
PHFI Inaugural Workshops

A summary of the key suggestions raised by workshop participants for consideration by PHFI as it evolves its academic, research and advocacy agenda. This summary represents views of participants who were invited from a wide variety of backgrounds – government, academia, research institutions and civil society

A. Stimulating demand for public health professionals

1. PHFI should address the perception of public health professionals (including PSM departments) that they are at the bottom of the pyramid in terms of status and positions among health professionals and enhance their self confidence an esteem as very important members of the future health team.
2. The NGO sector and the civil society in India have made great contributions to public health by maintaining the perspectives and practice of public health and giving it a new people oriented – community health perspective, inspite of the opposite trend in the government and the mainstream. PHFI must tap these resources and build on this rich experience and tradition.
3. Public health services and systems especially by government need to be made more accountable and NGOs and civil society have done this by evolving the concept of People's Health Movements and rights based approaches to health care which have begun to engage with government policy and programmes and challenge them to be more effective and accountable. PHFI must link into this sector be involve in advocacy and other initiatives.
4. The big challenge of advocacy is to move away from the bio-medical model focusing on drugs and vaccines to a more social / community health / public health module that focuses on public education and social processes.
5. There is urgent need to focus on and stimulate public demand for quality public health services which will strengthen the public health systems and increase the utilization of public health professionals who are available or may become available through various efforts including those of PHFI.
6. We need to expose the community and health systems to the benefits of trained public health personnel by creating a cadre of public health professionals on the line of the IAS and IPS.
7. We need to create a large number of fellowships in order to get young people in larger numbers to train in public health.
8. Human power management systems in government and other sectors also need modification to attract young people into this professional.
9. Post training opportunities must also be created in the NGO and the private sector and all the focus must not be only on the government sector.
10. Programmes like NRHM need public health professionals or public health oriented professionals at all levels of the pyramid to be successful. We need to have 4 to 5 time more people at every level.
11. Advocacy for public health must go hand in hand with greater decentralization of resources including human resources and we must communitise these untied resource at local level for strengthening public health.
12. Before we promote public health professionals we must be clear about who is a public health professional and what type of specialists are we looking for. The selection criteria must always focussed on those who spent time in a village or urban slum working with government or private sector or an individual who has done something in the field of community health.
13. Public health specialists and health workers should respect and trust each other and specialists must not see workers as impediment but as help in their work. This has been the experience of Bangladesh.
14. Public health professionals must have basic clinical knowledge or we end up with bureaucrats. They must also have training and experience in public speaking and communication and be able to go to the local bazaar and talk about public health measures.
15. The biggest challenge of PHFI institutions is to promote the values among its students that local health workers can do a lot in public health, that the doctor is a friend of the people and that they

have an awe and respect for life, nature and the community. The present market economy is moving in the opposite direction.

16. Public health is a vast multi-disciplinary field and we must have a clear plan about the type of public health skills and capacities we need at different levels and also where the products of these institutions will be placed in the health system.
17. We need to replace clinicians and generalists managers of India's health systems and national health programmes by public health professionals who are both problem analysts and problem solvers and are promoted as equivalent to the best in medical and engineering.
18. Beyond producing public health professionals, we should also seriously re-look at promoting public health perspectives and skills to all cadre of health professionals including health workers. Some of this may need to be taught in the local vernacular and inter-sectoral coordination should be important part of the training.
19. We should be cautious that the PHFI institutions do not glamorize public health and make them a privileged professional class that will not go to the remote districts and areas of country. We need less glamorous and more practical field oriented public health practitioners.
20. Public health practitioners need to be of different types - some practitioners, some teachers, some managers. We need to keep these distinctions in mind.
21. We should promote PHFI in a collaborative mode building on existing initiatives and experiences and promoting a new group of professionals that will create energy and synergy needed to inculcate a deep sense of respect for public health and improve the practice of public health in the country.

(based on inputs from
Arjun Rajagopalan (Sundaram Medical Foundation), Vijay Aruldas (CMAI), T. Sundarraman (SHRC),
N.K. Arora (Clinical Epidemiology Network), Salim Habayeb (WHO SEARO), Amarjeet Sinha (MOHFW),
Zafrullah Chowdhry (Gonoshasthya Kendra-Bangladesh),
N.H. Antia (FRCH), Thelma Narayan (CHC/SOCHARA), Vinayak Hussein (MOHFW),
Sunil Kaul (ANT), Arvind Mathur (WHO India office)

B. Creating & Sustaining Excellence, & Relevance & Designing the PHFI Institutes

1. **A core group of people need to be passionate about this institution and a shared vision.**
2. **Detailed planning exercise should be undertaken to make sure we plan exactly what is needed / to happen.**
3. **Every institution must have its own philosophy and must respond to real life problems not just theoretical issue.**
4. **The centre should be multidimensional and develop knowledge, skills and attitudes.**
5. **There should be strong and effective leadership.**
6. **Facilities for community based learning process (learn it in the field) with a strong focus on primary health care, which is the weakest link in our present medical education.**
7. **External embedded cycles?? (Shah Ebrahim)**
8. **The institution needs to emerge with a Vision and Mission not just be designed and staffed.**
9. **It must encourage a culture of learning that is constant among both students and faculty.**
10. **A core faculty team that have vision / capacity provided with a career development programme and judged by outcomes.**
11. **Autonomy for institution.**
12. **Building capacity to solve problems**
13. **Institutions should be residential to have better chance to orient students and faculty to values and institutional culture.**
14. **PHFI institutions should work in partnership with NRHM and other governmental initiatives. Isolated work will not succeed.**
15. **The institutions should promote field exposure and dialogue with the community to have a lived experience of poverty and inequity which will make an impact on the hearts and minds of the students.**
16. **Excellence should be measured not by number of papers published but by the concrete output that the student or the faculty contributes to the community.**
17. **Public health is too serious a matter to leave only to health professionals – hence the public and community representatives should be deeply involved with the institutions.**
18. **The PHFI institutions should not promote internal brain drain leading to collapse of other institutions but must work in the context of a collaborative network.**

19. **There should be career tracking within the system of public health for all students who graduate from these institutions.**
20. **Identify all the existing institutional and community experiences from which students and faculty can benefit.**

(based on the inputs from Jahar Saha (IIM), Shah Ebrahim (LSHTM), J.P. Muliyil (CMC-Vellore), Sanjana Bharadwaj (UNICEF), K.R. Thangappan (SCTIMS), Madhav Menon (NLSUI), Sneha Bhargava (AIIMS), Mirai Chatterjee (SEWA), Prem John (ACHAN) and Pat Naidoo (Rockerfeller Foundation)

C. Developing as a reputed research and advocacy group

1. The Foundation should work to foster networking, creating policies and working on areas of research that are not adequately addressed as of now. It should not compete with existing research institutions and public health departments which are already doing research in a number of public health problems – eg., communicable diseases, cancer, diabetes, cardio-vascular diseases, etc.
2. It should promote an interaction between research and the health care system – so that locally generated research that is responsive to an adverse economic situation is used by the health care system.
3. It should promote the nation wide acceptance of research methodologies and modules that have been set up by ICMR and other institutions.
4. It should promote interactive dialogue between researchers – biomedical and social and behavioural scientists and also with advocacy groups, planners and civil society and community.
5. It should promote the spread of research information to the community by more active partnership with grass root workers.
6. It should also promote evidence based decision making in health care planning by making available research evidence to help planners.
7. It must strengthen evidence based research in public health in general (only 3.3% of research papers in 2002 were dealing with public health) and not allow emotion based research.
8. It must strengthen the commitment of public health community to public health research (if something is not respected it does not get done).
9. It must foster research i.e., India centric and innovative because especially in public health we have to deal with less resources, large numbers and large distances. Focus of research should be on poor population not well to do.
10. It must assess new technology critically especially looking at how it can improve the health of our country and also promote technological innovations.
11. Research priorities could include
    a. studying implementation gap and implementation science
    b. socio-economic determinants of health including gender disparity, equity and access
    c. focus on unorganized sector and its impact on health
    d. women's health
    e. starvation and food / nutrition security as a public health issue.
    f. decentralization of public health system
    g. health as a human right issue
    h. health system research which should be fed back to the system to increase efficiency of the system.
    i. Public – private partnerships and their efficacy
    j. Health and social policy research including measurements of existing policy.
12. It should promote evidence based introduction of public health measures for communicable and non-communicable disease control.
13. The research promoter should be with a strong social medicine and community health approach and not just the orthodox bio-medical approach.
14. Research partnership should promote links with community based organizations, people's movement, groups of rational practitioners and PSM departments in medical colleges.
15. Research should reflect on entire health spectrum of disease and problems and systems and not just be bio-medical in its approach. It should be fostered by encouraging a deeper understanding of the social, economic, cultural, political and ecological dimensions of health and disease at the graduate education level and in the orientation and training of young researchers.
16. The research policies supported by PHFI must ensure that the benefits of research must reach the community / population otherwise the policy should be seen as incomplete.

17. It should balance focus on drugs, vaccines and new technologies with strong commitments to health system research, health promotion, and approaches that foster education and social processes.

(based on inputs from
Prof. Nirmal Ganguly (ICMR), Prof. Mashelkar (CSIR) , Sapna Desai (SEWA), Abhay Shukla (CEHAT), Andres de Francisco (Global Forum for Health Research) and Ravi Narayan (CHC / PHM)

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Compiled by Dr. Ravi Narayan and Sunil George (CHC Fellow)
Community Health Cell, Bangalore.
25th July 2006.

4. PUBLIC HEALTH EDUCATION IN INDIA - Some Reflections* (2007)

4.1 Context: Public Health Education Policy : 1946 to 2002

To understand the true significance of the crisis and challenges of Public Health Education in India, one must recall the main recommendations of the Bhore Committee (1946) and Mudaliar Committee (1961) reports, that tried to set the framework of pubic health education in India.

The Bhore Committee recommended the setting up of departments of preventive and social medicine (PSM) in medical colleges with the mandate to incorporate the then popular Diploma in Public Health into the training of all undergraduates as the syllabus for PSM, highlighting the need for all Indian doctors to be public health oriented – the 'social physician'. It also recommended post-graduate training of two types – a shorter training in PSM / Public Health for health workers (three months to one year); and a longer training for specialists in preventive health work for teaching, research and administrative needs of the public health system (3-5 years). It also recommended training of nurses in public health and a cadre of public health engineers, public health inspectors and public health laboratory workers to be trained by the All India Institute of Hygiene and Public Health and other institutions.

Fifteen years later, the Mudaliar Committee further strengthened public health education in the country by recommending schools of public health in every state to train medical officers, public health nurses, maternity and child welfare workers, public health engineers and sanitarians, dieticians, epidemiologists, nutrition workers malariologists and field workers. It also recommended degrees in public health in University for non medical personnel covering general public health, communicable diseases, immunization, environment sanitation, statistics, school health and the teaching of public health principles and hygiene in primary school with practical demonstrations. In addition, one year training in public health for a large number of medical officers to carry out public health / sanitation measures and higher training of MD/PhD to support public health system policy and development were also recommended.

While these recommendations were made in an era when public health was seen as a special skill and education of health personnel in these skills were seen as necessary for health system development in India, the first two decades of national health planning saw a series of negative policy trends that prevented the public health system and policy development from reaching its full potential with many of the Bhore and Mudaliar committee recommendations not being operationalised. Banerji (1985 and 1986) and Narayan (1984 and 1991) and Deodhar (2004) have written extensively, on what happened and why – highlighting the reasons and reviewing policy trends and policy distortions as well. They focused on many aspects of the health system including medical education and human resource development in public health education.

Banerji (1985) noted that "both the Government of India and the Medical Council of India had taken steps to establish upgraded departments of preventive and social medicine. However, these departments have not been able to attract the quality of scholars who could fulfill the challenging role assigned to the departments and, in the course of the past three decades, most of these find themselves at the very bottom of the prestige hierarchy in medical colleges". In his detailed epidemiological, socio-cultural and political analysis on Health and Family Planning Services in India, he concluded highlighting "the need for managerial physicians that understood health service development as a socio-cultural process, a political process, a technological and managerial process with a epidemiological and sociological perspective". In many ways without using the term 'public health professionals' – he was setting the agenda for public health oriented capacity building in the country. In a later oration, Banerji (1988) made a strong appeal for such an All India Public Health Cadre . He suggested "….. Action to strengthen public health practice must start from the political level.

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Formation of an all India cadre or at least strengthening of the existing cadre of Central Health Services is urgently called for. To improve the quality, it would be necessary for the political leadership to actively search for highly intelligent and dedicated public health workers and bringing them together to form a 'critical mass', which could strengthen the key institutions for practice, research, education and training in public health".

Narayan (1991) in a detailed analysis of 150 years of medical education as part of the medical education anthology process of mfc, noted that "hierarchical trends in medical colleges, non democratic spirit in curriculum planning and authoritarian methods in bringing about changes in medical colleges have prevented serious and meaningful change in the inherited structure". This was probably true not only of the main stream experiment but also of many of the emerging alternatives. He also commented on the "myths of PSM including a gross confusion between means and ends and inability to stimulate teachers and students to see the importance of socio-economic cultural and ecological factors in management of health and disease" – which were the original hopes when the department was created and integrated into medical education.

Later, Narayan, (1997) endorsed ".....the reorientation of all postgraduate education towards the goals of the National Health Policy and primary health care and enhanced commitment to post-graduate training in public health and allied disciplines. Linked to this would be the development of all India Public Health Cadres to strengthen the public health services in the country....". This was in the Chapter on Perspectives in Medical, Nursing and Paramedical Training and Education, the Independent Commission on Health in India, report by VHAI, New Delhi.

The same report (ICHI 1997) also recommended that "all major states should have at least one school of public health, along with modern public health research laboratories, smaller states may collaborate and have common public health schools..". It also recommended that Institutes of Health and Family Welfare established in many states should be developed into Schools of Public Health. The analysis by Deodhar (2004), of the regression of public health education in India in the last three decades is particularly relevant – since it focuses on PSM departments that were primarily set up to strengthen public health. "Departments of Preventive and Social Medicine have been the victims of neglect, assignment of lowest priority, low prestige, poor quality of staff, inadequate facilities, the staff full insulated themselves from the practice of public health and even of preventive medicine"

While academics, researchers and activists mentioned above have been highlighting the crisis and challenge of public health education from the 1980s, national policy documents also began to identify these trends and problems and suggested strategies of action to strengthen public health education in various ways.

- The National Health Policy document of 1982 identified three significant problems:
  1. "Wholesale adoption of health manpower development policies...based on western models...inappropriate and irrelevant to real needs..."
  2. "Continued high emphasis on curative approach led to neglect of preventive, promotive, public health and rehabilitative aspects of health care"
  3. "Prevailing policies in regard to education and training... resulting in development of a cultural gap between people and personnel providing care"

  It recommended many strategies of action – foremost of which were the need to formulate a national medical and health education policy, and the establishment of comprehensive primary health care and public health services within an integrated referral system.

- The National Education Policy for health sciences in 1989, which grew out of a response to the NHP 82 identified the problems as:
  1. Medical bias in the entire process of health systems planning and health manpower development
  2. Inadequate continuing education for updating existing skills and facilitating acquisition of new skills and knowledge by health team.

  It recommended the following strategies for action relevant to public health education:
  1. Efforts to produce adequate number of first level of specialists in medicine, surgery, paediatrics, OBG and **public health / community health**.....
  2. Essential that speciality of health management is recognized and an appropriate step taken to produce good health managers.
  3. Mandatory to establish linkages between health care delivery and education in health sciences to make the whole system efficient and effective.

The most comprehensive analysis of needs assessment and strategies for action was by the Expert Committee on Public Health System 1996, constituted by Government of India, which included public health stalwarts like Dr. Harcharan Singh (Planning Commission), Dr. Jayaprakash Muliyil (CMC Vellore), Dr. N.S. Deodhar, (MOHFW), Dr. K.J. Nath, (AIIHPH-Kolkata) and K.K. Datta, (NICD). This report which unfortunately did not receive attention it should have received was significant in its findings and recommendations. (See Annexure –1)

After 50 years of national planning and policy evaluation, it identified the problems as

- Public health services do not have requisite number of senior level public health professionals
- Many programme managers at national and state level are without any public health orientation or public health qualification.

It suggested many strategies for action to strengthen both the public health system in the country as well as public health education. The recommendation on the latter were:

- Need to open new schools of public health – so that more public health and para professionals can be trained.
- Existing public health schools to be strengthened (AIIHPH) – Eastern region and four regional schools to be set up – central, northern, western and southern.
- Existing medical colleges with significant expertise in PSM / Community Medicine should be upgraded as advanced centres for teaching public health and producing public health professionals (at least 25% of existing departments to be upgraded).

They also very succinctly reoriented the public health system concept by emphasizing eight policy constituents that were necessary for these systems to become more relevant to Indian community realities and public health challenges. These included :
decentralised health planning; higher budgetary allocation to the health sector; strengthening health information and early warning systems; inter-sectoral coordination; community participation; continuing education of all categories of health personnel; health services research; involvement of practitioners of the Indian Systems of Medicine.

Six years later, the National Health Policy 2002 reechoed these concerns in a different way by noting :

- Limited success of the public health system in meeting preventive and curative requirements of general population
- Financial resources and public health administration capacity far short of needs
- Public health machinery inadequate in quality, efficiency and too vertical and inadequately decentralised.
- Public health expertise non existent in private health sector and far short of requirement in public health sector.

It included the following strategies for action relevant to strengthening public health systems and public health education in the country:

- "Ensuring adequate availability of personnel with specialization in pubic health and family medicine disciplines to discharge public health responsibilities in the country
- Need to entrust limited public health functions to nurses / para medicals, practitioners of Indian systems of medicine and other personnel after adequate training, to enhance outreach of public health programmes.
- To increase efforts to strengthen decentralised state level public health systems and involving panchayat raj institutions in the governance and delivery.
- Developing capacity of state public health administration for scientific designing of public health projects suited to the local situation.
- All rural health staff to be available for the entire gamut of public health activities at decentralized levels".

A recent review of all these critiques in Narayan (2006) identifies four broad sets of issues that explains why public health education had been devalued or neglected in spite of all the debate, dialogue and policy recommendations. These include:

- **Medicalisation of public health** by preventive and social medicine departments, and their aloofness from state health programme managers, as well as th fact that these post-graduate degrees have been available only to medical professionals, though this trend is now beginning to slowly change.

- **Devaluation of public health as a discipline** in the 1960's and 70s by generalist administrators and clinicians becoming public health managers and state HRD policies not requiring public health degrees as job requirement for public health managers. This trend is also seen in a more subtle way in the NGO / civil society sector as well.
- **Disintegration of public health systems** by vertical national disease oriented programmes rather than sector wide approaches and externally funded projects focused on single disease programmes rather than on strengthening public health systems. New economic policies also reduced social sector expenditures including health budget further distorting the public health systems.
- **Dialectics of National Health Policy**
  The challenges of balancing public health / primary health care system development with the present trends towards privatization of health care and medical tourism and unregulated private sector development and commercialization of health care has led to inadequate focus on public health human resource development. This is also linked to new economic policies that focus on the needs of 'India' rather than of 'Bharath'.

It must however be noted that by early 2000 AD, a National consensus had begun to emerge especially in policy circles for comprehensive initiatives in strengthening public health capacities in the country. This emerging consensus included

- need for many more schools of public health / institutions and public health courses to cover state and regional needs;
- need for making available public health training for health and social science professional other than doctors;
- need for strengthening public health planning, management and response to emergencies in state and national health systems and
- need to ensure public health human power development policies at state and central level that gave public health qualifications, skill s and capacities their due importance.

Any public health capacity building dialogue like the one being undertaken by the medico friends circle or capacity building initiative like the Public Health Foundation of India must take into account these historical documents, the critiques and the pleas for action and the emerging policy consensus.

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4.2 Overview of Public Health / Community Health Education initiatives in India since 1970

A very large number of initiatives to strengthen public health/community health education have evolved in India since 1970s with an increasing spurt of activity since the 1990s. These have been in response to the emerging unmet needs in public health oriented personnel. They also represent the emerging national consensus at policy and other levels for greater initiatives to strengthen capacity, quality and quantity of community oriented, public health personnel. An important clarification is necessary, since the alternative sector uses 'community health' more than 'public health' in its description of courses. These are not synonymous. However, for the sake of this document, community health will be defined as 'the new public health- which includes a strong focus on social, economic, political and cultural determinants and the involvement of the community in the organization of the action as a right and a responsibility'.

These initiatives have been primarily of two types: (a) Mainstream; (b) Alternative.

A. MAINSTREAM INITIATIVES:

Institutes / Courses

These include all the newly created PSM departments since Independence which have begun to produce post-graduate MDs and older institutions like AIIHPH and NIHFW which have continued their earlier degrees and added new ones. Some of these institutions have also developed diploma in public health and related courses.

There is no directory as yet of all these programmes but the South East Asia Public Health Education Institutional Network (SEAPHEIN) has began to document these recently (WHO-SEARO 2002) as part of a process to evolve an accreditation system. This listing shows that as of 2002, we have 180 medical colleges teaching PSM as part of the MBBS curriculum, Of these 58 offer a degree of MD in Social & Preventive Medicine or Community Medicine of 3 years duration; and 13 offer a Diploma in Public Health of 2 years duration. All these courses recognized by the Medical Council of India and are available only to medical professionals. All India Institute of Public Health & Hygiene-Kolkata offers DPH, MD and Ph.D courses with some of the shorter public health courses open to other health professionals.

Apart from this, we have the Masters in Community Health of JNU; the Masters in Public Health of Sri Chitra; the Masters in Epidemiology of CMC-Vellore – all of which are open to graduates any discipline. Since 2001, we also have a Masters of Applied Epidemiology from the National Institute of Epidemiology – Chennai, which is open to state and district level public health programme managers. In addition we have the short courses and in-service training by NIHFW-New Delhi, for deputies and CMOs of districts. In 2005-06, the ICMR announced its plans for 4 school of public health of which the Kolkata and Chennai schools have been inaugurated in June and October 2006. Finally NICD-New Delhi; PGIMER-Chandigarh; and Centre for Interdisciplinary Studies, Pune University, have also announced their new MPH programmes. The proposed institutes and courses to be started by the Public Health Foundation of India (PHFI) will be over and above all these existing institutes and courses .

Networks

Three professional networks have contributed to a varying degree, to the debate and experimentation in public health education in the country. These include

a) **The Indian Public Health Association (IPHA),** which is a very old network of public health professionals meeting annually and producing the Indian Journal of Public Health. They tend to be mostly public health professionals working in the Government Public Health system with some exceptions.
b) **The Indian Association of Preventive and Social Medicine (IAPSM)** which is national association of Teachers of PSM departments with some exceptions.
c) **The Indian Clinical Epidemiology Network (INCLEN)** – which is a network that emerged through a Rockefeller initiative that stimulated and strengthened the training of clinicians in epidemiology and field based research, making them more public health oriented.

Some issues relevant to the mainstream sector

While it may seem relevant, that so many institutions and colleges are already running or initiating public health courses in mainstream institutions, some issues of concern need to be noted. Some of these are anecdotal and not based on a comprehensive review but are valid since CHC has had a close contact with most of these initiatives and has participated in many of the courses.

a) Each institution is evolving its own public health course without any standardization or reference to a national consensus.

b) The Medical Council of India and the National Academy of Medical Sciences have not been very proactive in recognizing courses opened to non medicos in public health. Therefore, in exploring accreditation for public health courses for non medicos, each institution is evolving its own recognition with the local University or other Universities.

c) There is urgent need for a National Accreditation council – perhaps a Public Health Council of India - so that all these DPH and MPH courses are part of some nationally, relevant framework. Such a council however must encourage experimentation, diversity and autonomy.

d) There are no national standards for faculty requirements, course contents, methodology of teaching, requirements of field centers and field experiences for these newer MPH and DPH courses. MCI has recommendations for PSM departments and the undergraduate and MD curricula. The WHO-SEARO has just started this process since 2000 AD through the SEAPHEIN network (see details later in the paper).

e) Finally, there is urgent need for policy advocacy with States, to recognize these DPH and MPH courses as requirements for specific jobs in the public health systems at state level. Only then will these education efforts help strengthen state capacity and programme effectivity. In the absence of such a proactive policy advocacy process, this anarchic development of institutions and courses could result in the human resources generated serving a market need and fueling a 'brain-drain' rather than responding to the national public health system needs.

f) A brief word, about the three professional networks, that should be logically involved in any discussion on public health capacity building in India. The two associations – IPHA and IAPSM have not been working as closely as they should because of a subtle hierarchy between the three year MD and the one to two year DPH/MPH course, though this is now beginning to change. In Karnataka state we have managed to bring these two groups in to one association – The Karnataka Association of Community Health. In addition the INCLEN network is also not so closely associated with the other two because of the subtle differences between the clinical epidemiologists and the 'purists'. The dialogue of all this networks with the policy makers has been relatively weak.

B) THE ALTERNATIVE SECTOR:

The 'alternative sector' is a term we have used to describe a group of public health / community health training and educational initiatives that have not followed the orthodox MD- PSM and MPH/DPH tracks. This sector evolved through the experimentation of a large number of community health action initiators in the late 1970's mostly from the NGO/ Voluntary sector. After many years of community based action some of these projects metamorphosed into training centres, that could orient other doctors, nurses and health professionals to initiate and innovate similar community health projects. We can classify them into two groups: (a) short term training programmes and (b) long term training programmes

Short term training programmes

i. These include Community Health training programmes of Deenabandhu Medical Mission (Tamil Nadu); Christian Medical Centre (Miraj); Christian Fellowship Hospital, (Ambilikkai;, Tamil Nadu), Institute for Rural Health Management – (Pachod, Maharashtra); International Nurses Service Association, INSA (Bangalore); THREAD (Orissa), Child in Need Institute – (Kolkata). Many of these courses, were particularly popular in the 1970s to 1990s. Some of them have now been discontinued.

ii. NGO Networks like VHAI, CHAI and CMAI also started short courses in community health planning and management particularly for their member institutions.

iii. Some educational institutions like St. John's Medical College-Bangalore (3 month course in Community Health), and NIMHANS -Bangalore (one month course in Mental Health Care), also started such short term courses.

Long term training programmes

i. The Voluntary Health Association of India evolved a VHAI, Educational Council which has been offering a Diploma in Community Health Management, in collaboration with Rural Unit for Health and Social Affairs (RUHSA) and Christian Medical College, Vellore – since 1983. This course is for a year. A distance learning module was also attempted.

ii. In 2003 the Society for Community Health Awareness, Research and Action (SOCHARA / CHC, Bangalore) – has evolved a six month internship / fellowship for medical and social science graduates, to strengthen public health as choice of career / vocation. This initiative entitled the Community Health Fellowship Scheme is an ongoing experimental project, which has just been externally evaluated and discussed at a national workshop of Public health /community health trainers in July 2006 at Bangalore.

Some issues relevant to the alternative sector

Some important features of these short courses have been described in CHC studies (Narayan, R et al, 1993 and Kasturi .A. 1993). These included the following:

i. The courses experimented with an alternative philosophy of education that was participatory, experiential, learner centred and action oriented.
ii. They used small group techniques and methodologies.
iii. They had a strong community orientation, since most of the training was community based and non hospital oriented.
iv. They had a strong social analysis, exploring broader determinants of health
v. There was a focus on skill development for community based work.
vi. There was a greater learner centredness with participants giving feedback and evolving the curriculum further course by course.
vii. The focus of training was on cognitive and affective aspects of training and on work related skills as well.
viii. Many of them evolved innovative case studies, simulation games and problem solving exercises.
ix. While the orientation of the courses were very different the over view suggested that they focused on two sets of roles – the first as alternative service providers or programme managers and the second as enablers and empoweres of the community or process managers.

A very important and significant characteristic of this group of innovative trainers, was that nearly all the trainers had been trained in public health mostly in US and UK universities and had returned to the country to initiative community health projects as part of such a movement in the 70's. Most of them actively and creatively modified their own public health skills to the challenges of local realities. Some of them strengthened their initial efforts as generalist by acquiring public health degrees along the way.

The current anxiety that somehow a foreign education in skills or capacities makes you unable to be a creative adaptor to a different social, economic, cultural, and political reality is a highly exaggerated fear not borne by Indian experience. In fact if the voluntary sector of health in India is to be studied as an indicator, then there is significant evidence that an Indian educational experience especially from a mainstream institution kills the innovative spirit rather than stimulates it, with foreign trained and foreign returned professionals continuing to show more capacity and initiative then their local counter parts. This may be more an indicator of the training methodology and the dialogue environment of academic centres abroad as opposed to the more hierarchical and didactic academic environment locally.

C) OTHER DEVELOPMENTS

While the earlier sections focused on courses and training centres in the main stream and alternative sector, two process of networking in the region, since 2000 AD are beginning to have an important impact on public health/community health dialogue and health human power development in the country. This includes a) A public health demand creating movement- the People's Health Movement- Global and Indian. b) A public health education network – the South East Asian Public Health Education Institution Network (SEAPHEIN)

i. People's Health Movement (PHM) – Global and India

A Global Peoples Health Movement and a People's Charter for Health arose out of an important People's Health Assembly, held at Gonoshasthya Kendra, Savar, Bangladesh, in December 2000. when over 1454 people from 75 countries gathered to reflect on why 'Health for All' had not been reached by 2000 AD. This had been the goal of the famous Alma Ata declaration of 1978 committed to primary health care. This global assembly was preceded by the First National People's Health Assembly in Kolkata, which also resulted in an Indian People's Charter for Health. Both these documents have led to the emergence of a growing People's Health Movement in India, known as Jana Swasthya Abhiyan (JSA), which brings together over 18 national networks committed to strengthening the Right to Health and Health Care in the country. The leadership of this Movement includes a wide variety of public health / community health oriented professionals and activists from all over the country and are slowly becoming a force to reckon with in public health policy and system development. The Charters both global and national have a series of recommendations of great significance to public health, public health system development and public health education in India and abroad. (PHM 2000 and JSA 2000) Members of the JSA are now actively involved with advocacy initiatives with the Ministry of Health and Family Welfare, Planning Commission, and other national bodies and also participating on task forces of the National Rural Health Mission and other schemes.

ii. **The South East Asia Public Health Education Institutes Network (SEAPHEIN)** is an initiative that has evolved as an outcome of the regional conference of 'Public Health in South-East Asia in the 21st century' in 1999, hosted by the IPHA which led to the 'Kolkata Declaration'. The Declaration had four major strategic directions relevant to India as well:
   a) Promoting public health as a discipline and as an essential requirement for health development in the region;
   b) Recognizing the leadership role of public health in formulating and implementing evidence-based healthy public policies;
   c) Strengthening public health by creating career structures at national, state, provincial and district levels; and
   d) Strengthening and reforming public health education and training and research.

   Five consultations have followed in the South East Asia Region in which some of the existing public health institutes in India have participated especially CMC-Vellore,; Sri Chitra, Trivandrum; AIIHPH-Kolkata; IHMR- Jaipur; and NIE-ICMR- Chennai; and more recently CHC and PHFI. These consultations have focused on:
   a) Accreditation Guidelines; (b) Curriculum structure (c) Networking (d) Future Directions; (e) Regional Guidelines for Public health education standards and accreditation (WHO-SEARO 2000, 2005 and 2006). (See Annexure –2)

This over view of development in public health/ community health education in the main stream and alternative sectors and related developments of key networks would be an eye -opener for many of us in mfc, who may have been unaware of all these diverse, plural and anarchic nature of development of public health and community health courses in India. Very few reviews or overviews are available on them except those undertaken by CHC and mentioned in this paper earlier. There is need for a more evidence based and standardized assessment of the content, methodology and relevance of all these ongoing experiments and initiatives even as we focus on the newer developments like the PHFI. Many institutions like AIIHPH, NIHFW JNU-CSM CH, CHAD–CMCV, NIE-Chennai, IRHM-Jaipur and Sri Chitra – Trivandrum – have contributed to the challenge of public health education in India. By focusing on the practitioners who have been trained by these institutions and feedback from them on the relevance of the training, we can help build an evidence based national consensus on what works and what doesn't from a people's health and a Health for All perspective. This is an urgent imperative and the MFC dialogue could be the initiator of such a process especially if we want to move from being a 'thought current' to also being an 'action current'

D) POLICY RECOGNITION OF THE 'ALTERNATIVE SECTOR' :

In 2004, CHC was invited to the First National Consultation on Schools of Public Health organized by the Ministry of Health & Family Welfare, in New Delhi, to reflect on the contributions of the alternative sector of public health / community health education in India. Taking an overview of the sector and building on all the previous studies and reports , Narayan, R (2004) identified some of the key challenges faced by the alternative sector, which included: the experience of building capacity from grass-roots workers up to reorientation and skill development of health professionals: community

capacity building including strategies for system development and demand creation; the evolution of the concept of a 'new public health' with strong focus on community dynamics, social and development determinants and alternative pedagogy: and various efforts through campaigns and movements to counter distortions and market deviations in public health policy and action.

Three recommendations were made to the policy makers and public health professionals gathered at this consultation:

5. *"Recognize alternative sector as strong public health resource in the country for training, policy action, system development and demand creation (not as 'appendage' or 'after thought');*
6. *Involve alternative sector in development of relevant / creative learning modules which could be included in the mainstream courses. The themes would include (a) social and developmental determinants (including social, economic, political, cultural and environmental factors; (b) public health policy and action; (c) public health and social science research ethics; (d) public health and community process management, etc.*
7. *Include some alternative training centres in evolving networks to strengthen public health capacity in the country, which would be offering MPH and shorter courses".*

There were some interesting outcomes of this strong plea by CHC on behalf of the alternative sector at the National Consultation:

i. In the strategic framework evolved for strengthening public health education in WHO-SEARO region entitled 'South East Asia Public Health Initiative 2004-2008 (WHO-SEARO, 2004), the following significant inclusion in the section on Partnerships shows that the demand has been taken seriously. (See box item)

Partnerships with Alternative Sector

"Many alternative institutions, both organized and informal, have been actively involved in public health work as well as public health capacity building. Sometimes, they have been termed as alternative sectors. For example, in India, the following organizations, among others have been active in public health education and training – some since the 1980s and others more recently:

- **VHAI Educational Council (diploma in community health management);**
- **Network of community health trainers: with inputs from many voluntary organizations, they have conducted short courses in community health development and management;**
- **People's Health Movement;**
- **Society for Community Health Awareness, Research and Action (CHC);**
- **Centre for Enquiry into Health and Alternatives (CEHAT)**

The list can be enriched by examples from other countries, as well as with more examples from India. These organizations have become active in public health development due to dissatisfaction with existing government-owned PH institutions, usually run by conventional Preventive and Social Medicine Departments, and also having low status for public health and increasing inequity and social exclusion. A wave of community health NGO movements have taken place to try alternative experiments and actions, and to build capacity from communities and grass root workers. Unless the national apex institutions or schools of public health recognize these alternative sectors as strong resources and involve them in training and research, a large portion of creative energy in public health will remain untapped"

Source:
South-East Asia Public Health Initiative 2004-2008, WHO-SEARO

ii. When the Public Health Foundation of India was set up in consultation with the Ministry of Health and Family Welfare, the Planning Commission and the PMO's office, in February 2004, a representative of the alternative sector of public health / community health was included as a stakeholder in the Governing Board and it is in that capacity that CHC is represented on the Governing Board. This is therefore, an opportunity for all of us in the alternative sector to engage with the initiative and make its academic, research and policy endeavours more India relevant and pro-people oriented. By this active engagement we may be successful in countering other agendas that any such multi stake holder initiative is bound to be subjected to. This opportunity rather than threat is described in the next section.

In conclusion, as we dialogue and debate on public health education in India at our mfc meeting, we should recognize the large plurality and diversity of ongoing initiatives and not just focus on one of them – however high profile. We need to identify trends including externalities and agendas and also recognize both opportunities for engagements with a wide variety of on going initiatives while at the same time evolving our own initiatives to counter 'market oriented and other trends. A great challenge would be to build up as soon as possible the India relevant pro-people public health capacity building curriculum that many centres and initiatives are talking about today.

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4.3 Reflections on 'public health teaching, learning and competency building*

For over three decades, we have facilitated teaching, learning experiences in public health, preventive and social medicine, occupational health and community health. Since the 1970s, we have had 'real life' experience and engagement with all aspects and dimensions of the topic being discussed. This includes being students of post-graduate courses in India and abroad; teaching in India for a decade in St. John's Medical College as faculty members of the department of Community Health; Ravi has been an overseas lecturer of the London School of Hygiene and Tropical Medicine (LSHTM); a visiting professor for a year each at the School in mid 80s and mid 90s; during the years in CHC evolving the 'alternative paradigm' of Community Health (the new public health) we have been involved through praxis and engagement with movements and health systems – both alternative and mainstream; and have lectured and facilitated teaching sessions in public health schools in India, and several countries. More recently, we have taught modules on public health policy and public health

system management at the National Institute of Epidemiology, Chennai and interacted with public health faculty, students and colleagues in the PHM from all over the world at conferences, the International People's Health University (IPHU) and at the annual Global Forum for Health Research (GFHR). From this more global and 'praxis' perspective, we wish to highlight issues that may be relevant for discussion.

1) Public health with a community health perspective (the new public health) is not only an attitude of mind and a perspective - but also a discipline. While an undergraduate, clinician, general practitioner or allied health professional can develop attitudes and perspectives, the discipline needs periods of discipleship to develop skills and competencies based on public health principles and methods. Public health practice requires academic rigour, the capacity to analyze a public health problem not only bio-medically and techno-managerially, but also to consider the social, economic, political, cultural, and environmental roots of the problem, and thereby evolve responses and systems that address this complexity with the involvement of the public or the community.
2) Knowledge of the discipline can be built to some extent through didactics and classroom teaching, utilizing new pedagogical approaches like problem solving methods, case studies and simulations, audio-visual aids and computer assisted learning. However what is more urgent as a prerequisite is 'hands on' learning by involvement in programmes/systems at field level. This involvement should include:
   - meeting, observing, interacting and working with the community supported by 'mentors' involved in 'public health system building' or 'public health movement building'.
   - Learning from practitioners of public health, at different levels of the system, tackling public health problems in 'real life' situations;
   - listening to their sharing in a spirit of learning and identifying the strengths, weaknesses, opportunities and threats of their action at community level, system level, or policy level.

   Teaching programmes that only include theoretical analysis both quantitative and qualitative without a live contact with the system as found in many mainstream and alternative public health educational programmes in the country continue to be less inspiring and effective.

   The Community Health Fellowship Scheme of CHC - which recently concluded its first four year phase and was externally evaluated and reported in July 2006 was based on these principles. We are confident that this method is capable of creating in young public health / community health students, a passion for this discipline. Further work is progressing to develop modules and frameworks of learning that can build further skills and capacities. CHC now has nearly 40 young people who can share about this initiative from their own diverse learning experiences.
3) The academic environment in which public health and community health skills and capacities are best developed are also environments which foster a spirit of self learning and a capacity for analysis by the student. To sharpen this skill, it is also necessary to expose students to different streams of thought, different types of public health action, and new paradigms and new approaches. This is important even if the trainers have a certain definitive point of view or preference for a certain paradigm.

   We have surprisingly discovered this more in academic environments and public health schools abroad - rather than in teaching /training centers in India (both mainstream and alternative). The culture of hierarchy together with dependency, part of our wider social traditions, prevails greatly affecting the learning process. We need to actively encourage a culture of interactive, participatory discussion; of student feedback completing the full loop of educational planning; learning that challenges gender bias, caste and class hierarchies even within our institutional ethos; and a culture that allows the teacher and taught to discover and analyze perspectives together. All these need to be internalized in training programmes, teaching methodologies, assessment and examination systems in order to produce practitioners and personal and social transformation.

4) Too much emphasis has been on placed on basic training and post graduate courses. There is need for an equal emphasis on continuing education, in-service training and distance learning since the complexity of public health challenges is changing everyday. No course however well planned or however long can cover everything that needs to be taught and every skill that needs to be developed. All public health educational institutions must build working links with public health systems, and not be confined to over-utilized, over funded, over-studied and over staffed field practice areas. The faculty can then prepare students for real life situations and not models.

This will also move faculty from theoretical analysis and / or unrealistic models to praxis based on engagement with real life systems and situations. Institutions will discover opportunities for offering short courses, distance learning modules and learning by doing.

5) We often hold on to some notions of reality based on past situation analysis and not necessarily grounded in today's complex and changing situations. We just share a few examples.
   (a) There is a continuing belief that public health /community health is still low priority in student careers choice in India. While this may be true of the 70's or 80's, the situation has changed dramatically. Many good students, keen and competent are now opting for a post graduation in public health. While cynics may link this to increasing job opportunities in international health, or to a back door entry into the US medical system (since public health courses do not require medical registration to begin with), close interaction with many students in recent years shows that this is not always true. Even if 25% of those who are starting this journey are serious, we still have the prospect of a very large number of public health professionals arriving on the scene, seeking training, research and work opportunities. Already in many schools abroad, Asians including Indians and not only NRIs are a substantial percentage of the student population. Similarly, there is the phenomena of NRIs increasing on the faculty of these schools. Both these factors are also additional pull and push factors for initiatives such as the PHFI.
      1. We have been tracking interesting public health training programmes and research projects in many parts of the world – both North and South, developed and developing countries – trying to learn from praxis everywhere. The older and new public health institutes and departments of public health in India need to be open to a wide variety of ideas which include initiatives such as the National School of Brazil; modular courses of the University of Western Cape, South Africa, which starts with rural nurses and offer credits and courses to health team members at different levels; distance learning initiatives in many countries; special courses in socio-epidemiology, inequalities in health and health care, social determinants and human rights in universities in the USA and other countries.
      2. In many parts of the world, alternative and mainstream public health professionals are also much more in dialogue with each other through professional associations and meetings unlike in India. If we, in the alternative sector feel we have evolved knowledge or alternative skills and capacities, we need to share them with the mainstream more proactively. Our recent experiences as part of the PHM team, in the World Public Health Congress at Rio or in the Global Forum for Health Research meetings since 2002 show that dialogue is possible and necessary (see report on Research Priorities for Schools of Public Health in the Global South and the Social Vaccine on the CHC and PHM website (www.sochara.org; www.phmovement.org)

Evolving a public health movement

We would like to conclude by making a plea for a public health movement in India initiated in 2006, to supplement the People's Health Movement that evolved in 2000 AD. The rationale is as follows:

a. Public health capacity building, including establishment of a stand alone public health cadre is long overdue in the country, in order to strengthen public health systems and make them responsive to complex public health challenges. The introduction of PSM in under-graduate medical education and growth of post-graduate courses in PSM have not produced enough numbers of public health physicians with adequate practical skills and capacities to tackle challenges in health and the health system, currently under further assault by neo-liberal economic policies. The issues are not of tension between generalist vs. specialists; doctors vs. health workers; primary health care vs. public health; clinicians vs. public health; communicable vs. non communicable diseases; bio medical vs social community models. These are old debates and will continue, though they mask deeper more difficult societal conditions that produce ill-health. The situation of public health and health systems is so bleak that we need action on all fronts with a strong 'new public health / community health movement' that can support 'demand creation' with a rights based perspective among the disempowered on the one hand; and support development of public policies and systems, that are responsive and relevant to the demands of the people on the other. In other words, a pincer strategy is required for a public health movement and a

public health system development policy initiative. It is only when this complexity is understood in the context of today's political economy of health that these debates will lead to concrete action. Already many people's health movement activists have dual involvements – proactive watching as well as critical engagement.

b. Today's complexity also requires that the focus of attention is not just on PHFI and its emerging institutions and initiatives however high profile they may be in the media – but on all the ongoing and evolving initiatives in educational, strategies for public health and community health in India – subjecting them to the same questions and scrutiny, reviewing their relevance, contribution, lessons learnt through their experience, and their potential contribution or continued irrelevance to the new challenges.

The questions we are asking of PHFI are also questions that we should be asking ourselves in the context of the pre-PHFI developments in HRD in India in both the mainstream and the alternative sector. Have any of our initiatives made a significant difference?

c. In the current market place that prevails in policy and system development, and with the dialectics of medial tourism vs the National Rural Health Mission, this debate needs to move from radical spaces to critical engagement. This engagement could be through a public health watch and a public health movement that tackles the continuing lacunae of human resources for Health for All in the country.

d. A few years before the national and global people's health assemblies and the adoption of the Indian and Global People's Charter for Health, CHC identified a 12 point agenda for action to strengthen health human resource development in the country to counter the disturbing and distorting trends evident in the 1990s. These included:

- Banning medical college expansion;
- Strengthening MCI – making it more professional and socially oriented;
- Setting up a National Human Power Development Commission with a strong multi-disciplinary focus to evolve need based and evidence based change;
- Strengthening existing medical education efforts including medical education cells and social and community orientation;
- Examination reforms towards rational and ethical systems;
- Promoting creative autonomy for experimentation towards primary health care, community health and general practice;
- Strengthening continuing education of health and allied professions involving IGNOU approaches and expertise;
- Strengthening public health capacity building and development of public health cadre;
- Research in health human power development including implications of privatization, brain-drain and new economic policies;
- Regulation of privatization and commercialization of medical education and health;
- Promoting training of health worker training ; and finally,

strengthening the movement dimension of health which in 1997, we had defined as follows: *"What is needed is a strong countervailing movement initiated by health and development activists, consumer and people's organizations that will bring health care and medical education (including public health education) and their right orientation high on the political agenda of the country"*

Since 2000 AD, the People's Health Movement in India (*Jan Swasthya Abhiyan*) has developed as this emerging countervailing movement in which we all are actively involved. What is also needed urgently is an alternative public health network that brings together all those united in their concerns for public health capacity building - both civil society networks like JSA, MFC or professional associations like the Indian Association of Preventive and Social Medicine (IAPSM), Indian Public Health Association (IPHA), INCLEN and other alternative training groups. An active engagement with initiatives such as NRHM, PHFI, SEAPHEIN as well as with social movements are part of the challenges and opportunities ahead.

Can the mfc meeting in December 2006 or the second National Health Assembly in March 2007 be the starting point for such a network – the Public Health Movement of India to complement and strengthen the people's health movement? Our inaction or failure to move beyond discussion in radical spaces to offer concrete, well defined alternatives may be the greatest threat of all. This is the imperative before us.

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* * *

5. PUBLIC HEALTH IN INDIA SCORE (WWW.COMMUNITY.IN)

PUBLIC HEALTH IN INDIA – SCORE

SOCHARA-SOPHEA

What is your PHIN – SCORE?

Note: This compilation of key documents, reports, publications, experiments, events and initiatives covers most of the important aspects of Public Health Policy and System Development in India since Independence.

- As a staff / faculty member of a school of public health and or ngo/ institution / network involved in public health education, research, system development, policy advocacy and community health action, it is necessary to be aware of all these important and historical contributions to India relevant public health.
- The list covers ten groups of resources and ten key items in each. Together they form a list of hundred resources that every public health professionals or activist in India should be aware of.
- You are invited to tick these hundred items and find your PHIN Score (Public Health in India score). You should tick this item only if you feel you can actually share the key features or describe the significance / content of the document / item to another colleague or to your students. Just knowing the name or having heard vaguely about it is not enough.
- If you cannot tick some of the items then write to us for another complementary document that gives you web reference for each of these items. (cphe@sochara.org, or clic@sochara.org)
- This effort is not to find out whether you have a high or low score but to encourage you to improve your score so that your team member, students, fellows and others will be oriented to India relevant Public Health through your informed writings, reflections, teaching and learning facilitation.
- This self assessment score sheet has been tested out on a series of postgraduates in public health, preventive and social medicine, and fellows and ngo staff members from various organizations. We thank them for their participation in the test run of this document and for all the suggestions given.
- We hope you have enjoyed participating in this small self assessment score sheet that we are releasing to support team/ faculty / institutional development in Public Health in India. From time to time we hope to update this list or add supplementary/complementary lists to enhance the India relevant context and focus in all our efforts.

- Please note that all the documents/publications that we considered significant for evolving the score were not available always on the internet. We have currently included shortnotes/reviews in the list of web references prepared by us as supplementary documents. We are making efforts to scan the originals with permission where required and hope to constantly update the score and the reference list.

- The score may be used freely by all crediting SOCHARA and ensuring that we receive information about this use, to continue producing revised and updated scoring instruments. These communications may be sent to clic@sochara.org or cphe@sochara.org.

10/1/2013.

Team CPHE – SOCHARA

(Ravi Narayan, Deepak Kumaraswamy, HRM Swamy, Lalit Narayan, Prashanth NS.)

A. POLICY DOCUMENTS

	PHIN Score
1. National Health Policy (GOI-1983).	☐
2. National Education Policy (GOI-1986).	☐
3. National Education Policy for Health Sciences (GOI-1989).	☐
4. National Population Policy (GOI-2000).	☐
5. National Health Policy (GOI-2002).	☐
6. National Policy and Programs on Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (GOI-2002).	☐
7. National Pharmaceutical Policy (GOI-2002).	☐
8. Karnataka State Integrated Health Policy (GOI-2003).	☐
9. National Rural Health Mission (GOI-2005 – 2012).	☐
10. National Knowledge Commission Repot of Working group on Medical Education and Community Health (GOI-2007).	☐

B. EXPERT COMMITTEE REPORTS

	PHIN Score
1. Health Survey and Development Committee (Bhore, 1946).	☐
2. Health Survey and Planning Committee (Mudaliar, 1961).	☐

3.Report on Multipurpose Workers (Kartar Singh, 1973).

4. Report on Medical Education and Support Manpower (Srivastava, 1974).

5. Report of the Committee on Drugs and Pharmaceutical Industry, Ministry of Petroleum and Chemicals, GOI. – (HATHI committee, 1975).

6. Health For All: An alternative Strategy (ICSSR- ICMR, 1981).

7. Report of the Expert Committee on Public Health Systems (Draft-GOI-1996).

8. Report of the National Commission on Macroeconomic and Health (GOI-2005).

9 Annual Report to the People on Health (MOHFW - GOI, 2010).

10. High Level Expert Group Report on Universal Health Coverage for India- (GOI-Planning Commission-2010).

C. KEY MONOGRAPHS / REFERENCE BOOKS

PHIN Score

1. Alternative Approaches to Health Care, (ICMR – 1976).

2. Evaluation of Primary Health Care Programmes, (ICMR – 1980).

3. Appropriate technology for primary health care, (ICMR-1981).

4. Health and Family Planning Services in India: An Epidemiological,Socio-Cultural and Political Analysis a Perspective, (Banerji, D. 1985).

5. Experiences in Community Health, (Anubhav Series) (VHAI / Ford Foundation – 1987).

6. State of India's Health Report (VHAI – 1992).

7. Report of the Independent Commission on Health in India, (VHAI – 1997).

8. Towards Equity, Quality and Integrity in Health – Report of the Task Force on Health and Family Welfare, (Govt. of Karnataka. 2001).

9. Review of Health care in India (CEHAT-2005)

10. Report: Task force on Medical education for The National Rural Health Mission, (MoHFW-GOI-2006).

D. ALTERNATIVE SECTOR – KEY PUBLICATIONS

1. In Search of Diagnosis: Analysis of the Present System of Healthcare (Patel, A. 1977) ☐
2. Poverty, class and health culture in India, (Banerji. D, 1982) ☐
3. Health Care Which Way to go?: Examination of issues and alternatives, (Bang, A & Patel A, -1982). ☐
4. Rakku's Story: Structures of ill-health and the source of change,(Zurbrigg, S, 1984). ☐
5. Under the Lens – Health and Medicine, (Rao, Kamala. & Patel, Ashwin. 1985). ☐
6. Taking Sides: Choices before health worker, (Sathyamala. C et al, -1986). ☐
7. Medical Education Re-examined, (Mankad, Dhruv. 1991). ☐
8. People's Health in People's Hands – A model for panchayati raj, (Antia, N.H. and Bhatia, K – 1993). ☐
9. Health for All Now!: The People's Health Source Book, (JSA 2000). ☐
10. The Rights Approach to Health and Health Care – A compiled review- 2007. ☐

E. GOVERNMENT /NATIONAL PROJECTS EXPERIMENTS

1. Narangwal Project. ☐
2. Najafgarh Project. ☐
3. Singur Project. ☐
4. Gandhigram Insitute of Rural Health and Family Welfare. ☐
5. Chittaranjan Mobile Hospitals. ☐
6. ROME Scheme (Reorientation of Medical Education). ☐
7. Expanded Program of Immunization. ☐
8. Integrated Disease Surveillance Programme. ☐
9. Janswasthya Rakshak – Janata Scheme. ☐
10. State Health Systems Resource Centre- Mitanin ☐

F. INSTITUTES OF PUBLIC HEALTH SIGNIFICANCE (NATIONAL)

1. All India Institute of Hygiene and Public Health, Kolkatta. ☐
2. Centre for Social Medicine and Community Health, JNU, New Delhi. ☐
3. Malaria Research Centre/ National Institute of Malaria Research. ☐
4. National Health Systems Resource Centre (NHSRC), New Delhi. ☐
5. National Institute of Communicable Diseases, New Delhi. ☐
6. National Institute of Epidemiology –Chennai. ☐
7. National Institute of Health and Family Welfare, New Delhi. ☐
8. National Institute of Nutrition, Hyderabad. ☐
9. National Institute of Occupational Health, Ahmadabad. ☐
10. National Tuberculosis Institute, Bangalore. ☐

G. PUBLIC HEALTH/COMMUNITY HEALTH RESOURCE CENTRES / NETWORKS (ALTERNATIVE SECTOR)

1. Anusandhan Trust (CEHAT, Mumbai; SATHI, Pune. and CSER, Mumbai). ☐
2. All India Drug Action Network (AIDAN) ☐
3. Catholic Health Association of India, Secunderabad, (CHAI). ☐
4. Christian Medical Association of India, New Delhi, (CMAI). ☐
5. Foundations for Research in Community Health, Mumbai, (FRCH). ☐
6. Jan Swasthya Abhiyan, (People's Health Movement, India). ☐
7. Medico friend circle, (mfc). ☐
8. Public Health Resource Network, India, (PHRN). ☐
9. Society for Community Health Awareness, Research and Action, Bangalore. (SOCHARA) ☐
10. Voluntary Health Association of India, New Delhi. (VHAI). ☐

H. EVENTS/DEVELOPMENT OF PUBLIC HEALTH SIGNIFICANCE (Mainstream)

1.The Calcutta Declaration – 1999 ☐

2. South East Asia Public Health Education Information Network, SEARO – 2003, (SEAPEN) ☐

3. National Consultation on Institutes of Public Health in India – 2004 ☐

4. NRHM – Advisory Group for Community Action (AGCA)-2005 ☐

5. Public Health Foundation of India (PHFI) – 2006 ☐

6. Public Health Global Network, (PHGN) New Directions for Public Health Education in Low and Middle Income Countries' 2008 ☐

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8. National Consultation on Public Health Workforce –WHO India Office, 2009. ☐

9. Indian Public Health Standards, NRHM – 2010. ☐

10. Indian Public Health Association (IPHA) and Indian Association of Preventive and Social Medicine (IAPSM). ☐

I. EVENTS/DEVELOPMENT OF PUBLIC HEALTH SIGNIFICANCE (Civil Society)

1. Indian People's Health Charter, 2000. ☐

2. Community Health Environment Skill Shares (CHESS) – 2002. ☐

3. The Mumbai Declaration- 2004. ☐

4. Pre Election Policy Briefs/ Health Manifestos for 2004 & 2009. ☐

5. National Human Rights Commission –Right to Health Initiative including Peoples Health Tribunals-2004. ☐

6. The Second National Health Assembly-2007. ☐

7. Learning Programmes for Community Health and Public Health- Report of a National Workshop. -2009. ☐

8. People's Rural Health Watch -2009. ☐

9. South East Asia Regional Conference on Epidemiology-WHOSEARO/IEA-2010. ☐

10. Community health Wikipedia-2010.

J. GLOBAL EVENTS /DEVELOPMENTS THAT HAVE A NATIONAL CONNECTION /LINKAGE

1.Alma Ata Declaration - WHO UNICEF – (1978)

2.Ottawa Charter on Health Promotion - (1986)

3.World Development Report – Investing in Health (1993)

4.Millennium Development Goals - (1999)

5.People's Charter for Health of PHM –(2000)

6. Commission on Macro Economics and Health (CMH)-2003

7. Global Health Watches –I (2005) and II – (2008) and III- (2011)

8. International People's Health University (IPHU) – (2005)

9. The World Health Report,- Primary Health Care- Now More Than Ever-(2008)

10. WHO Commission on Social Determinants of Health (WHO CSDH) (2008)

Count the ticks to get your score

Date: **Total Score** ? /100

Now check the list of internet references available on line from www.communityhealth.in and or www.sochara.org

6. COMMUNITY HEALTH LEARNING PROGRAMME OF SOCHARA: 52 Week Curriculum

COLLECTIVE -1 (8 Weeks)Week:1-8	THEMES
Week-1	**C01-BUILDING BLOCKS FOR FELLOWSHIP - LEARNING TOGETHER**
	Understanding oneself - intra personal and Inter personal skills
	Inside learning, outside learning, learning skills, social skills and self-learning
	What is Health? Physical, Mental, Social, Economic, Political, Cultural, Ecological. Differentiating Health and Medical Paradigms
	Values: Equity, rights, gender, social justice, inclusiveness, respect for local health culture, solidarity, secularism
	Perspective on self-transformation while engaging in social action
Week-2	**C02-UNDERSTANDING COMMUNITY/ SOCIETY / DEVELOPMENT AND HEALTH**
	What is community, society, family, collective, cooperative
	Class, caste, gender, social exclusion, marginalization
	Structures, stratification, power dynamics, conflicts, transitions
	Understanding dalit issue; adivasi issue; agrarian distress;
	Community dynamics, perceptions, mobilization, capacity building
Week-3	**C03-UNDERSTANDING COMMUNITY HEALTH/ PUBLIC HEALTH - PRINCIPLES AND AXIOMS and Primary Health Care**
	Community Health, Public Health, Community Medicine, Preventive and Social Medicine
	Social, economic, political, cultural, ecological determinants of health and their inter relationships and dynamics
	Axioms and principles of Community Health
	History and relevance of comprehensive primary health care and strategy / approach towards health for all
	Learning from community health initiatives and action for health
Week-4	**C04-SITUATION ANALYSIS OF HEALTH AND HEALTH CARE IN INDIA**
	Situation Analysis of Health and Health Determinants in India
	Regional Disparities and inequalities, trends
	Understanding Health care sectors - public, private, voluntary tradition, people sector and local health tradition – strengthens / weaknesses
Week-5	**C05-SOCIAL DETERMINANTS OF HEALTH AND SOCIAL ACTION**
	Social Determinants of Health, action on determinants and social vaccine
	Environmental Sanitation and Community led total sanitation
	Environmental and Health
	Culture and health and cross cultural dialogue

Week-6	**C06-GLOBALIZATION AND HEALTH**
	Political economy of health and forces of liberalization, privatization and globalization
	What is Globalization and its impact and consequences and health and equity
	Challenge of equity – geographical, gender, social exclusion and marginalization
	Challenges: Social Dimension, Health Equity, Health Policy, Access to Health, Disease Risks, Patents, Trade and Health, Technology
	Globalization Risks, Responses, Alternatives and solidarity from below (PHM)
Week-7	**C07-RESEARCH- I – Measuring Health and Disease**
	Measuring Health and Disease - why and how
	Basic Biostatics : Concepts and Tools
	Summarizing data- tables, graphics, Pie-charts, Maps, Bar Charts, Line Graphs, Frequency distribution
	Defining health, Measuring disease frequency
	Summarising numbers: mean, mode, median, variances, standard deviation
Week-8	**C08-HEALTH SYSTEMS AND HEALTH POLICY – (3 days)**
	Health systems and health policy in India - history and evolution
	Health system at different levels – local, district, state, central
	Issues of access acceptability, affordability, availability, quality
	CONSOLIDATING FELLOWSHIP PLAN – (3 days)
	Planning the fellowship learning journey
	Goal Setting objectives and learning framework
	Interaction with mentor and planning field work
FIELD WORK-I (8 Weeks) Week:9-16	**FW1-UNDERSTANDING COMMUNITY** (Understanding and describing a community, Understanding community priorities, Understanding the field placement organisation and their projects Social determinants of health and Intersectoral collaboration, Framework for a Situational Analysis, Health Care Providers and Medical Pluralism Understanding NRHM and Communitization, Understanding Mental Health)
COLLECTIVE-II (4 Weeks) Week: 17-20	**THEMES**
Week-17	**C09-NUTRITION, and WOMEN and CHILDRENS HEALTH**
	Understanding Nutrition & Food Security
	Understanding Women's Health (beyond RCH)
	Understanding Child Health
	Understanding Adolescent Health and Life Skill Education
Week-18	**C10-COMMUNICABLE DISEASES– Community health responses**
	TB/Malaria/ HIV/AIDS
	Water borne diseases
	Vector borne diseases – Malaria, Dengue, Filaria and other diseases
Week-19	**C11-RESEARCH-II – Epidemiology (data and responses)**
	Basic Epidemiology - What / Who/ When/ Where/ Why/ How
	Epidemiological perspective and understanding data
	Analysis of situation and data and response

	Understanding steps in research
Week-20	**C12-NON-COMMUNICABLE DISEASES - Community health responses**
	Heart Disease/ Stroke/ Diabetes
	Mental Health and Substance abuse
	Cancer/ Accidents etc
	Risk reduction, life style change, prevention and promotion
Field Work-II (8 Weeks) Week: 21- 28	**FW2-UNDERSTANDING COMMUNITY HEALTH APPROACH TO A PUBLIC HEALTH PROBLEM** (learning and reflective on the community health axioms)
COLLECTIVE-III (4 Weeks) Week: 29-32	**THEMES**
Week-29	**C13-HEALTH TECHNOLOGY AND INNOVATION**
	Understanding rational drug policy and prescription, pharmaceutical policy
	Immunization challenges, policy and action
	Appropriate Technology and innovation
	Information and communication technology (ICT)
Week-30	**C14-EQUITY IN HEALTH**
	Promoting community mental health and intervention
	Understanding Social Exclusion/ Marginalisation including stigma and discrimination
	People with Disability
Week-31	**C15-RESEARCH- III- DESIGN AND METHODS**
	Qualitative Methods in research
	Quantitative Methods in research
Week-32	**C-16OCCUPATIONAL HEALTH AND URBAN HEALTH**
	Occupational health of workers – organized and unorganized
	Social security and social protection and occupational safety
	Urbanization and urban health challenges
	National Urban Health Mission
FIELD WORK-III (9 Weeks) Week:33-40	**FW3-CONDUCTING FIELD STUDY/COMMUNITY HEALTH ACTION**
FINAL COLLECTIVE (10 Weeks)Week:41-49	**THEMES**
Week-41	**C17-HEALTH POLICY**
	Understanding health policy process
	Understanding health policy history and current situation
	Primary Health Care and Health For All
	Universal Health Coverage
Week-42	**C18-PUBLIC HEALTH MANAGEMENT**
	Understanding Systems and Management Principles
	Public Health Management at community and district levels
	Managing partnerships with community and other sectors
	Health research project- planning basic steps

Week-43	**C19-RESEARCH IV**
	Participatory Action Research
	Knowledge Translation and Advocacy
Week-44	**C20-HEALTH MOVEMENTS, SOCIAL MOVEMENTS AND SOCIAL CHANGE**
	Community Health Movement in India and Networking
	People's Health Movement (Global, National and State Levels), GHW and IPHU
	Social Movements and Social Change (beyond PHM)
	Community action for accountability including monitoring , health watches, people's tribunals (COPASAH)
	Decentralization in health and panchayat raj
Week-45	**C21-SPECIAL CHALLENGES**
	Climate Change and Health
	AYUSH and Public Health – Challenges and Opportunities including LHTs
	War / conflict / disaster / displacement
	Agrarian Distress and Farmers Suicide
Week-46	**C22-RIGHT TO HEALTH**
	Right to Health and Health Care, entitlements and fundamental human right
	Constitutional and legal aspects of health
	Ethics of health and health care
Week-47	**C23-HEALTH ECONOMICS**
	Health Equity and Universal Health Coverage
	Basics of Health Economics including Health Financing, Budget analysis
	Community Financing and insurance
Week-48	**C24SPECIAL COMPETENCIES – I**
	Leadership
	Governance and Decentralization
	Partnership and Advocacy
Week-49	**C25SPECIAL COMPETENCIES – II**
	Communication including informatics
	Monitoring and Evaluation
	Conflict Resolution
Week-50-52	**FINAL ASSESSMENT AND PLAN FOR NEXT STEPS / FINALIZATION OF REPORTS** (see FA-1, FA-2)
	THE BEGINNING OF COMMUNITY HEALTH JOURNEY

25 Week of collective teaching learning
24 weeks of field work
3 week final assessment and next steps
Total 52 Weeks

7. COMMUNITY HEALTH ORIENTED, COMPETENCY BASED MODULES BY SOCHARA FOR TRAINING IN INDIA (RGIPH-MPH HONORS COURSE)
7.1 VALUES ORIENTATION IN PUBLIC HEALTH
7.2 SOCIO-CULTURAL AND COMMUNITY HEALTH
7.3 PLURAL HEALTH SYSTEMS

Community Health Oriented, Competency based Special Modules for Community/Public Health/Social Work Training in India

Introduction

The Community Health Learning Programme (CHLP) of SOCHARA is an interactive, participatory, person centric, field based programme which has evolved since 2003. It caters to young people from multi-disciplinary backgrounds wanting to explore community health and take-up practice of community health as a career.

The Rajiv Gandhi University of Health Sciences established the Rajiv Gandhi Institute of Public Health and Centre for Disease Control (RGIPH&CDC), Bengaluru in 2013 and SOCHARA was invited to be part of the Advisory Committee to evolve a three year Masters of Public Health (Honors)[i] course to be recognised by University Grants Commission and to be an innovative, India relevant training with some special additional modules and features. Two members of SOCHARA (Drs. Ravi Narayan and Rahul ASGR) were part of the Advisory Committee and based on a review of syllabus of existing MPH courses in India identified areas lacking in these and introduce some additional competency based modules and re-orient some existing ones through a consultative process.

SOCHARA was then requested to develop the syllabus for some of these unique modules and different team members contributed to evolving them in designated framework suggested by RGIPH.

These modules were developed incorporating ideas and experiences of the ongoing Community Health Learning Programme and were submitted to RGIPH for their use and further modification/adaptation based on teaching-learning experience for different batches. SOCHARA is uploading these modules to its website, www.SOCHARA.org. so that other community/public health learning programmes and courses can use and adapt it according to their needs and contexts:

1. **Values Orientation in Public Health (Contributors - Ravi Narayan, Thelma Narayan and Prasanna Saligram)**
2. **Socio-Cultural and Community Health**
3. Universal Health Policy
4. Ecological Sensitivity
5. **Plural Health Systems**
6. Global and International Health
7. Public Health Capacity Building
8. Research Competency

Each of these modules is available separately on the website.

[i] Rajiv Gandhi Institute of Public Health and Centre for Disease Control. Ordinance Governing Master of Public Health (Honors) Regulations and Curriculum. Karnataka: Department of Public Health Rajiv Gandhi University of Health Sciences; 2014

SOCHARA
May 2016

7.1 COURSE ON VALUE ORIENTATION IN PUBLIC HEALTH

(5 Credits, 3 Weeks Teaching Learning with 14 days of sessions)

VALUE ORIENTATION IN PUBLIC HEALTH	
• Right to Health • Equity and health • Gender and health • Ethics/integrity and health • Quality in health	• Lectures and lecture discussions • Case scenarios • Student presentations • Journal Club **Source: RGUHS - MPH (Hons) Regulations and Curriculum (2014)**

1. OBJECTIVES

a. **To understand and appreciate the values dimension in public health**

b. **To be able to apply these values**

   i. **in the practice of public health**

   ii. **Programmes related to achievement of Health for All**

c. **To appreciate the challenges in the application of these values**

2. SPECIFIC OBJECTIVES

To explore, appreciate and apply the following value dimensions in Public health practice:

a. **Right to Health**

b. **Equity in Health**

c. **Gender equality**

d. **Ethics and Integrity**

e. **Quality in public health**

3. ASSESSMENT

a. Formative Assessment- based on participation in group discussions and critical reading sessions

b. Summative- Written test with short questions and case scenarios

4. EVALUATION

Participants will evaluate the sessions and programs of the above module, especially regarding the topics, quality of content, delivery of content and assessment

5. ORGANISATION

a. General introduction and exploration of documents- 2 days

b. Right to Health – 3 days

c. Equity and health- 3 days

d. Gender and health- 3 days

e. Ethics/integrity and health- 3 days

f. Quality in health- 3 days

g. Assessment- 1 day

(Three days for each value includes lecture discussions, Critical reading, Student presentations, Group discussions)

6. **SCHEDULE based on experience of 2014-17 batch of RGIPH which incorporated the 5th National Bio-ethics Conference sessions into it as part of learning of Ethics/integrity in health – (Can be adapted further according to context, situation and available resource persons)**

Day One		
Time	**Theme**	**Method**
10 am – 1 pm	Introduction to Values and their role in public health practice Review key documents to identify values • Alma Ata Declaration • National Health Policy 2002 • Peoples Health Charter 2000 • NRHM Mission Statement 2005	Interactive Discussion
1.30 pm – 3.00 pm	**EQUITY AND HEALTH:** • Understanding equity and equality • Inequalities in health status, access to healthcare and services, and health enhancing environments; • Inequities due to geography, gender, marginalization and social exclusion	Lecture Discussion
3.15 pm – 4.30 pm	Case studies on Equity Challenges in Bhopal, CHESS and Environmental Health	Case Study
Day Two		
10 am – 1 pm	**EQUITY AND HEALTH(continued)** An introduction to Equity gauge: • Measuring equity, indices and equity stratifiers • Equity lens, equity gauges, equity assessment, equity oriented health system and health equity audits	Lecture Discussion
1.30 pm – 4.30 pm	Case Study on Regional Disparities in Health in Karnataka (2001) Planning Exercise on Equity and regional Inequalities in Health in Karnataka – Current (DLHS 2012-13)	Presentation and planning exercise
Day Three		
10 am to 5 pm	Field visit to Ayush Grama, Gollahalli, Devanahalli Taluk (field practice area of I-AIM) to explore the community context of the values – Right to Health, Equity in Health., Gender equality, Ethics and Integrity, Quality in public health (Or any other suitable community field practice area can be chosen)	Group discussions with the community – each student will focus on one value and two on quality (Anganwadi Centre and Health Centre)
Day Four, Five and Six		

Refer to programme	Attend National Bio-ethics Conference at St Johns National Academy for Health Sciences. An indicative list of public health oriented plenaries and parallel sessions (workshops and presentations) will be given to the students to guide their participation. Workshops to attend: 1. Corruption in healthcare- Working towards solutions 2. Professional and civil society perspectives on challenges and approaches in ethical practice of occupational health in India 3. Accountability for Reasonableness: Addressing Challenges in Public Health by Harmonizing Ethics, Economics & Evidence 4. Public Health Ethics 5. Policy Ethics and Just Health Systems: The Pursuit of People-Centred Care 6. WHO session on integrity and corruption in healthcare Plenaries for later discussion: 1. Day 1- PLENARY – I: Keynote address -2 2. Day 2- PLENARY – III: Keynote address-1,2 and 3 3. Day 3- PLENARY – V: Keynote address 1 and 2	All students will be allotted certain sessions or presentations to focus on and present summaries at debriefing session indicated later in the schedule.
	Day Seven	
10 am – 1 pm	**GENDER AND HEALTH:** • Understanding gender, roles, unequal social and economic variables and power • Gender inequity including vulnerabilities, nature-severity and symptoms of health problems, health seeking behaviour and long term health and social consequences • Global issues related to gender	Lecture Discussion
2.00 pm – 3.00 pm	• Victoria Hospital - Burns report: Gender and Epidemiological Perspective • Gender, Sanitation and Mental Health- A study	Case study Case study
3.15 pm – 5.00 pm	Group discussion on Gender and Health- Challenges in Public Health and Primary Health Practice (From participants perspective)	
	Day Eight	
10 am – 1 pm	**GENDER AND HEALTH (continued)**	Lecture

	• Gender discrimination and violence against women • Legal aspects related to gender • Developing gender sensitivity through a gender lens	Discussion
1.30 pm – 4.30 pm	**Debriefing on Ethics and Integrity in Health (NBC)**	Presentation of student assignments and summaries
	Day Nine	
10 am – 1 pm	**RIGHT TO HEALTH-1:** • The Right to Health and Health Care including theoretical perspectives, political economy of assault on health, paradigm shift from charity to rights,	Lecture Discussion
1.30 pm – 3.15 pm	**RIGHT TO HEALTH-2:** • Universal Declaration on Human Rights and the International Covenant on Economic, Social and Cultural Rights and the emerging rights language in various international declarations.	Lecture Discussion
3.30 pm – 4.30 pm	**RIGHT TO HEALTH-3:** The Right to Health movement at national, regional and international level.	Lecture Discussion
	Day Ten	
10 am – 1 pm	Reviewing the Universal Declaration on Human Rights and the International Covenant on Economic, Social and Cultural Rights	Review
1.30 pm – 4.30 pm	**QUALITY IN HEALTH-1:** • Understanding dimensions of quality, tools of quality assurance, standards • Quality improvement programs, quality circle and accreditations • Balancing quality and equity	Lecture Discussion
	Day Eleven	
10 am – 1 pm	**QUALITY IN HEALTH -2:** • Understanding current standards – Reviewing Indian Public Health Standards (NHM) with exercises	Review and exercises
1.30 pm – 4.30 pm	- National Accreditation Board for Hospital standards - Understanding standards under Clinical Establishments Act	Review and exercises
	Day Twelve	
10 am – 1 pm	Case Discussion of sterilisation deaths in Chhattisgarh and exploring the compromise in	

	all the five values- Right to Health, Equity in Health., Gender equality, Ethics and Integrity, Quality in public health	
Day Thirteen		
10 am – 4.30 pm	**Seminar based on journal articles on all the values. Each student will be allotted one article. Session 1(Values: Philosophy, relevance and guidelines)**	Presentation of one paper each by the students
Day Fourteen		
10 am – 1 pm	**Summative Assessment- Written test with short questions and case scenarios**	

7. LEARNING RESOURCE MATERIAL

I. Exercises and journal club

a. Values Exercise

i. World Health Organization. Alma Ata Declaration. Geneva World Health Organ. 1978. Available at: www.who.int/publications/almaata_declaration_en.pdf

ii. National Health Policy-2002. Government of India. Available at: http://mohfw.nic.in/showfile.php?lid=2325

iii. People's Charter for Health. Peoples Health Movement. Available at: http://www.phmovement.org/en/resources

iv. A Promise of Better Healthcare Service for the Poor. National Rural Health Mission. Ministry of Health and Family Welfare. Government of India. Available at: www.chsj.org/uploads/1/0/2/1/10215849/entitlement_english.pdf

b. Review Exercise for Rights

i. The Universal Declaration of Human Rights. Available at: http://www.un.org/en/documents/udhr/

ii. International Covenant on Economic, Social and Cultural Rights. Available at: http://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

c. Understanding current standards

i. Indian Public Health Standards. Available at: http://nrhm.gov.in/nhm/nrhm/guidelines/indian-public-health-standards.html

ii. National Accreditation Board for Hospitals & Healthcare Providers - See more at: http://www.nabh.co/Index.aspx#sthash.MuMqH0Fw.dpuf

iii. Draft Minimum Standards. The Clinical Establishments (Registration and Regulation) Act, 2010. Available at: http://clinicalestablishments.nic.in/cms/Home.aspx

d. For Journal Club

i. Session 1(Values: Philosophy, relevance and guidelines)

1. Stewart KA, Keusch GT, Kleinman A. Values and moral experience in global health: Bridging the local and the global. Glob Public Health. 2010;5(2):115–21.
2. Jesani A, Barai T. Ethical guidelines for social science research in health. Mumbai Centre for Enquiry into Health and Allied Themes. 2000
3. Mann JM, Gostin L, Gruskin S, Brennan T, Lazzarini Z, Fineberg HV. Health and human rights. Health Hum Rights. 1994;6–23

ii. **Session 2(Values: Evidence gathering and analysis)**

4. Babu GR, TN S, Bhan A, Lakshmi JK, Kishore M. An appraisal of the tuberculosis programme in India using an ethics framework. Indian J Med Ethics.2014;11(1):12-15
5. Subramanian S, Nandy S, Irving M, Gordon D, Lambert H, Smith GD. The mortality divide in India: the differential contributions of gender, caste, and standard of living across the life course. Am J Public Health. 2006;96(5):818.
6. Roy T, Kulkarni S, Vaidehi Y. Social inequalities in health and nutrition in selected states. Econ Polit Wkly. 2004;677–83.

II. Basic Reading

a. Values(General)

i. Public Health Management at District Level - Concepts and Values. A hand out from the project on "Integrated management of public health programmes at district level. SOCHARA-SEARO
ii. Issues of concern and an agenda for action. Towards Equity, Quality and Integrity in Health: Final Report of the Taskforce on Health & Family Welfare. Government of Karnataka; 2001:xv-xxiv
iii. Macinko J, Montenegro H, Nebot Adell C, Etienne C. Renewing primary health care in the Americas. Revista Panamericana de Salud Pública. 2007

b. Right to Health

i. Shukla A. The Rights Approach to Health and Health Care- A Compiled Review. MASUM Publications; 2007
ii. London L. What is a human rights-based approach to health and does it matter? Health Hum Rights. 2008;10(1):65-80

c. Equity and health

i. Feachem RG. Poverty and inequity: a proper focus for the new century. Bull World Health Organ. 2000;78(1):1–2.
ii. Anand S. The concern for equity in health. J Epidemiol Community Health. 2002;56(7):485.
iii. Braveman P, Gruskin S. Defining equity in health. J Epidemiol Community Health. 2003;57(4):254–8.
iv. Global Equity Gauge Alliance, Concepts and Definitions, Available from http://www.gega.org.za/concepts.php

d. Gender and health

i. Garcia-Moreno C. Gender and health: Technical Paper. Geneva World Health Organ. 1998;
ii. Narayan T. Gender and power issues in medical education. Gender and Medical Education : Report of National Consultation and Background Material. Eds: Jesani A and Neha M. Centre for Enquiry into Health and Allied Themes, Mumbai: 2002
iii. World Health Organization. Integrating gender perspectives in the work of WHO: WHO Gender Policy. 2002;
iv. Gaitonde R. Community medicine: incorporating gender sensitivity. Econ Polit Wkly. 2005;1887–92

e. Ethics/integrity and health

i. Macer DRJ. A cross-cultural introduction to bioethics. Eubios Ethics Institute Prakanong, Bangkok, Thailand; 2006
ii. Jesani A, Barai T. Ethical guidelines for social science research in health. Mumbai: Centre for Enquiry into Health and Allied Themes. 2000
iii. Ethical Guidelines for Biomedical Research on Human Participants. Indian Council for Medical Research. New Delhi: 2006
iv. Timms O.

f. Quality in health

i. Quality concepts and tools. Quality and accreditation in health care services: a global review. World Health Organization, Geneva: 2003;51-102
ii. Gupta JP and Sood AK. Quality of Care in Contemporary Public Health: Policy, Planning, Management. Apothecaries Foundation: New Delhi, 2005: 2.57-2.61
iii. Richard KS. Quality Assurance and Quality Improvement in Public Health and Preventive Medicine. Eds: Rober Wallace. McGraw Hill Medical: New York, 2008: 1277- 1280

III. Additional Reading

a. Values(General)

i. Confronting Commercialization of Health Care! Towards the Peoples Health Assembly Section-5. National Coordination Committee, Jan Swasthya Sabha; 2000
ii. Benatar SR. Moral imagination: The missing component in global health. PLoS Medicine. 2005;2(12):e400.
iii. Stewart KA, Keusch GT, Kleinman A. Values and moral experience in global health: Bridging the local and the global. Global public health. 2010;5(2):115–21.

b. Right to Health

i. Mann JM, Gostin L, Gruskin S, Brennan T, Lazzarini Z, Fineberg HV. Health and human rights. Health Hum Rights. 1994;6–23.
ii. International Dual Loyalty Working Group, Physicians for Human Rights (US), University of Cape Town. School of Public Health, Primary Health Care. Dual loyalty & human rights in health professional

practice: proposed guidelines & institutional mechanisms. Physicians for Human Rights; 2002.
iii. The assessment of the Right to Health and Healthcare at the country level. A People's Health Movement Guide; 2006

c. Equity and health

i. Sen G, Iyer A, George A. Structural reforms and health equity: a comparison of NSS surveys, 1986-87 and 1995-96. Econ Polit Wkly. 2002;1342–52.
ii. Sen A. Why health equity? Health Econ. 2002;11(8):659–66.
iii. Gupta I, Datta A. Inequities in health and health care in India: can the poor hope for a respite. Inst Econ Growth: Delhi Univ. 2003
iv. Schuftan C. Poverty and inequity in the era of globalization: our need to change and to re-conceptualize. Int J Equity Health. 2003;2(1):4.
v. Roy T, Kulkarni S, Vaidehi Y. Social inequalities in health and nutrition in selected states. Econ Polit Wkly. 2004;677–83.
vi. Srinivasan K, Mohanty S. Deprivation of basic amenities by caste and religion: Empirical study using NFHS data. Econ Polit Wkly. 2004;728–35.
vii. Dilip T. Extent of inequity in access to health care services in India. Rev Health Care India. 2005;247–68.
viii. Subramanian S, Nandy S, Irving M, Gordon D, Lambert H, Smith GD. The mortality divide in India: the differential contributions of gender, caste, and standard of living across the life course. Am J Public Health. 2006;96(5):818.
ix. Subramanian S, Kawachi I, Smith GD. Income inequality and the double burden of under-and overnutrition in India. J Epidemiol Community Health. 2007;61(9):802–9.
x. Linares-Péreza N, López-Arellano O. Health equity: conceptual models, essential aspects and the perspective of collective health. Soc Med. 2008;3(3):194–206.

d. Gender and health

i. Garcia-Moreno C. Gender and health: Technical Paper. Geneva World Health Organ. 1998;
ii. Narayan T. Gender and power issues in medical education. Gender and Medical Education : Report of National Consultation and Background Material. Eds: Jesani A and Neha M. Centre for Enquiry into Health and Allied Themes, Mumbai: 2002
iii. World Health Organization. Integrating gender perspectives in the work of WHO: WHO Gender Policy. 2002;
iv. Gaitonde R. Community medicine: incorporating gender sensitivity. Econ Polit Wkly. 2005;1887–92

e. Ethics/integrity and health

i. Francis CM. Medical Ethics. New Delhi: Jaypee Publications; 1993
ii. Teaching of medical ethics in Undergraduate Medical Education. Proceedings of Workshop. Bangalore: RGUHS; 1999
iii. Indian Journal of Medical Ethics

7.2 SOCIO-CULTURAL AND COMMUNITY HEALTH COMPETENCY- I

(5 Credits, 3 Weeks Teaching Learning)

SOCIO-CULTURAL AND COMMUNITY HEALTH COMPETENCY-I	
• Social Determinants of Health • Social and behavioral sciences • Health economics • Anthropological perspectives in health • Political economy of health	• Lectures and lecture discussions • Case studies • Visits */Postings/ Study /Internship to district and community level centers to explore social determinants • Community empowerment skill training **Source: RGUHS - MPH (Hons) Regulations and Curriculum (2014)**

1. GENERAL OBJECTIVES – (COURSE DESCRIPTION):

Students in this competency would be exposed to alternative paradigms in addressing issues of health and health care. They would learn to appreciate how health and ill health are produced at the intersections between biology, culture, politics and society and why perspectives other than the biomedicine are needed to address the complexity of health, diseases and health system management. They would learn core concepts and theories in community health and learn the scope and challenges in building healthy communities.

2. SPECIFIC OBJECTIVES - (LEARNING OUTCOMES):

a. **Develop sensitivity to the need for plural perspectives, more specifically the contributions of social sciences to public health**

b. **Develop a critical and deeper understanding of notions of 'culture', 'power' and 'actors' as these shape the domain of health, health systems and its management**

c. **Ability to examine the social, cultural, economic and political determinants of health in order to develop strategies to improve the health of communities and populations**

d. **Acquire skills in engaging with different kinds of data - visual text, narratives, ethnography**

3. CONTENT/LEARNING METHODS/ORGANISATION (INTEGRATED):

i. WEEK 1: SOCIAL AND CULTURAL CONTEXT OF HEALTH AND ILLNESS

In this week, students would develop a deeper understanding of the contributions of social sciences, more specifically, Sociology, Anthropology, Economics and Political Science to understand the social, cultural, economic and political context of health and health care. They would learn about how to approach the complex reality of health and diseases in society. This would involve a discussion of what

is health, who constitutes a community, what are some of the analytical perspectives in social and behavioral sciences that help to understand community health including the classic social science debate on structure and agency. The perspective building exercises in this week would be carried out through lectures followed by discussions, watching a documentary film followed by discussion and analyzing two case studies from two different cultural contexts.

MODES OF TEACHING

- Talk- Reflection on Professional Journey by SOCHARA into Community Health discovering the Social- Economic- Political- Cultural- Ecological determinants of health and potential for action on these determinants- followed by discussion (as an ice breaker)
- Film 'Yesterday' that documents the travails of a poor young mother named 'Yesterday' infected with HIV/AIDS along with her husband who had been a migrant worker in the South African mines. Based in South Africa, the film succinctly captures the economic and gender dynamics at household level, plight of migrant mine workers, disease related stigma practices at community level, health system constraints to access timely treatment and the role of individual agency to cope with the illness hoping to give a better future for the next generation through education.
- **Case study discussion:**
  - Case Study 1 'Rakku's Story' (India) in Shiela Zurbrigg Structures of ill health and social change 1991
  - Case Study 2: Jean's story (Haiti, Africa) in Paul Farmer Infections and Inequalities

ii. WEEK 2: SOCIAL DETERMINANTS OF HEALTH, POLITICAL ECONOMY OF HEALTH

During this week, students would learn about evidence on health inequities at a global level and learn to identify the social and political determinants of health that explain such inequities. They would learn how politics is key to understand social determinants of health as factors like gender, caste, residence, education as determinants of health are neither natural nor inevitable. It would discuss the recent WHO Commission on Social Determinants of Health framework (2008) and unpack the role of different actors and processes that have contributed to health inequities at global, nation and local levels. The discussion on understanding social determinants of health would essentially take a political economy approach. Students would be taught to examine actions taken on social determinants of health through specific case studies at international, national and local levels.

MODES OF TEACHING/LEARNING

- *Field visits and writing health diaries.* Students would be divided in groups. They would visit different communities and prepare health diaries based on household and community experiences of illness, seeking care, managing chronic illness if any, barriers faced identifying these at different levels (household, community, health system). These dairies would be presented in the class for discussion.
- Field visits would also involve observations of Health and Nutrition Days as part of inter-sectoral actions within the NRHM.
- *Facilitating class debates* on specific actions on social determinants of health undertaken in key select sites.
- Group work based on case scenarios (eg: infant mortality, diabetes, maternal health) identifying social determinants of health and possible actions (what, who, where) that could be taken to intervene in these determinants.

iii. WEEK 3: HEALTH ECONOMICS AND HEALTH SYSTEM FINANCING

During this week, students would learn about key principles of health economics in terms of the role of the state, market and community in health care provision. These will be discussed in the philosophical debates about theories of social justice and health, health equity and role of the state. Topics on health spending in India and other countries, out of pocket expenditure, need, demand and supply of health care, economic rationale for government interventions, subsidies, public provision, cash transfer schemes, performance based financing would be discussed. Students would learn the larger economic and political context within which provision of health care is placed. They would be equipped with skills to evaluate different health financing measures as part of health systems reforms in different countries.

MODES OF TEACHING

- Lectures followed by discussion
- Film 'Sicko' on insurance in US followed by discussion

4. ASSESSMENT

d. Formative Assessment- based on participation in group discussions and critical reading sessions

e. Summative- Written test with short questions and case scenarios

5. EVALUATION

Participants will evaluate the sessions and programs of the above module, especially regarding the topics, quality of content, delivery of content and assessment

6. LEARNING RESOURCES MATERIALS

i. WEEK ONE:

- Cecil Helman *Culture, Health and Illness* (Fifth Edition), Chapters 5 and 15

- Nichter, Mark (2003) Smoking: What does culture have to do with it? *Addiction,* 98: 139-145
- Austin, La Toya T et al (2002) Breast and cervical cancer screening in Hispanic Women: A literature review using a health belief model, *Women's Health Issues,* Vol. 12(3): 1-7
- Arthur Kleinman, Leon Isenberg and Byron Good 1978 Culture, illness and care: Lessons from Anthropologic and cross-cultural research, *Ann Internal Medicine* 88 (2): 251-258
- Gilson, Lucy et al (2011) Building the field of health policy and systems research: Social Science matters, *PLoS Medicine,* 8 (8)
- NIH (2005) Theory at a glance: A Guide for Health Promotion Practice (2nd edition) select chapters

ii. WEEK TWO:

- James Hargreaves et al (2011) The social determinants of tuberculosis: From Evidence to Action, *American Journal of Public Health,* 101: 654-662
- Iyer, Aditi, Asha George and Gita Sen (2007) Systematic hierarchies and systematic failures, *Economic and Political Weekly*, Vol. XLII (8)
- Marmot M. Social determinants of health inequalities. *Lancet 2005:* 365: 1099-1014.
- WHO (2008) *Closing the gap in a generation: Health equity through action on social determinants of health.* Geneva: World Health Organization http:/www.who.int/social_determinants/the commission/final report/en/index.html (Executive Summary)
- Erik Blas et al (2008) Addressing social determinants of health inequities: What can the state and civil society do? *The Lancet* 372: 1684-1689
- Paul Farmer et al (2006) Structural violence and clinical medicine, *PLoS Medicine,* 3(10): 1-6
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- Minkler, M., Wallace SP and McDonald, M (1994) The political economy of health: A useful theoretical tool for health education practice, *International Quarterly for Community Health Education,* 15(2): 111-126.
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iii. WEEK THREE

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- Cutler, David M. and Jonathan Gruber (1996) "Does Public Insurance Crowd Out Private Insurance?" *The Quarterly Journal of Economics*, 111 (2): 391-430
- M. GovindaRao & Choudhury, Mita, (2012) Health Care Financing Reforms in India, Working Paper, 12/100, *National Institute of Public Finance and Policy*, New Delhi
- World Bank (1993) *World Development Report 1993: Investing in Health*, Oxford University Press. (Chapter 3: The roles of the government and market in health).

SOCIO-CULTURAL AND COMMUNITY HEALTH COMPETENCY – II

SOCIO-CULTURAL AND COMMUNITY HEALTH COMPETENCY-II	
• Communitisation: community needs assessment, community participation and working with community • Social exclusion and Vulnerable groups- working child, elderly, people with disabilities, Dalit and Adivasi, sexual minorities • Community action on Social determinants • Community mental health • Foundations of Social Care Policy	• Lectures and lecture discussions • Case studies • Visits */Postings/ Study to district and community level centers to explore social determinants • Community empowerment skill training (During internship) **Source: RGUHS - MPH (Hons) Regulations and Curriculum (2014)**

(5 Credits, 3 Weeks Teaching Learning)

1. GENERAL OBJECTIVES

a. **To understand the principles of Communitisation: community needs assessment, community participation and working with community**
b. **To understand the concept of social exclusion, marginalization and vulnerability and health related challenges with focus on specific groups**
c. **To be oriented towards community action on social determinants including social exclusion and vulnerability**
d. **To understand community mental health and community responses**
e. **To be oriented towards Social Care Policy and its key component as part of public health policy**

2. SPECIFIC OBJECTIVES

a. **To be able to perform community needs assessment and mobilise communities for monitoring and action**

b. **To understand the concept of social exclusion, marginalization and vulnerability and health related challenges with focus on**
   i. **working child,**
   ii. **elderly,**
   iii. **people with disabilities,**
   iv. **Dalit**
   v. **Adivasi,**
   vi. **sexual minorities**

c. **To explore the basic principles and axioms of community health action with a focus on social determinants**

d. **To explore the challenges of mental health at the community level and evolve responses at both community and primary health care system levels**

e. **To be conversant with all social care policies and actions that affect health and well-being, and explore convergence health and social policy**

3. CONTENTS

- **Communitisation-**
  - Community needs assessment
  - Community monitoring
  - Mobilising Community participation
  - Community action for health
- **Social exclusion and Vulnerable groups**
  - Working child
  - Elderly
  - People with disabilities
  - Dalit
  - Adivasi
  - Sexual minorities
- **Community action on Social determinants**
  - Improving basic needs and living conditions
  - Fair employment and decent work
  - Social protection across the life course
  - Tackling inequalities of power, money and resources
  - Political empowerment- inclusion and voice
  - Measurement of problems and measuring impacts of action
- **Community mental health**
  - Mental Health Situation in India: The Challenges
  - Recognition of The Rights of Persons with Mental Illness
  - National Responses to Mental Health Challenges
    - National Mental Health Programme
    - Community-Level Mental Health Services Including Family Support

- Traditional Responses to Mental Health
- Human Resource Development, Training And Resreach
- The Evolving new Mental Health Policy

- **Foundations of Social Care Policy**
  - Legislation
  - Social Insurance
  - Social Care Policy and Support
  - Community based action

4. LEARNING METHODS

a. Lecture discussions
b. Case Studies- ICMR Monographs, ANUBHAV Series and others
c. Community visits and interactions with NGO's, PHC teams involved in community action
d. Interactive visits to NGO's and government programmes involved with socially excluded and vulnerable groups
e. Interactive visits to NGO's and government programmes involved with mental health
f. Journal clubs and seminars
g. Simulation games like Monsoons and Chikkanahalli

5. ORGANISATION

a. Communitisation- 2 days
b. Social exclusion and Vulnerable groups- 5 days (including field visit)
c. Community action on Social determinants- 5 days (including field visit)
d. Community mental health- 4 days (including field visit)
e. Foundations of Social Care Policy- 2 days

6. ASSESSMENT

a. Formative Assessment- based on participation in group discussions and critical reading sessions
b. Summative- Written test with short questions and case scenarios

7. EVALUATION

Participants will evaluate the sessions and programs of the above module, especially regarding the topics, quality of content, delivery of content and assessment

8. RESOURCE MATERIALS (Being prepared)

7.3 PLURAL HEALTH SYSTEMS COMPETENCY
(5 CREDITS, 3 WEEKS TEACHING LEARNING)

PLURAL HEALTH SYSTEMS COMPETENCY	
• Plural public health systems • Local health traditions • Local healers and • Alternative systems of healthcare (AYUSH/TCAM) • Mainstreaming AYUSH in public health • Trans disciplinary research- an introduction	• Lectures and lecture discussions • Visits */Postings/ Study /Internship to district and community level centres where AYUSH staff are located • Interactions with local healers, AYUSH doctors and AYUSH institutions including department of AYUSH and I-AIM **Source: RGUHS - MPH (Hons) Regulations and Curriculum (2014)**

1. GENERAL OBJECTIVE

- **To understand the potential of Plural Health systems**
- **To understand the plurality within the health systems and approaches for community health/ public health through plural health systems**

2. SPECIFIC OBJECTIVES

- **To explore the plural options, and opportunities in the public health systems and services in India(AYUSH), Japan, Sri Lanka, China**
- **To explore the availability, access, content and process of health care through local health traditions (LHTs) and all other Indian Systems of Medicine and Homeopathy in the country (AYUSH)**
- **To understand the role of LHTs and AYUSH in primary health care and Universal health coverage**
- **To explore the Public Health policy development and challenges in evolving and sustaining a plural health policy and systems**
- **To explore the intercultural aspects and challenges of health seeking and health care in a pluralistic health system**

3. CONTENTS

The contents of the above module are as follows:

i. **Introduction to Plural Health Systems**
   - Plural Health systems an overview
   - Understanding Plurality within health systems
   - Mapping Plural Health systems in India and selected other countries

ii. **Culture, health and disease/illness**
   - Concepts of medical anthropology relating to pluralism and public health such as
     i. Intercultural aspects of knowledge systems

ii. Epistemology
iii. Inter/trans disciplinarity
iv. Hierarchical pluralism
v. Medical absorption
vi. Other concepts in pluralisms such as romanticism, syncretism, co-evolution, complematarity, integration

iii. **Understanding the role of Local health traditions and Local healers including traditional birth attendants**
- Community based Oral Health traditions in rural India
- Contemporary History of community based oral health traditions
- Local Health traditions and AYUSH
- Mapping Local Health Traditions in India
- Our living Medical heritage; Examples of successful local healers
- Documenting Local health Traditions
- A participatory approach in assessing health traditions
- Community health registers
- Community role of Indigenous healers
- Validity of documentation and assessments
- Health at our door steps: Home herbal garden

iv. **Ecosystems and health**
- Traditional medicine and efforts to medicinal plant conservation,
- Protection of traditional knowledge,
- Relevance biodiversity and ecosystem services in health and wellbeing including therapeutic landscapes

v. **Understanding the principles and practice and public health contributions of Alternative health care Systems (Ayurveda, Yoga, Unani, Siddha, Sow-rigpa and Homeopathy)**
- Introduction to Ayurveda: History, Concepts, Principles, current infrastructure and practice
- Introduction to Unani: History, Concepts, Principles, current infrastructure and practice
- Introduction to Siddha: History, Concepts, Principles, current infrastructure and practice
- Introduction to Sow- rigpa: History, Concepts, Principles, current infrastructure and practice
- Introduction to Yoga: History, Concepts, Principles, current infrastructure and practice
- Introduction to Naturopathy: History, Concepts, Principles, current infrastructure and practice
- Introduction to Homeopathy: History, Concepts, Principles, current infrastructure and practice

vi. **Policy options and challenges in regulating and mainstreaming LHT and AYUSH in primary health care and public health systems towards a national Integrated Health Mission**
- Medical pluralism from a multilevel perspective including WHO policies, national policies as well as policy practice linkages

- What is Mainstreaming AYUSH in Public Health
- Integrating Traditional Medicine into Modern Health Care Systems
- The Indian Health Care System & the Diversity of Traditional Medicine in India
- Status and Role of AYUSH in Public Health and local health traditions Under NRHM
- Role of traditional medicines in primary health care

vii. **Perspectives and principles of Trans-Disciplinary Research in the context of pluralistic health systems**

4. LEARNING METHODS

The learning-teaching methods shall include lectures/ presentations, lecture discussions, demonstrations, case studies, visits, interactions with local healers, AYUSH doctors, AYUSH institutions including Department of AYUSH and Institute of Ayurveda and Integrative Medicine and postings, internship to district and community level AYUSH clinics and health centres and NGOs Integrating AYUSH in their services:

1. Lectures
2. Case studies
3. Journal clubs
4. Group work: Plural health systems and Public Health - Check Lists.
5. Panel Discussion: Public Health Systemic Challenges to integrate local health traditions and AYUSH (practitioners and Policy makers)
6. Visit to AYUSH Directorate, I-AIM- (A short report to be submitted about the learnings from the visit)
7. Visit to a AYUSH co-located PHCs- (A short report to be submitted about the learnings from the visit)
8. Internship to district and community level AYUSH clinics and health centres and NGOs Integrating AYUSH in their services (during internship phase)

5. ORGANISATION

Day 1; Introduction to Plural Health Systems,
Days 2: Culture, Health and Disease
Day3 – day 5: Understanding the role of Herbal medicines, Local health traditions and Local healers including traditional birth attendants.
Day 6 Visit to I-AIM/Any
7th day – Weekend
Day 8 to Day 13: Alternative health care Systems
14th day – Weekend
Day 15 to Day 16: Mainstreaming AYUSH in Public Health
Day 17: Trans-Disciplinary Research
Day 18 to Day 19: Visits, Interactions with local healers, AYUSH doctors, AYUSH institutions including Department of AYUSH and community level AYUSH clinics and health centres

Day 20: Evaluation
21st day – Weekend

6. ASSESSMENT

i. Multiple choice questionnaire at the end of topics

ii. Weekly assignments in topics covered under syllabus to be submitted by the 4th day of every week.

iii. At the end of the module, a written examination and viva voce will be conducted on the 20th day of the module.

7. EVALUATION

The participants will evaluate the sessions and programs of the above module, especially regarding the topics, quality of content, delivery of content and assessment.

8. LEARNING RESOURCE MATERIAL

Must read:

1. Darshan Shankar, Unnikrishnan PM, (ed); **Challenging the Indian Medical Heritage** , New Delhi, foundation Books, 2004.
2. Lokhare, M., Davar, BV., **The community role of Indigenous Healers** In Sheikh, K, George, A.,Health providers in India on the front lines of Change, New Delhi, Routledge, 161-181. 2010
3. Unnikrishnan PM, lokesh kuamr HP, Darshan Shankar. **Traditional Orthopedic practitioners in Contemporary Health** In Sheikh, K, George, A.,Health providers in India on the front lines of Change, New Delhi, Routledge, 182-199. 2010
4. Robert H. Bannerman, John Bruton, Ch'en Wen –Chieh, **Traditional Medicine and Health care Coverage A reader for Health Administrators and practitioners,** Geneva, World Heallth Organization, 1983.
5. Narayan R, Mankad D, **Medical Pluralism A case for Critical Attention,** Medico Friend Circle Bulletin 155-156.
6. Consensus statement –South Asian regional conference on traditional medicine, 2006
7. Priya R. conceptualizing **UAHC Bottom UP: implications for Provisioning and financing**, Medico Friend Circle Bulletin 2011; 345-347; 15-27.
8. National Health systems Resource Centre, Mainstreaming AYUSH and Revitalizing local health traditions under NRHM- a health systems perspective.
9. Report by Shailaja Chandra on AYUSH and LHTs
10. Wujastyk, Dominik, Evolution Traditional Medicine Policy in India
11. **AIFO Bangalore Seminar**
12. **Planning Commission 12th Plan AYUSH Steering Group**

Additional Reading:

1. Introduction to Ayurveda by C. Dwarakanath and selected books, articles from Amruth Heritage, Ancient Science of Life and journals i.e. Journal of Ayurveda and Integrative Medicine

CHLP NW 02092016
Background Paper – 8

8. PUBLIC HEALTH SYSTEM IN KARNATAKA
8.1 A STATE PUBLIC HEALTH CHARTER
8.2 STRENGTHENING STATE PUBLIC HEALTH CAPACITY AND HRD (2013)

Towards a Community Oriented Public Health System in Karnataka

Mission Group on Public Health
Karnataka Jnana Aayoga
(Karnataka Knowledge Commission)
Government of Karnataka
www.jnanaayoga.in

8.1: A STATE PUBLIC HEALTH CHARTER

The Karnataka State Task Force on Health and Family Welfare considered the following definition by the Association of Epidemiologists as the frame work for public health system development.

"Public Health is one of the efforts organised by society to protect, promote and restore people's health. It is the combination of services, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective or social actions. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population on the whole. Public Health activities change with changing technology and social values, but the goals remain the same; to reduce the amount of disease, premature death and discomfort of diseases in the population"

The Task Force also emphasized the following principles when considering Public Health System development in the State. These included:

1. **State's primary responsibility for Health and Health Care**
2. **Recognizing the political economy of public health system development and the challenge of access and universality**
3. **The challenge of Inter-sectoral action including safe water supply, sanitation and nutrition**
4. **The Primary Health Care approach to infectious disease and non-communicable disease control**
5. **The focus on Equity and Social Justice in health and health care**
6. **The convergence of AYUSH, LHTs and the Public Health System**

The Mission Group on Public Health endorsed the above definition and principles and held many deliberations to evolve the following Public Health Charter:

The Public Health Charter for Karnataka

Building on the historic Public Health consciousness in the State which has been neglected and distorted in recent years, the State has to evolve policies and programs based on recommendations of the taskforce to cover the following challenges and system development issues outlined in this Public Health Charter.

Through the Public Health Charter, the Karnataka State will continue to develop a comprehensive, integrated Public Health System that will be committed to the following values: **Equity, Quality** and **Integrity** emphasized by the earlier Taskforce

and **Communitization, Pluralism, Gender Sensitivity** and **Accountability** added by the current Mission Group.

The existing system will be further strengthened by initiatives in the following six dimensions:

1. **Public Health – Capacity building**

- The State will evolve and establish a **Public Health Cadre** to strengthen the capacity of the health system particularly focusing on the district and beyond.

- The state will develop a **HRD unit in Health Department** which will rationalize the functions, salaries, promotions and transfers and also focus on capacity development and continuing education of all cadres.

- The State will promote a **School of Public Health** to strengthen public health capacity and skills at all levels from district level health administrators to ANM's and ASHA's. This will enhance the development of evidence based policies, strengthen institutional capacities and human resources, promote health promotion, public health regulations and research towards the goal for Health for All.

2. **Public Health – Governance**

- The State will evolve mechanisms of **Accountability and Transparency** in all its public health programs and campaigns.

- The State will **enhance governance** and supervision of peripheral Public Health care systems with a special focus on **decentralization and partnership with Panchayat Raj Institutions.**

- The State will promote **community participation** in all its programs and also enhance the role of **community in monitoring** and providing feedback through the **Communitization** process now evolved by the National Rural Health Mission.

- To enhance outreach and access, within the public health system the State in **partnership with NGOs and private sector will promote values of equity, social justice** and strengthen the government's role towards 'Health for All' without compromising the constitutional mandate and taking care to prevent market distortions of such partnerships.

3. Public Health – Inter-sectoral action

- **Nutrition**: The State will tackle the increasing malnutrition challenges using inter-sectoral and multi-disciplinary approaches that address the problem from grass root level upwards by strengthening the public distribution systems and food security, food and agricultural policy, anganwadi and school feeding programs, individual and community nutrition education and health promotion campaigns.

- **Safe water supply**: The State will promoting safe water supply and mechanisms to apply standards for water quality at all levels using appropriate technology to enhance access and purification of water, while preventing commercialization and commodification of water.

- **Sanitation Campaigns:**
  - The State will support the recently announced **Total Sanitation Abhiyan** and enhance promotion of sanitation with the focus on schools, meeting halls, bus stands and public places even as individual house and communities are encouraged to adapt sanitation systems.
  - While promoting sanitation, the State will also take steps to:
    - **Abolish manual scavenging**
    - Strengthen measures to enhance the **Health of Pourakarmikas**

4. Public Health-Response to some current health system challenges

- The State will enhance **access to Free Medicines** for Primary Health Care throughout the State by adopting an essential medicines list, rationalizing logistics of medicine warehousing and distribution mechanisms, promoting rational medicine prescribing and policy initiatives and tackling some of the obstacles to universalizing access to medicines.

- The State will evolve an **urban primary health charter** that will focus on multi-sectoral services integrated through a primary health care approach

focusing on women and children's health, violence against women. The Charter should include access to basic health services, mental health and other emerging urban health challenges.

- The State will adopt the newly announced national program for non-communicable diseases and enhance **the primary health care approach to chronic diseases** with focus on management and re-orientation of personnel, providing support and upgrading services, improving HMIS, building new partnerships and strengthening operational research.

- The State will enhance **healthy life style promotion** as part of the youth oriented policies of the State while simultaneously linking it to **health promotion and education against substance abuse.**

5. **Public Health – Promoting pluralism and Integration**
   - The State will evolve **Accreditation and Certification System for local Health Practitioners and Knowledgeable Women** involving Universities such as IGNOU to support Traditional /Community Knowledge Systems.

   - The State will promote **Public Health Orientation and Training for all AYUSH Health Personnel** starting with government sector and later offering it to private registered medical practitioners as well as including community supported LH practitioners on voluntary basis.

   - The State will **strengthen Swasthya Vritta Programme** presently being experimented in five districts and enlarge this program to cover the whole State gradually. It will also draw upon the health promoting traditions of other system as well.

   - The State will **strengthen Yoga awareness and skills through Health Promotion** in School and college curriculum.

   - The State will **strengthen community health and knowledge practices related to food and dietary practices** using traditional knowledge and practices for promoting healthy nutritional status.

   - The State will **strengthen documentation of clinical outcomes in AYUSH** sector including LHTs at all levels by introducing a standardized system.

6. **Public health – Strengthening HMIS and Knowledge translation**
   - The State will further strengthen the **Health Information system** by providing universal access to available information to all categories of users by removing the present imbalance between providers and users.
   - The State will adopt and enhance **e-governance within public health system** at all levels.
   - The State in collaboration of the Health Department and the evolving State GIS platform will enhance the development of **an effective health GIS.**

In conclusion, through the adoption of this six point, Public Health Charter, committed to the above values, the State will enhance the capacity of the Public Health System to handle the emerging health problems and challenges; enhance the commitment to human resource development; enhance accountability, decentralised government, communitization and strengthen the ability of the existing system to deal with the new emerging challenges.

8.2: STRENGTHENING STATE PUBLIC HEALTH CAPACITY AND HRD

Strengthening Public Health Capacity

Human Resource Development in Health and their public health orientation and capacity remain the biggest challenge of public health system development in the State. The four major challenges of HRD are coverage, competence, motivation and governance. These challenges operate at all levels from primary health centre to taluk hospitals and upwards and need responses that are both standard management practice and out of the box solutions.

The three most important recommendations that the Mission Group would like to propose the following:

- A Human Resource Development unit in the Health Department
- The formation of a Public Health Cadre and its expansion, continuing education and sustainability
- Strengthening public health capacity and training at all levels including the development of a State School of Public Health that will spearhead the capacity building at all levels

The first two recommendations had been deliberated upon and detail recommendations had been made to the Health Department in the earlier phase of the KJA.

The present Mission Group has focused specifically on public health capacity building and recommends the following:

- A State School of Public Health
- Some general steps to strengthen public health capacity

A State School of Public health – A capacity building policy imperative

Karnataka State urgently needs a path breaking initiative to strengthen Primary health care and Public Health system development in the State to address equity, quality and integrity of health and health care. Karnataka had a good practice of appointing Public Health trained individuals for Government Health Services. But over a period of time, this mandatory requirement was dropped. Health professional and health officers must have a public health skills and capacities and for this all those in public health positions need to undergo a formal training in public health to get an insight and skills in the practice of public health and capacity to strengthen the systems and improve outcomes. It is only then that health services will be manned by appropriately trained health professionals.

Recently on the recommendation of the Knowledge Commission an expert group has already reported on the need for public health cadre development and this welcome development now needs an important complimentary initiative for urgent state intervention and investment. This initiative is to focus on the evolution and sustained development of a range of Public Health courses and educational initiatives to strengthen the capacities and public health skills of the relevant health human power in the State. A State School of Public Health is therefore an urgent policy imperative.

1. Towards multidisciplinary and multi-sectoral Public Health

The Task Force on Health and Family Welfare, 2001 and Integrated State Health Policy, 2003 proposed to have a State School of Public Health in Karnataka. On the similar lines, Karnataka Jnana Aayoga had already recommended a School of Public Health in Karnataka in its first phase to cater to the needs of human resources development. The re-consitituted commission now wishes to re-endorse this path breaking initiative for a "State School of Public Health" to address the specific public health training needs of Karnataka.

The multi-disciplinary, inter-disciplinary, and multi-sectoral nature and challenges of public health this School should collaborate with Universities and other multidisciplinary professional institutions and bodies to make the school a comprehensive learning centre drawing upon the state's rich institutional and educational resource network.

2. *Structure*

In addition to All India Institute of Hygiene and Public Health which was started before Indepedence and the Achutha Menon Centre of Sri Chitra which started in 1996, there has been recently a new revival of public health education. In other states well known educational institutional like TISS- Mumbai, CMC- Vellore etc have also introduced public health courses. As part of this revival there is urgent need for a School of Public Health in Karnataka which could be a governmental initiative with a strong core public purpose supported by a network of partner institutions and networks, but similar in focus and framework to these other schools.

Since 2006 the Public Health Foundation of India (PHFI) has already started four Schools of Public Health one each at Delhi, Hyderabad. Gandhinagar, and Bhubaneshwar. Other schools have been started by Indian Council of Medical Research at NIE Chennai, NICD Delhi, and other centres.

This School of Public Health would interact and build further on the State Institute of Health and Family Welfare and the more recently created State Health Systems Resource Centre, both of which are mandated to strengthen public health skills and capacities and resources including policy research in the state. Based on the Magadi Road Campus, these institutions already form a strong core of state resources that can be creatively upgraded into a more well resourced and comprehensive multidisciplinary School of Public Health.

3. *Additional Features*

- **Campus**: One alternative would be to creatively evolve the SOPH in the Magadi road campus which has adequate land for the purpose. This has often been the main constraining factor in many states.

- **Departments**: Keeping in mind the core multidisciplinary nature of public health, the school will need to develop core expertise in:
  - Public health planning and management,
  - Epidemiology & bio statistics,
  - Social and population sciences (Sociology, Social Work, Anthropology, Demography)
  - Health information and communication systems including IT for health
  - Environmental and occupational health,
  - Health policy and health systems (including economics)

This core expertise will be in-house resource and will also draw upon additional human resources from a supportive network of institutions already available in the city of Bangalore.

- **University affiliations & Accreditation of courses**: To be negotiated with RGUHS and or later with any National autonomous University or accrediting body. RGUHS has recently created a new unit of Public Health in the University campus.

- **Financial Support:** An initial Corpus fund should be provided by the State supplemented by funds for training from all existing national and state health programs. In addition, in keeping with the importance of public health systems research the State should also consider a basic core research endowment to enhance this evidence gathering and policy development aspect of the SOPH.

4. Governance

A governing body of Advisory and Resource persons drawn from multi disciplinary and multi-sectoral backgrounds who are already contributing to Public Health system development in the State and/or Country should be formed to support the growth and development of the institution.

5. Bench Marking

An Academic Research Council to set benchmarks for SOPH at all levels and resource network that can be brought in to enhance the training/teaching resources. This should include mission and objectives; curriculum models and instructional methods; public health competencies; curriculum structure, composition and duration; faculty position and recruitment, assessment methodology, admission policy; student support and counseling; pedagogy expertise; exchange with other educational institutions; student performance; interaction of health sector and continuous renewal of the school.

6. Technical Resources

The State including Bengaluru already has the stronger cluster of Public Health Institutions and multi-disciplinary hubs that are already involved on State and National level in public health system development and policy advocacy. These include NIMHANS, KACH, SOCHARA, IPH, IHMR,IIM, NLSUI, ISEC and so many others already supporting national activities like NRHM, NHSRC, PHFI and NIHFW.

Drawing upon these resources through a network would be the most cost effective and realistic way to evolve this SOPH.

7. Educational and IT Technology

In keeping with the latest developments in educational and IT technology a planned continuing medical education program for all cadres of public health staff at all levels should be operational using distant learning, methods and modules, and supplemented by contact workshops and telemedicine so that all parts of the State can be reached through a decentralized and disperse network, enhancing accessibility of training and human resource development.

8. Courses and Training Programmes

WHO has recommended that Schools of Public Health in the region should focus on the following:

- Post –basic and post graduate training for public health professionals
- Pre-service training for public health workers
- Public health content in pre-service training of other health workers
- In service training of health workers
- Continuing education of public health workers and
- Public health content in the training of workers in related sectors.

Based on the recommendations of the Task force and various expert groups over the years, the **School of Public Health would be involved in:**

- **Public Health (Short certificate course)**

  A 3 month induction course in Public Health for PHC Medical Officers, Dental Surgeons, Public Health Nurses and AYUSH Physicians posted in co-located Public Health Services in the State

- **Public Health Management (PG Diploma)**

  A one year or 6 months crash Public Health program and induction training for existing and or newly appointed District Level Medical Officers on the lines of the present NRHM linked PG Diploma in Public Health Management (PGDPHM). Already the State is sending such candidates to different institutions in other states but the SOPH could start a similar course and greatly enhance learning opportunities and career development in the State.

- **Public Health Masters programe**

  A Two year MPH Program for Doctors, Nurses, Dental Surgeons and AYUSH Physicians before they are appointed as District MOs or even at CHCs or before promotion to higher levels of public health technical /administrative responsibilities.

- **Public Health: Special Courses**

  Focused Public Health Training programmes for special groups that can supplement the public health cadre derived from bio-medical backgrounds. To begin with this could include the following:

  a. **Public Health Engineers**-Young engineers trained for a Masters in Public health engineering

  b. **Health Promoters**-Young social scientist trained for a Masters in Health promotion and advocacy

- **Public Health : Induction orientation courses**

  Shorter Public Health Oriented capacity building courses for PHC team members including Public Health Nurses, ANM's, Aanganwadi workers and ASHAs and operationalised through TOTs for staff of the numerous Health Training centres in the State. If this is based on incremental modules then they can also be linked into a step ladder type, career enhancement initiative.

- **Strengthening Public Health Consciousness: Public Health modules in other disciplines**

  The SOPH would ultimately also dialogue with other academic disciplines like social and behavioral sciences, social work, law, management, engineering, agriculture, environment, journalism, and evolve Public Health oriented modules to supplement the teachings in those disciplines and enhance the overall Public health consciousness in the State and in academia and research. Simultaneously the SOPH would also work closely with the PSM/ community medicine departments of medical colleges, nursing, dentistry, AYUSH institutions and enhance the multidisciplinary public health competence of the under graduates from this institutions which will ultimately feed into many considering post graduate opportunities in public health. A module is also required for clinicians to orient them in all public health aspects.

9. *Competency based Skill Development*

Public Health capacity building is increasingly becoming competency based skill development with increasing focus on how to do rather than only what and why. Last year the Ministry of Health along with IPHA, WHO India Office and many other public health resource groups evolved a set of 24 competencies relevant to the Indian situation and evolved a table of the level of this competency to be taught at DPH; MPH; MHA; and MD levels. The State school of public health could use this frame work as a background and evolve training needs and frame work for each category of public health worker. The competencies are outlined below.

BOX – 1

COMPETENCIES IN PUBLIC HEALTH RELEVANT TO THE INDIAN SCENARIO:

CORE

1. **Health Planning**
2. **Epidemiological Skills,**
3. **Family and Community diagnosis**
4. **Health Management including Financial Management**
5. **Managing and Implementing Health Programmes**
6. **Monitoring and Evaluation including health surveillance**
7. **Health Promotion including prevention and protection.**
8. **Training and Capacity Building**
9. **Research including Bio Statistics and demography**
10. **Working with community including communitization.**
11. **Building Partnership and Network**
12. **Public Health Law and Ethics**
13. **Public Health Biology**
14. **Environmental Health.**
15. **Socio cultural competency including SEPC analysis**
16. **Health Policy and advocacy**

CROSS CUTTING:

17. **Critical analysis and systems thinking including problem solving**
18. **Leadership**
19. **Communications including informatics.**
20. **Lifelong learning**
21. **Equity**
22. **Human Resources Development**
23. **Governance and decentralization**
24. **Conflict resolution.**

10. *Research*

There is an urgent need to support the public health policy and system development in the state through multidisciplinary research that should include focus on:

- Socio epidemiological research

- Health system research
- Health policy research
- Health economics
- Health impact assessment
- Health policy advocacy and knowledge translation

This will enhance public health policy and system development in the State based on evidence rather than just expert opinion. This is a major lacuna in public health system development in the Country and the State School of Public Health should invest strongly in this dimension of learning activity to enhance sustainable and relevant public health development in the State. Research projects could be introduced to enhance partnership with other research and training institutions interested and involved in public health.

Strengthening Public Health Capacity: some additional initiatives

At the stakeholders' consultation a small sub-group deliberated on public health capacity building focusing on additional initiatives other than the school of public health.

1. **Basic orientation and exposure to public health:** All persons involved in the delivery of health care and health services at various levels (right from ASHAs to Medical Officers) should at least have a basic orientation to and awareness of the concept and practice of public health. They must be made aware of their place in the public health system and the specific role they are expected to execute.

2. **Training and capacity building:** Apart from the basic orientation, all personnel within the health system must be equipped with the necessary knowledge and skills to handle the public health functions at their respective levels and make them fit for purpose. We need a knowledge (formal/informal, accredited/non-accredited) skills matrix to define these competencies and assist in the training and capacity building of the public health cadre.

3. **Infusion of trained public health professionals:** Public health must be made more broad-based. The public health cadre should include the existing health workforce (equipped with public health training) as well as the emerging class of qualified and trained public health professionals to fill in the current deficit in capacity for planning and execution of public health activities. A major challenge in this regard will be to overcome the inherent tensions between the entrenched medical fraternity within the establishment and new public health professionals entering

the system, especially when the latter may be better equipped for certain public health roles. Ways to bridge traditional boundaries and promote joint efforts will have to be found.

4. **Interdepartmental convergence:** Current approaches to public health are disjointed and lack functional linkages between the relevant government departments concerned with public health, viz. between the Departments of Health and Family Welfare Services, Women and Child Development, Medical Education, Public Works etc. This is a major issue since public health is essentially interdisciplinary. Interdepartmental convergence is essential for a more comprehensive approach to public health.

The following recommendations were made:

- Develop a separate training cadre for building public health capacity in the state. Set up a faculty development programme to upgrade the training skills in both the state and regional training institutes

- Training needs assessment and curriculum development for all health cadres (especially for frontline health workers)

- Clear policies for graded capacity building and career advancement

- Develop district public health cadres to facilitate faster promotions and better career advancement.

- Health supervisor training, mentoring and supportive supervision for frontline health workers (particularly LHVs)

- Short term (one month) management training courses for Taluka Health Officers

- Clearly define and establish operational roles and responsibilities for AYUSH doctors in the health system.

- Capacity building for AYUSH doctors for public health roles with a strong focus on national health programmes (possibly a three month training at induction and continual in-service training)

- Public health training for at least one faculty member in each AYUSH medical institute with relevant job roles, incentives and career opportunities

- Develop the public health curriculum in medical (AYUSH/non-AYUSH)/ paramedical education (e.g. a one month NRHM module)

- Cross-pollination between persons involved with medical education and those providing health services:
  a. Compulsory postings for postgraduate medical trainees in preventive and social medicine (six months) and those in other specialities like obstetrics and gynaecology, surgery and general medicine (three months) in PHCs, CHCs and District Health Offices
  b. Systematically involve persons engaged in the delivery of public health services at various levels as resource persons or faculty in medical education programmes

- Public health capacity building for private family/general practitioners and their involvement in public health programmes/activities

A healthy human resource policy must continually balance the need for functional health teams at primary, secondary and tertiary levels of health care and also facilitate a judicious mix of public health practitioners and clinical practitioners and specialists. The problem of non-availability and uneven distribution of skilled health care providers is the central challenge to meeting our health goals

Source: *Annual Report to the People on Health, GoI, September, 2010*