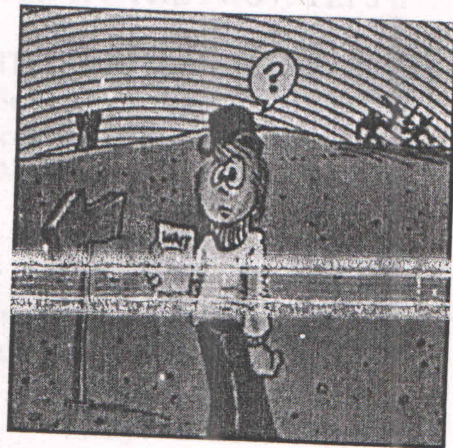
New beginnings at Cross roads



a report of the community health fellowship experience

eddie premdas

july 1, 2005 – march 31, 2006

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ACKNOWLEDGEMENTS

The year 2005, at the age of 38, turned out to be a turning point in my life with surge of events that took place in both my personal as well as professional life. Call it middle age crisis or mid-career crisis.........!

Before I took up the community health fellowship I was pretty sure, that whatever direction that I was to take, was going to determine the rest of my professional life, with quite a good number of choices that I had. So it was amidst the turmoil of events and processes and the confusion of choices that I happen to opt for the Community Health Fellowship. This happened due to a small discussion that I had with Dr. Ravi towards the fag end of the consultation workshop that was held at CHC on the issue of the centre for community health in April, 2005 where the possibility of this fellowship was thrown open before me. I tarried for a little while with this idea, and once convinced that it was the best thing to do, I just decided to go ahead. with it.

Though I have been an associate, friend of CHC and a SOCHARA member for quite a sometime now, yet fellowship programme was a completely different experience in many ways. Besides rejuvenating and resurrecting me to newer possibilities, it also gave me opportunity to be rooted in Community Health.

I thank all my fellow colleagues of my batch – Asha, Satyawati, Sathyasree, Shekar Saha and Arun Gupta -, number of other fellows who I met and forged deep bonds of love and solidarity with. The friends at CHC – Kamalamma, Joseph, James, Naveen, Chander, Ameer, Victor, Maria, Noreen, Nagraj, Anil and Mahadev Swamy – were constant companions to me for over 10 months. Besides number of people that I interacted with during the course of this fellowship, especially the SOCHARA members, have contributed immensely to my growth. My limited English vocabulary wouldn't be able to describe the strength and support that I have received from Dr. Ravi Narayan and Dr. Thelma Narayan, not only during the fellowship period but also during my professional growth even earlier. I just want to say that I deeply appreciate their support to me.

This fellowship programme has been supported by Sir Ratan Tata Trust (SRTT). From my own experience and that of other fellows I would vouch for the fact it has been a great experiment and a great contribution to the Community Health Movement in the country.

It's been a great learning experience for me and a journey which was worth undertaking. The learning space that it gave and the avenues that it opened up are infinite. I gratefully acknowledge whoever has been instrumental in my growth and in getting clarity in my confusions towards deciding what to do in the coming years. At the end of fellowship, I am carrying forward; with me a larger framework of 'Health and Human Rights' and the vision of working with a particular focus on 'Community Health Workers' in the unorganized sector. And of course, a vast sea of friends and memories of interesting people and places that I visited, still linger in my mind. Thanks to all.

• ***Eddie Premdas***

SECTION I

MY JOURNEY OF FELLOWSHIP

NEW BEGINNINGS
AT
CROSSROADS

1.1 **My Journey of Fellowship – *"At crossroads, in search of new beginnings"***

1.2 **A Journey of Learning- Inward and Outward : An Abstract**

1.3 **Reflections and Learning Experiences**

1.4 **Fellowship Itinerary**

SECTION 1.1:

MY JOURNEY OF FELLOWSHIP NEW BEGINNINGS AT CROSSROADS

"The objective of the Community Health Fellowship Programme is to provide career options in CH for the young confused professionals. As you have already worked for certain number of years, how do you think you fit within this objective to be eligible for the fellowship?"

Question at the interview by Dr. C. M. Francis startled and dumbfounded me!

To be honest I was again at the crossroads! At 38 in life!!

I had always considered my life as a pilgrim's journey constantly in search of something that my heart could repose in. I had said no to the option of choosing medicine or engineering in 1982 and being filled with a spirit of social justice associated with an organisation affiliated to a great Italian reformer called St. Francis of Assisi. During the course of my association with this organisation I had to say no to many enticing teaching cum administrative posts each time opting for the alternative which bound me to the marginalized people or individuals. Having said no to doctoral studies in philosophy in Rome in 1997 I had opted to Masters in Social Work, and having said no to building a 'huge' NGO - which the organization thought I would - I had opted to do the socio-political mobilisation work with the spirit of the movement in 1999. In 2005, I had to wean out the collective of women from the NGO which had links to the religious organization to be on their own with their own identity, I had to wean myself out from the safety and security of the religious organization with which I was associated for the last 23 years when it was pretty clear that social justice and equity is not a easy thing to be fought for within the institutions which themselves do not want to address the social injustice and inequity within. I was again out in search of the path of social justice without the religious or ideological bigotry.

Having done number of small time things I had thought I was finally settled at POTNAL (Raichur District, Karnataka). During and after the course of post-graduation in 1999 from Tata Institute of Social Sciences, Mumbai I had the unique privilege of spending about 8 months with the activists of Narmada Bachao Andolan and people of the Narmada valley. This unique experience gave

new twist to the already turning points in my life. It added the element of 'radicalism' to the 'idealism' that was already in me. New perspectives, new 'world vision', new way of understanding and linking up knowledge, information and real life began in the valley. Though pilgrimage to the valley every year and in times of need as volunteers remained a constant practice in the coming days, the spirit of the valley brought a band of friends together and all of us headed to the forlorn destination of Potnal in 2000. Dalit communities, Dalit women, political empowerment, collectivisation of Dalit women for better political bargaining, confronting the intensive feudal society, watershed, education and such other dreams were the driving forces behind this venture under the banner of Vimukti social Action Cell. Vimukti slowly made place for Jagrutha Mahila Okkoota, which when women gathered sufficient strength became Jagrutha Mahila Sanghatan (JMS).

2004-05.... Year of 'krises'/crisis = passage again!! The JMS was on its own. They had their own office. The team had the leadership change which was needed. It was important for me in my own political thinking that my creative energies do not get sucked into the administration. It was important for me avoid the temptation and to move out before I become the 'reference point' due to a different class that I represented vis-à-vis the women agricultural labourers. I had also heard the words of wisdom that the best energies are invested in the first 5 – 7 years and then the demon of institutionalization sets into the best of processes. And I decided to move out and move on in life for number of personal and professional reasons.

At this point I was confused, unsettled and really at cross roads. Because of different professional fronts or skills that I had acquired ,my choices were very difficult to make. Everything was seeming very important even from the point of people's movement.

I had a M.A. in social sciences and seven years of hardcore professional and near to earth experience with one of the most margainalized communities of dalit women. During the course of work with JMS I also became an advocate. Legal aid, lack of advocates with perspectives was a need that I had realized when I did my internship with Criminal Justice Initiative team at India Centre for Human Rights and Law and with Labour lawyers in Mumbai. Meanwhile, through the experiences I had also got the passion for the Right to Food Security, a campaign which JMS had initiated in Raichur also. A near to 'yes' talk had happened between ICHRL and me to spearhead the Right to Food security campaign in Maharashtra. Besides, teaching also came calling from some corners as I had passed my NET some time ago. It was too tempting as I had a joyous aptitude for teaching and training and many of my teachers too had expressed to me that unless people with perspectives had become teachers one can't expect to pass on perspective to students. The bottom line of my career was very clear to me...social justice, the marginalized communities, the people's movements. But considering the professional skills as strategies towards this, I did not know which one I was to adopt at this point of time in life when I was 38.

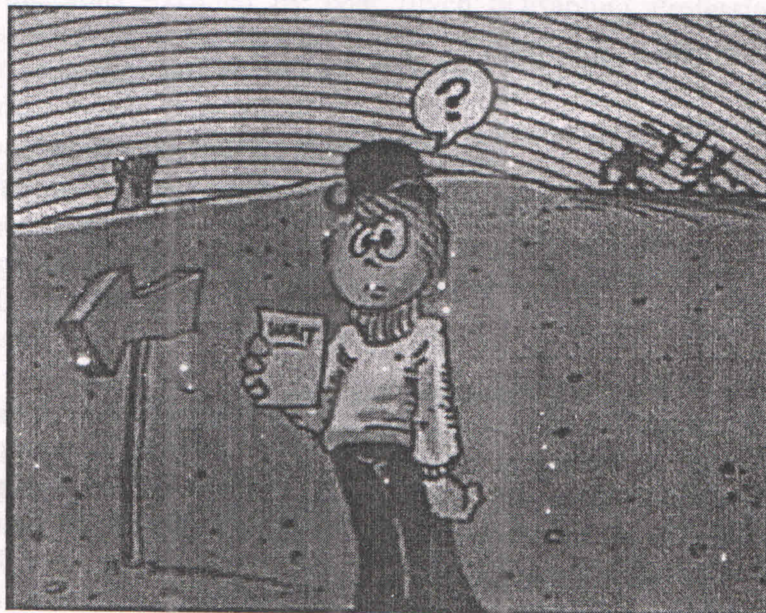
Participating in the planning workshop as a SOCHARA member, organised by CHC in April 2005 helped me break this jinx! In one corner of my life also was a

gift that I was a 'naam ke vaaste' member of SOCHARA and I thought I should give some time to contribute to the processes of CHC. And no time could be more right than when you make a transition. I also needed to stop for a while and reflect. In a brief hurried talk after the workshop, Ravi in his innate capacity to make meaning out of chaos, also helped to think that fellowship is a possibility where I would get time to think and also to make a study (what we called then the feasibility study) regarding the centre for community health (Alternative learning centre, nomenclature then used). Though I had just come to Bangalore after talking to Adv. Mihir Desai and Ms. Deepika D'Souza, the executive directors of ICHRL and my face had turned almost Mumbaiwards for Right to Food Security Campaign, many of my friends told me that Community Health Fellowship might be a good option to think and reflect on what I really want to do in the future. Once I decided to opt for the fellowship it was only matter of time when I would turn my face Bangalorewards…

Dr. CM Francis' question really made me think again. My answer was: "I am exploring if Community Health is my future career…". When some of my colleagues are peaking in their career I was still finding out if Community Health was my career… my ego and pride was troubling me a bit…

However, I had always kept for myself the philosophical principle: "In the school of life everyone remains a student always". I had always done newer things. A little bit of Community Health work in terms of training health workers with JMS had also enthused me. It was a challenge and opportunity…

A Senior Fellow in the Community Health
Fellowship Programme…
It was to be a new journey…Perhaps a new beginning at crossroads….



1.2 Abstract

MY JOURNEY OF LEARNING: INWARD AND OUTWARD

LEARNING OBJECTIVES

- ***To get an in-depth understanding of Community Health***
- ***To try and understand the issues regarding the Centre for Community Health and attempt towards the conceptual framework***
- ***To visit and learn from the organisations linked to Public/Community Health in order to consolidate the understanding of Community Health.***

LEARNING EXPERIENCES

Looking Inward:

The nine months of fellowship was more of a journey inward as much as it was outward. From confusion to clarity, having focus to fine-tuning the focus.

1.0 Perspectives

1.1 From perspectives to finer aspects of perspectives is a long journey:

- Alma Ata Declaration slogan 'Health for all by 2000' to **'health for all NOW'**. The people's health movement, the national and international assemblies are now stressing 'health for all NOW'.
- No models: It's a journey with different facets
- From intervention to rights perspectives, from rights to human rights is a long long journey.
- Transformation and collective vision: a range of interventions and perspectives contribute to this process

1.2 Adventurous and Path breaking Journey of Individuals:

1.3 Social change/social transformation is a collective effort:

1.4 Catalyst mode of work: Being on the fellowship a great learning was to see what is the mode of working as facilitators or catalysts. Major learning took place at CHC: the facilitators or empire builders, the balloonists or the microscopic workers

1.5 Politics of Working Together: The catalyst approach leads to the politics of alliance/working together, a Herculean task given the egos, undemocratic functioning in the voluntary sector, parochial short sighted approaches to work etc. People's Health Movement and Jan Swasthya Abhiyan was a great learning to this learning.

- Collectives/groups mature over a period of time:
- Collective work is a process for common goals with common vision involving a lot of individual compromises in stands and positions.

2.0 Skills and ideas:

- Skill of Interviewing:
- Planning an itinerary.
- Skill of writing is revived:
- Skill to conduct sessions/ training:
- Skill of self-reflection and self-analysis

3.0 Self-awareness:

Reflection through the year made me aware of many areas in me which need growth:

- Judgemental attitude
- Anti-intellectual bias
- Strong Opinions
- Reality is multi-faceted

4.0 Professional Development:

- **Identifying the components and challenges in CH:** Professional knowledge of the field, the theoretical frame work of Community Health/Public Health, skills that are required and be associated with the professionals in the field.
- **Challenging and pushing the frontiers of 'disabling professions':** During the fellowship it was time to learn from professionals like Dr. Ravi and Thelma at CHC and other professionals in the Community Health/Public Health field who have expanded the scope of their professions from medical profession to community health profession. While professions – called by Ivan Illych "Disabling Professions"– becoming narrower and narrower in scope in the name of specialization and super specialisation. expanding the scope of professions by pushing the limiting frontiers is an anti-thesis.
- **Professionalism requires a lot of commitment.**
- **They dynamics of 'personal' and 'professional'** – is a still dilemma that I am reflecting upon
- Knowledge, skills and perspectives:

5.0 Looking Ahead:

- **Where do I go from here?** I weighed and reweighed various options that are open to me in the field. But my passion remains with the people's movement at a conceptual level and with the unorganised sector at a practical level. The women agricultural labourer's union at Potnal Raichur and the Unorganised Sector like the Paurakarmika Union (Sanitation workers) in Bangalore city that have attracted my attention.

  I would like to locate these for some years from the context of 'COMMUNITY HEALTH' and 'HEALTH AS A HUMAN RIGHT'.

- **Career transitioning at mid-career phase:** Looking at Dr. Ravi, Dr. Thelma and others in the field I have realized that transition in personal journeys, career is part of any change. Looking within, I see myself at a mid-career level professionally: Professionally, it is a time for me to integrate what skills that I have gathered professionally or otherwise and take myself forward. In this process, reflection and evaluating oneself is very important. Fellowship was the time to reflect on my journey professionally. The career transitioning that I have reflected upon is that I should go forward in the profession of Community Health/Public Health integrating all that I have professionally acquired so far. May be we could term it career/professional transition or professional integration?

6.0 Community Health:

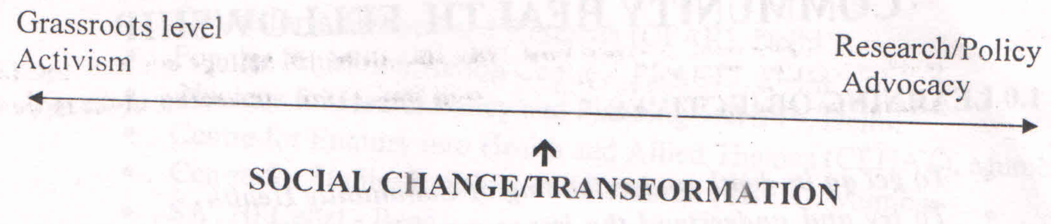
- Community Health is that process of empowering communities
  - Which **enables them to know the processes**, powers and dynamics (micro-meso-macro) that affect the lives and health of the 'community' (Community not necessarily geographic e.g. sex workers) and
  - **investing such efforts which will equip them** with knowledge/information, skills and decision making power to choose such factors that favourably determine their health, and
  - also **enable them with awareness to take such actions** to counteract such forces that will adversely affect their health.
- A range of activities with the 'perspective' of the most marginalized in the communities: from training, to collective efforts to policy and research which will make health for all now (universal access and availability of health resources) possible for 'people'.

Summary:

Social change and transformation is a collective effort and it involves range of efforts and strategies: It shall not be brought about by any single person or by any single intervention. Hence I pitch myself in history as one of the tiny sparks in the process of social transformation. Historically all efforts originating from the alternative paradigm in the praxis of reflection and action are to be pitched in this framework of collective effort for social transformation, towards the inauguration of a just and equitable social order.

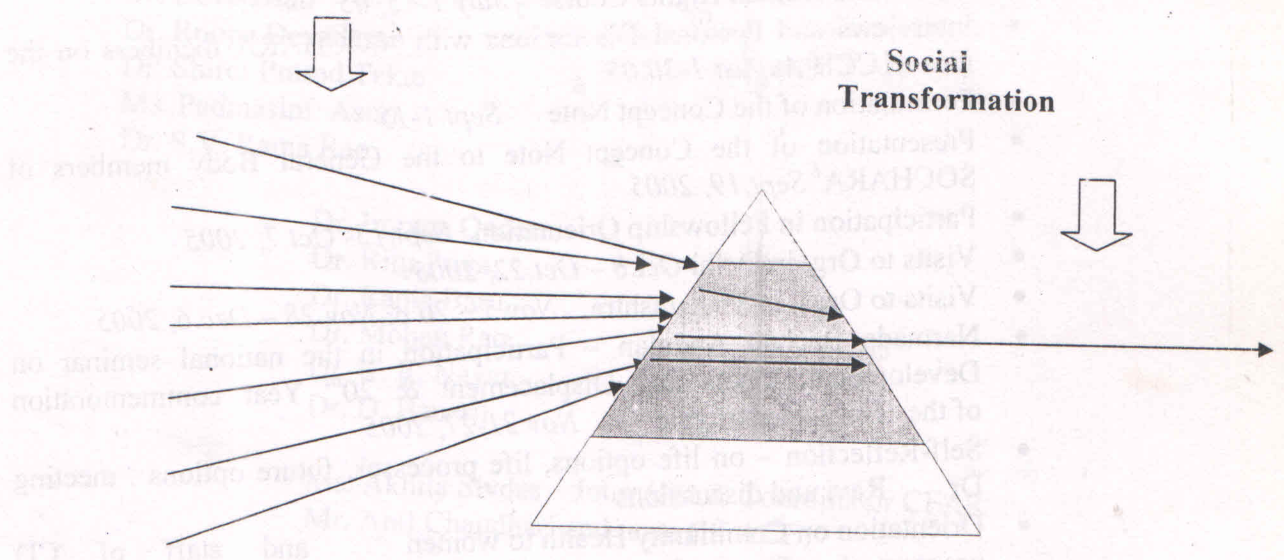
This could be summarised in the following metaphors of continuum/range and reverse prism.

RANGE/CONTINUUM:



2. SPECTRUM: Reverse Prism

Various efforts/movements/interventions



I.3 Reflections and Learning Experiences

MY JOURNEY OF COMMUNITY HEALTH FELLOWSHIP

1.0 LEARNING OBJECTIVES

- ***To get an in-depth understanding of Community Health***
- ***To try and understand the issues regarding the Centre for Community Health and attempt towards the conceptual framework***
- ***To visit and learn from the organisations linked to Public/Community Health in order to consolidate the understanding of Community Health.***

In the process of the attainment of above objectives the following were the milestones:

2.0 Milestones on the journey ……

- Health and Human Rights Course *July 1-15, 05*
- Interviews and Personal Discussions with SOCHARA members on the idea of CCH *August 1-30,05*
- Formulation of the Concept Note *Sept.1-15*
- Presentation of the Concept Note to the General Body members of SOCHARA *Sept.19, 2005*
- Participation in Fellowship Orientation *Sept.15- Oct.7, 2005*
- Visits to Org. in Delhi *Oct.8 – Oct.22, 2005*
- Visits to Orgs. in Maharashtra *Nov.5 – 20 & Nov.28 – Dec.6, 2005*
- Narmada Bachao Andolan – Participation in the national seminar on Development, Dams and Displacement & 20th Year commemoration of the Narmada struggle *Nov.21-27, 2005*
- Self-Reflection – on life options, life processes, future options : meeting Dr. Ravi and discussions
- Orientation on Community Health to women and staff of CD program of Centre for Social Action, Hoskote Taluka (Bang. Rural dist.) *Jan 03, 05*
- Visit to Chennai – CH program of CHC *Jan.15-21, 2005*
- Mid – term review of the fellowship Jan. 23-28
- *AIDAN, MFC meet Jan 26-28 (Vellore)*
- Right to Food Security – Holy Cross Comprehensive Rural Health Project, Hanur (Kollegal, Chamarajanagar dist.): Feb. 6-11, 2006-03-14
- Health Perspectives and Capacity Building, JMS Potnal (Raichur dist); February 13-22, 2006
- JSA material preparation workshop, Bangalore Feb.24-25,2006
- Staff Development Programme CHC Feb.27-28, 2006

INSTITUTIONS/ORGANISATIONS VISITED

- Centre for Social Medicine and Community Health (CSMCH), JNU Delhi
- Centre for Advocacy and Research (CFAR), Delhi
- Popular Education Action Centre – PEACE-, Delhi.
- Nucleus for Health Policy and Planning –NHPP-, Delhi.
- Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai
- Centre for Studies in Ethics and Research (CSER), Mumbai
- SATHI Cehat - Pune
- Tata Institute of Social Sciences (TISS), Mumbai
- Foundation for Research in Community Health (FRCH), Pune
- Comprehensive Rural Health Project (CRHP), Jamkhed, Maharashtra
- Institute of Health Management, Pachod- Maharashtra
- School of Interdisciplinary Health Sciences, Pune University, Pune.

PERSONALITIES INTERACTED WITH

Dr. C. M. Francis
Fr. Claude D'Souza
Dr. Devadasan
Dr. Roopa Devadasan
Dr Shirdi Prasad Tekur
Ms. Padmasini Asuri
Dr. S.V. Rama Rao

Sochara members

Dr. Imrana Qadeer,
Dr. Ritu Priya,
Dr. Rama Baru,
Dr. Mohan Rao,
Dr. K. R. Nayar
Dr. D. Banerji

JNU

Ms. Akhila Sivdas – Journalist & Coordinator CFAR
Mr. Anil Chaudhari and team (PEACE)

Ms. Padma Deosthil – coordinator, Ms. Amita Pitre (Cehat)
Dr. Amar Jesani (CSER)
Dr. Sunita Bandewar – Anthropologist (CSER)
Dr. Ananth Phadke, (Sathi)
Dr. Abhay Shukla (Sathi)
Dr. Ramila Bisht (TISS)
Dr. Kanchan Mukherji (TISS)

Dr. Raj Arole, the team (CRHP Jamkhed)
Smt. Salubai, Kalpana and other Village Health Workers, (CRHP Jamkhed)
Dr. Ahok Dayalchand, Field and Training Coordinators (IHM, Pachod)
Dr. Anita Kar – Coordinator. Health Sciences Dept. Uni. of Pune
Dr. N. H. Antia, FRCH, Pune.

CH Fellows:

Dr. Anant Bhan, Dr. Rakhal, Manjusha, Amen, Jyothi, Neeta

3.0 The process and learning experiences :

PROCESS	LEARNING
1. The 'Right' start – Health and Human Rights Course	• Health and Rights are so far treated as two exclusive fields – Now need to converge • Currently the relevant framework • National and International dimensions of Human Rights framework to which health can be taken • Range of Issues – from hospital setting to working with CSWs – which need to be addressed under community health
2. Search for an understanding of the issues of Centre for Community Health – The encounter with members of SOCHARA	• Personal encounters with the journeys, their current thinking and the growth (SOCHARA members) • Variety of things that they are involved in • People who have walked this path and are still not tired.
3. A legendary journey - Understanding Various facets of Community Health	• CRHP, Jamkhed: Primary Health Care, Demystifying medicines, rural illiterate people if trained adequately can be effective tools in primary health care • IHM Pachod: Even at grass roots level research and effective management are required and to be made use of for the empowerment and for primary health care. • FRCH, Pune: the experiments of Mandwa, Malsirus, Parinche bring out the aspect of People's sector, people taking charge of health. • MHW, TISS Mumbai: Skill based rigorous learning in health management • CSMCH, JNU, Delhi: Strong political perspectives on the politics of health, and the political economy of health. • School of Health Sciences, Uni. Pune: use of technology in health, molecular biology and laboratory based learning. • Cehat, Sathi, CSER: Research based policy work, interventions, trainings: how research and documentation can be a support to the people's movement • CHC, Bangalore: To work with a facilitator's catalyst approach. To look at CH with a balloonist perspectives.

4. Story of an untiring struggle -20 years of NARMADA BACHAO ANDOLAN	• PH to become a respectable profession took almost 35 years • People's struggle and movement never stop: health should become part of people's movements. • Never a point of clear victory/ success and achievement: it is not a project or a programme.
5. Tsunami – after one year	• The good, bad and the ugly faces of Tsunami – first experience • Learnt about the hopes, despairs and opportunities
6. Mid year review: Participation in the AIDAN and MFC	AIDAN/MFC: • 'Friendship' becoming part of the life-processes and journeys • PHM – experience of a collective journey of diverse personalities • Hope: where differences are scary the hope to work together • Handling differences and conflicts
7. Jan Swasthya Abhiyan: Participation in the Material Preparation Workshop	• The joys and struggles of working together where you have no individual gain • Inspiring to learn from the 'untiring' people
8. Participation in the discussions, strategy meetings, weekly team meetings, special staff development sessions at CHC	• A microscopic view of making things happen: the pains and gains, the joys and sorrows • History of the processes CH: historical overview • Journey of CHC

4.0 LEARNING EXPERIENCES

4.1 Looking Inward:

The nine months of fellowship was more of a journey inward as much as it was outward. From confusion to clarity, having focus to fine-tuning the focus.

4.1.1 Perspectives

4.1.1.1 From perspectives to finer aspects of perspectives is a long journey:

It has always been my understanding that there is no end to learning and 'in the school of life one always remains a student'. My prior involvements and work had given me a lot of perspectives of people's power, people's politics, gender, class and caste analysis and perspectives in work. However, the journeys of fellowship, discussions and readings made me realize that from having perspectives to fine-tuning these perspectives, having perspectives which are socially relevant and sound is a long journey and it is also a long struggle. Though Alma Ata Declaration slogan 'Health for all by 2000' came in vogue in 1978, it took 23 years to come to the realization that if it is not now, keeping these illusory deadlines is not going to bring about **'health for all'**. The people's health movement, the national and international assemblies are now stressing **'health for all NOW'.** I had occasion to visit the widely known projects in Community Health like Jamkhed. Though these projects are widely known and are known as model projects it has taken a lot of time and experimentation for the realisation to come that there are no model projects and only a micro level intervention cannot bring about health for all. It was very sad to see that the internationally known programmes in community health like CRHP Jamkhed, IHM Pachod are not involved in JSA. From intervention to rights perspectives, from rights to human rights is a long long journey. Attending the Health and Human Rights course at TISS Mumbai was an eye opener that we are still a long way from the understanding of health as human right.

Though working with Dalit women was a great experience, the time of fellowship gave me time to discuss about the finer aspects of gender empowerment, politics of alliance, working together, networking, social change, ... No single intervention can be taken in isolation and the only thing. Interventions have to be seen on a spectrum of social change and transformation.

Human Rights: Human Rights has been in the discourse for the last 50 years. However, it is only restricted to judicial processes, direct state violence on citizens. Health as a cultural and social right has not been discussed adequately. With the emergence of People's Health Movement and in the era of 'corporatising' all health facilities the denial of health has been taking a great toll of the lives of the poor. Human Rights is currently the right framework to talk of health. To this I was introduced in the HHR course. It gave me national and international perspectives on health rights.

4.1.1.2 **Adventurous and Path breaking Life-Journey of Individuals:** Meeting different people reinforced one single factor that bringing about change, adding quality to the change already brought about, giving birth to alternative processes has involved the adventurous and risk taking journeys of various individuals, and their commitment to the processes over a long time. Dr. Aroles have contributed to the concept of Primary Health Care and demystifying medicine. It has been a journey of over 33 years along with the people of the village that they are working with. Dr. Ashok Dayalchand and his team stressing the idea of professional approach to community health care has also taken decades of consistent work. Though they are the faculties in JNU, Ritu Priya, Rama Baru, Mohan Rao, Imrana Qadeer inspire how a faculty is still committed to the people's health movement. Their consistent perspectives and inputs have supported the alternative journey immensely. They needed to think out of the crowd and think differently from their own band of teachers and professors. The life of Dr. D. Banerji is a saga of an alternative journey from the days he spent his time in Himachal Pradesh to National Tuberculosis Institute and then to JNU setting up the CSMCH.

4.1.1.3 **Social change/social transformation is a collective effort:** The important thing that confirmed in me is that social change and social transformation is a collective effort. It drives home to me the folly of ghettoising social work, parochialism experienced so much among NGOs, building kingdoms for oneself. All efforts have to be seen through the prism of collective efforts for a collective change.

- *CRHP, Jamkhed:* Primary Health Care, Demystifying medicines, rural illiterate people if trained adequately can be effective tools in primary health care
- *IHM Pachod:* Even at grass roots level research and effective management are required and to be made use of for the empowerment and for primary health care.
- *FRCH, Pune:* the experiments of Mandwa, Malsiras, Parinche bring out the aspect of People's sector, people taking charge of health.
- *MHW, TISS Mumbai:* Skill based rigorous learning in health management
- *CSMCH, JNU, Delhi*: Strong political perspectives on the politics of health, and the political economy of health.
- *School of Health Sciences, Uni. Pune:* use of technology in health, molecular biology and laboratory based learning.
- *Cehat, Sathi, CSER:* Research based policy work, interventions, trainings: how research and documentation can be a support to the people's movement
- *CHC, Bangalore:* To work with a facilitator's catalyst approach. To look at CH with a balloonist perspectives.

4.1.1.4 **Catalyst mode of work:** Being on the fellowship a great learning was to understand the mode of working as facilitators or catalysts. CHC is a resource centre of different type: it provides space for people to come together, exchange ideas and encourages people to do something different. Going round the projects at different places I found people who have had lot of satisfaction in life because of what they did. However, the sense of satisfaction can be misplaced if one closes the mind and if project becomes the 'be all and end all'. However, seeing

the processes of PHA II and CHC's own works made me understand the importance of looking at the processes from a balloonist point of view. Without getting into the danger of being only too local but working through all those who are involved in different projects with a much larger perspective and facilitating the process of thinking and working together seems to me is the catalyst mode of work.

4.1.1.5 **Politics of Working Together:** The catalyst approach leads to the politics of alliance/working together, a Herculean task given the egos, undemocratic functioning in the voluntary sector, parochial short sighted approaches to work etc. People's Health Movement and Jan Swasthya Abhiyan was a great learning to this learning. Constant inputs from Dr. Ravi Narayan on his experiences of coordinating PHM for 3 years and participating in the material preparation workshop and attending the JAA-K meet in Bangalore was a learning about the thrills and challenges of working with a catalyst approach. Bringing together and keeping together the NGOs can be a killing job indeed. While PHM was an exciting job the pulls and pushes from different corners, and working with the leftists, not so leftists, the centrists, the feminists and the environmentalists respecting their diversities still trying to find the thread of commonality in purpose and approach is a great challenge. Participating in the JSA material preparation workshop enthused me seeing individuals and groups believing in working together and maturing together. However, it was disheartening to see a very few of the people involved in this process. Are people getting simply lost in projects without having a larger perspective while some have only perspectives and have no work? A combination of the two factors was something that I discovered in CHC. In the process of alliances and working through others I learnt the following:

- *Collectives/groups mature over a period of time:* Participating in the MFC, AIDAN, JSA meet the positive experience stayed in my mind was that it is very pleasant to work together. The people who came there came with passion and commitment to the issue of people's health. It is also a group which has matured over period of time and they are able to handle many conflicting issues and differences with maturity. It was also a learning for me that friends of MFC made JSA happen and contributed significantly to it. Hence it is important to belong somewhere and to a productive and positive thinking group. On the other hand Jana Arogya Andolana Karnataka (JAA-K) is a group which can still learn from the others and grow.

- *Collective work is a process* for common goals with common vision involving a lot of individual compromises in stands and positions.

4.1.2 Skills and ideas:

- Skill of Interviewing: The visit to Centre for Social Medicine and Community Health at JNU was a moment after a long time to boost my confidence in meeting professionals and stalwart personalities of whom I had then only heard about. Meeting Ritu Priya, Rama Baru, Mohan Rao, Imrana Qadeer, K. R. Nayar, Mohan Rao was a learning experience of great quality. Spending time at Dr. D. Banerji's house and talking to him for over 3 ½ hours
- Planning an itinerary: Meeting the SOCHARA members, visits to JNU in Delhi and a host of organizations and individuals in Maharashtra gave me an occasion to exercise and learn the skill of planning and fixing up the itinerary. It also taught me that a good planning helps one work better and with more clarity. A lot of stress could be reduced with better planning.
- Skill of writing is revived: Over a period of time I had developed sufficiently good amount of skill in writing. However, intensive field experience at Potnal (Raichur dist.) was a period somewhere this was shelved and only in times of pressure it was revised. With the fellowship there was the exercise of preparing the concept note and then the interview notes and the reports. It again sharpened the writing part of the skills.
- Skill to conduct sessions/ training: In the context of CHC which is a professional group and in the environment of a lot of experience as back up, it was an occasion to put new horizons and limits and standards in the training. I had the occasion to do sessions on social analysis, health rights to fellow-collegues, sessions on food security to grass roots people at Hanur, staff and women of CSA project at Hoskote, women and people of JMS Potnal (Raichur). For me personally, it was interacting with people with new perspectives and approaches to community health.

4.1.3 Self-awareness:

Reflection through the year made me aware of many areas in me which need growth:

- *Judgemental attitude:* Six and half years of intense involvement in the process of collectivising women agricultural labourers and the tough circumstances of Raichur had made me quite tough: Intellectually and emotionally. The stark and raw realities of poverty and marginalization, caste discrimination and the finer ways it takes place, the Dalit politics and power struggles, the corrupt public service system, the domination of upper castes in economy and politics etc. did desensitize me to many things in reality. Though one understood in theory that we need to strengthen the public system, I had grown very sceptical of the possibility of redeeming the public system or finding anything worthwhile in it. That there can be sensitive people in the system who are pro people, there can be genuine individuals of the upper castes who are sensitive to caste issues, that there can be Dalit leaders who are sensitive to gender equity etc. was more an issue of doubt rather than belief. However, I realized that this has taken

toll of being very sensitive and objective to realities. I also realized that I am very polarised in my evaluations and judgements.

- *Anti-intellectual bias:* Being part of the process I knew what was necessary at the grass roots level in the context of Raichur. Hence, anyone who spoke about policies and research would put me off and close my mind to that. That only work at the bottom of the pyramid can change things was a belief that came to stay with me.
- *Strong Opinions:* I also realized that I had cherished very strong opinions and I too understood gradually that these were based on some experiences. It took time for me to realize that these are personal positions and need not be strictly based on any objective criteria. It also took some time for me to understand that people oriented work has to go on from the policy advocacy to community intervention level. A convergence has to take place with these interventions. Hence even an intellectual alliance of perspectives and strategies is required to bring about change. Presently, we are all affected by pro-corporate policies and all the work even at the grass roots level is affected and dictated by this.
- *Reality is multi-faceted:* Any issue is not so simple and one cannot make simplistic analysis. Reality is multi-faceted and at any point of time we do not know everything. Hence it calls for more consideration and reflection than having judgmental attitudes is a great learning for me.

Personally,

- **Interaction with personalities in academics, organisations in public health, people who have spent time and life time in community health was a unique experience**
- **Persons and organisations included a range of aspects in community health: Field based work (Jamkhed, Ralegan), Academics and Policy work (CSMCH, Health Science Dept., TISS, Cehat)**
- **Field visits to Ralegan, Jamkhed, Pachod, Chennai were new experiences – made me understand the different facets of CH.**
- **Meeting Salubai and other women who have spent about 30 years as VHWs was a unique experience of an pre-Alma Ata experiment**
- **A week with NBA revived my activist spirit.**

4.1.4 Professional Development:

- CHFP was a time for professional development in terms of professional knowledge of the field, the theoretical frame work of Community Health/Public Health, at least be aware of the skills that are required and be associated with the professionals in the field.
- As a social work professional specialised in community development I had so far learnt to look at the issues around from the rights of the community (social movement) perspective. People awakening themselves to demand

creation, demanding from the state their rights. During the fellowship it was time to learn from professionals like Dr. Ravi and Thelma at CHC and other professionals in the Community Health/Public Health field who have expanded the scope of their professions from medical profession to community health profession. While professions – called by Ivan Illych "Disabling Professions" – becoming narrower and narrower in scope in the name of specialization and super specialisation, expanding the scope of professions by pushing the limiting frontiers is an anti-thesis.

- Knowledge, skills and perspectives: Fellowship period gave me a lot of new information, knowledge and broadened the horizons of my perspectives.

4.2 Looking Ahead:

Where do I go from here? I weighed and reweighed various options that are open to me in the field. My one skill that I have realized over the years teaching and training. Having a National Eligibility Test (NET) certificate is an added temptation to this. The other academic qualification is that of an advocate. To be able to de-mystify law and legal procedures and to help out the poor in the process is also a strong pull that I had. The field also requires good lawyers. However, from being an advocate to be an efficient one is a long journey. But my passion remains with the people's movement at a conceptual level and with the unorganised sector at a practical level. The women agricultural labourer's union (JMS) at Pothnal and the City Sanitation Workers (paurakarmikas) union in particular is something that I feel need to continue my association with.

I would like to locate these efforts for some years within the context and framework of 'COMMUNITY HEALTH' and 'HEALTH AS A HUMAN RIGHT'.

Looking at the future, I do not want the next phase from the cross roads to be a complete break from the past. I want to go forward carrying along with me the skills that I have gathered in the past. And community health / public health could be the context to do all the three. I would like to grow as a public health professional with feet firmly in the community.

Career transitioning: Looking at Dr. Ravi, Dr. Thelma and others in the field, I have realized that transition in personal journeys, career is part of any change. Looking within, I see myself at a mid-career level professionally: Professionally, it is a time for me to integrate what skills that I have gathered professionally or otherwise and take myself forward. In this process, reflection and evaluating oneself is very important. Fellowship was the time to reflect on my journey professionally. The career transitioning that I have reflected upon is that I should go forward in the profession of Community Health/Public Health integrating all that I have professionally acquired so far. May be we could term it career/professional transition or professional integration?

4.3 Regarding Centre for Community Health:

Focusing on the issue of CCH was also a very good learning experience. The outcome of the whole exercise could be summarised as follows:

- *Putting the idea across:*
  - ➢ The visits served as space to put the idea across about the proposed CCH to people who had known about CHC.
- *In-depth discussion:*
  - ➢ Though a summary note was sent to all of them, it is only while discussing across the table that the discussants thought about it in details and were able to visualise it.
- *Suggestions and Critique:*
  - ➢ In the context of the discussion, many gave their suggestions and their visualisations about the concept of CCH which will feed into a broad based conceptualization.
- *Sharpening of the ideas:*
  - ➢ In the context of discussions there are reflections and questions which will help in sharpening our own ideas
- *Ideas of Networking and Collaborations:*
  - ➢ Ideas of possible tie-ups, availability of resource persons, making space available for fellows etc. was discussed. Some organisations like Cehat who have more similarities with CHC have shown overwhelming excitement over the idea. They also have suggested towards making it a collective/collaborative venture, an idea which needs further fine-tuning.

5.0 My Understanding of Community Health:

As far as I am able to articulate it now within my limited experiences in the field of community health I feel community health is a process with combination of many elements and it is one of the basic aspects of social transformation:

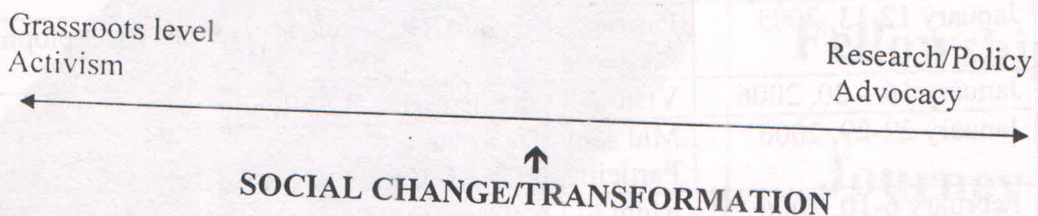
- Community Health is that process of empowering communities
  - ➢ Which **enables them to know the processes**, powers and dynamics (micro-meso-macro) that affect the lives and health of the 'community' (Community not necessarily geographic – e.g. sex workers)
  - ➢ **and investing such efforts which will equip them** with knowledge/information, skills and decision making power to choose such factors that favourably determine their health
  - ➢ and also **enable them with awareness to take such actions** to counteract such forces that will adversely affect their health.
- A range of activities with the 'perspective' of the most marginalized in the communities: from training, to collective efforts to policy and research which will make health for all now (universal access and availability of health resources) possible for 'people'.

6.0 Summary:

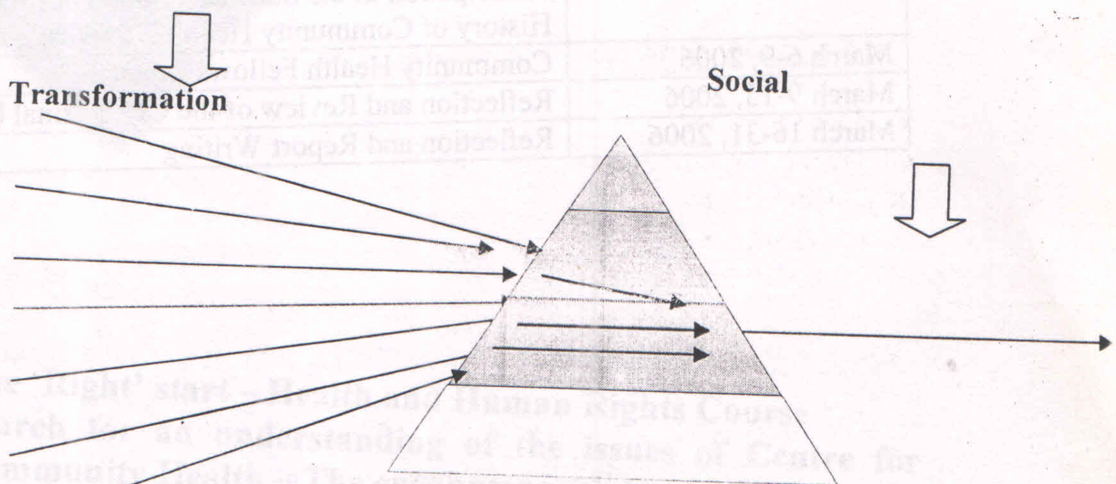
Social change and transformation is a collective effort and it involves range of efforts and strategies: It shall not be brought about by any single person or by any single intervention. Hence I pitch myself in history as one of the tiny sparks in the process of social transformation. Historically all efforts originating from the alternative paradigm in the praxis of reflection and action are to be pitched in this framework of collective effort for social transformation, towards the inauguration of a just and equitable social order.

This could be summarised in the following metaphors of continuum/range and reverse prism.

1. RANGE/CONTINUUM:



2. SPECTRUM: Reverse Prism

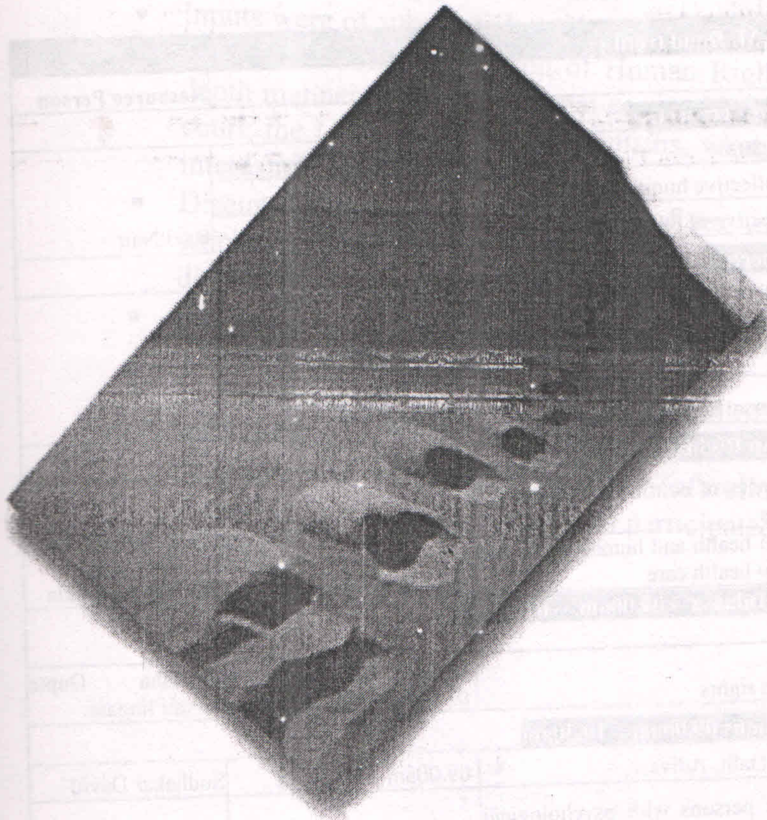


1.4 MY JOURNEY OF FELLOWSHIP: THE ITINERARY

Date/Duration	Particulars
July 3-15, 2005	Health and Human Rights Course, TISS/Cehat, Mumbai
July 15-August 30, 2005	Interviews with the SOCHARA members and discussions
Sept. 1–15, 2005	Formulation of the Concept Note on CCH
	Health Training at JMS
October 8 – 22, 2005	Visit to Delhi: CSMCH, PEACE, CFAR
Nov. 5 – Dec. 2005	Visits to Cehat, FRCH, CRHP, IHM, NBA
December 6, 2005 – January 15, 2006	Time for Reflection
January 12-13, 2005	Participation in CHC review and staff development session
January 16 – 20, 2006	Visit to Tsunami areas – Tamilnadu
January 22-29, 2006	Mid semester Review Participation in MFC, AIDAN meet
February 6-10, 2006	Right to Food Security discussions, Hanur, Kollegal
February 15- 23, 2006	Health Education and health Training, JMS, Potnal (Raichur)
February 24-25, 2006	Participation in JSA Material Preparation workshop
February 27-28, 2006	Participation in the Staff Development Program of CHC History of Community Health: 70s-90s
March 6-9, 2006	Community Health Fellows' Meet
March 9-15, 2006	Reflection and Review of the CHFP final batch
March 16-31, 2006	Reflection and Report Writing

SECTION 2

The Footsteps of the Fellowship Journey



1. The 'Right' start – Health and Human Rights Course
2. Search for an understanding of the issues of Centre for Community Health – The encounter with 'path makers'
3. A legendary journey - Understanding Various facets of Community Health
4. 20 years of NARMADA BACHAO ANDOLAN – story of an untiring struggle
5. Flashes of other learning:
   - Tsunami, Participation in the AIDAN and MFC, Jan Swasthya Abhiyan (JSA): Participation in the Material Preparation Workshop, staff development sessions at CHC

2.1 THE 'RIGHT' START – HEALTH AND HUMAN RIGHTS COURSE

Health and Human Rights course : The module on Health and Human Rights was jointly conducted by Tata Institute of Social Sciences, Mumbai and Centre for Enquiry into Health and Allied Themes (Cehat), Mumbai from 4th July 2005 – 13th July 2005 at TISS. This was meant for those who are involved in the field and to provide Human Rights framework for the participants and the work for their respective fields.

Inaugural Session: Honorable Justice S. M. Daud (retd.)				
Day	**Session**	**Topic**	**Time**	**Resource Person**
Module I - Introduction of Human Rights Perspective				
	Session 1	Philosophy of rights	10.00am – 11.00am	
	Session 2	The theory of collective human rights	11.15am – 01.00pm	
4/7/05	Session 3	Historical perspective of human rights	01.45pm – 05.30pm	Ravi Nair
Module II - Introduction of Health Perspective				
	Session 1	Political economy of health and health care	09.00am – 11.00am	
	Session 2	Public health and health care	11.15am – 01.00pm	
	Session 3	Health financing	01.45pm – 03.45pm	
5/7/05	Session 4	Health care universal access and equity	04.00pm – 06.00pm	Ravi Duggal
Module III - Exploring Health and Human Rights				
	Session 1	Health consequences of conflict situations and violation of rights	09.00am – 01.00pm	Dr. Harish Shetty
6/7/05	Session 2	Linkages between health and human rights and concept of right to health care	02.00pm – 06.00pm	Dr. Abhay Shukla
7/7/05 - Field Visit to Bhabha Hospital & Dilaasa - 09.00am – 01.00pm Half day Holiday - 02.00pm – 06.00pm				
8/7/05	Session 3	Gender and health rights	09.00am – 01.00pm 02.00am – 06.00pm	Manisha Gupte Laxmi lingam
Parallel sessions – plenary of the both sessions 09.00am – 10.30am				
	Session 4	Health impact on Dalit, Adivasi	09.00am – 06.00pm	Sudhakar David
9/7/05	Session 5	Health impact on persons with psychological disabilities	09.00am – 06.00pm	Bhargavi Davar
	Session 7	HIV/AIDS discriminations and human rights violations	09.00am – 01.00pm	Anand Grover
10/7/05	Session 8	HIV and Health impact on sexual minorities	02.00pm – 06.00pm	Meena Sheshu
11/7/05		Health impact on displaced and homeless	09.00am – 01.00pm	Dr. Parsuraman
11/7/05 - 02.00pm – 06.00pm Half Day Holiday				
		Prison Visit - Central Prison, Mumbai	09.00am – 01.00pm	TISS
12/7/05	Session 9	Torture – A health and human rights issue	02.00pm – 06.00pm	Dr. Amar Jesani
Module IV - Monitoring Right to Health and Health Care				
	Session 1	Basic elements of human rights: monitoring and act finding	09.00am – 01.00pm	
13/7/05	Session 2	International criminal court and international court of justice	02.00pm – 06.00pm	Ms. Aleid Bos
	Session 3	How to bring a case in un - the mechanism, shadow report	09.00am – 01.00pm	
14/7/05	Session 4	Participatory expenditure tracking and community based programme monitoring mechanisms	02.00pm – 06.00pm	Ms. Aleid Bos
15/7/05	Session 5	Indian judicial monitoring mechanism and National human rights commission	09.00am – 01.00pm	Adv. Mihir Desai
Evaluation, certificate distribution and closing ceremony - by Justice Mane, Chair Person SHRC				

Major Learnings from the Course:

- This course gave me the right start for my fellowship in the framework of Human Rights, a subject which I loved very much;
- There is a lot of expansion of the understanding of Human Rights and also of Health Rights. However these two disciplines have hardly met. This course gave linkage to each other.
- Inputs were of substantial quality.
- The international dimension of Human Rights was brought out in an in-depth manner. The international court of justice and international criminal court, the UN monitoring mechanisms, what NGOs can do etc. were very interesting aspects of learning.
- Discussion of gender, sexual rights of sex workers and sexual minorities, women and HIV positive persons, mentally challenged and of people with disability – was set in the framework of Human Rights
- Field visits to Dilaasa project at Bhabha Hospital and Central prison were also were very enriching.
- The wide variety of participants consisted of field workers in the field of sex work, HIV positive, hospital based work, practising doctors, participants from Bangladesh (Dr. Zafarullah Chowdery's Gonoshastra organisation also one of those who participated in the course)

2.2 ENCOUNTER WITH 'path makers'

History is full of people who walk the beaten track/the path walkers. But it is the 'pathmakers' who make history. At a time I was trying to understand the history of community health, my journey of fellowship gave me an opportunity to meet number of those people, most of whom have walked the path breaking journeys. It consisted of rare and daring personalities who have lived very humble lives but have dared to be path makers rather than path-walkers. These included the SOCHARA (Society for Community Health Awareness Research and Action) members and members from number of other organisations and significant individuals from within those organisations. It humbled me to meet less known people like Salubai at Jamkhed who have been the pillars of CRHP of international fame.

INSTITUTIONS/ORGANISATIONS VISITED

- Centre for Social Medicine and Community Health (CSMCH), JNU Delhi
- Centre for Advocacy and Research (CFAR), Delhi
- Popular Education Action Centre –PEACE-, Delhi.
- Nucleus for Health Policy and Planning –NHPP-, Delhi.
- Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai
- Centre for Studies in Ethics and Research (CSER), Mumbai
- SATHI Cehat - Pune
- Tata Institute of Social Sciences (TISS), Mumbai
- Foundations for Research in Community Health (FRCH), Pune
- Comprehensive Rural Health Project (CRHP), Jamkhed, Maharashtra
- Institute of Health Management, Pachod- Maharashtra
- School of Interdisciplinary Health Sciences, Pune University, Pune.

PERSONALITIES INTERACTED WITH

Dr. C. M. Francis
Fr. Claude D'Souza
Dr. Devadasan
Dr. Roopa Devadasan
Dr. Shirdi Prasad Tekur
Ms. Padmasini
Dr. Rama Rao

Sochara members

Dr. Imrana Qadeer,
Dr. Ritu Priya,
Dr. Rama Baru,
Dr. Mohan Rao,
Dr. K. R. Nayar
Dr. D. Banerji

JNU

Ms. Akhila Sivdas – Journalist & Coordinator CFAR
Mr. Anil Chaudhari and team (PEACE)

Ms. Padma Deosthil – coordinator, Ms. Amita Pitre (Cehat)
Dr. Amar Jesani (CSER)
Dr. Sunita Bandewar – Anthropologist (CSER)
Dr. Ananth Phadke, (Sathi)
Dr. Abhay Shukla (Sathi)
Dr. Ramila Bisht (TISS)
Dr. Kanchan Mukherji (TISS)

Dr. Raj Arole, the team (CRHP Jamkhed)
Smt. Salubai, Kalpana and other Village Health Workers, (CRHP Jamkhed)
Dr. Ahok Dayalchand, Field and Training Coordinators (IHM, Pachod)
Dr. Anita Kar – Coordinator. Health Sciences Dept. Uni. of Pune
Dr. N. H. Antia, FRCH, Pune.

CH Fellows:

Dr. Anant Bhan, Dr. Rakhal, Manjusha, Amen, Jyothi, Neeta

MEETING SOCHARA MEMBERS

The Society for Community Health Research and Action (SOCHARA) is composed of many eminent persons who have dedicated their lives in their respective fields and have worked with a pro poor perspective. The task of conceptualization on the Centre for Community Health (CCH) took me to discuss this issue with various members of the society. As Dr. Thelma, the Coordinator of CHC, and Dr. Ravi Narayan, the co-initiator of CHC, said that the society members have been the backbone of the work with their unstinted support all the time. The meeting was proved not only to be a business talk on the concept of CCH, but also a personal sharing of their work.

Dr. C. M. Francis

Ex-dean of St. John's Medical College and contributed his service to CHC as an advisor till late. He is also the founder of Kottayam Medical College which he said was started in small sheds but second to none in quality. He is known to be brain par excellence and he is an example who have surpassed his physical disability and excelled in his field. His simple life-style and being prompt in his work stands out in his personality.

Fr. Claude D'Souza

The vice-president of society, Fr. Claude D'souza is known for his concern for masses, mass education and mass movement. He is one of the rare personalities who has mentored many alternative path seekers in the past decades.

Dr. Devadasan & Dr. Roopa Devadasan :

Both have worked for number of years in Gudalur (Tamil Nadu) with the organisation by name ACCORD which worked with the tribals. They were also

with CHC for some time. Dr. Devadasan is doing his PhD from Belgium and is wanting to start an Institute of Public Health to train government doctors and middle level staff to improve the Public Health. Dr. Roopa is currently teaching in Valley school, Bangalore. Health Education, she says, has to start from children and that's why she feels that teaching also is an extension of her public health profession.

Dr. Shirdi Prasad Tekur:
Dr Shirdi was the coordinator of CHC earlier and he is known as a wonderful trainer in Community Health. He is also practitioner of multiple of systems of medicine and now he is into spiritual healing. Extremely unassuming and simple as he is, he travels extensively in Karnataka and supports many groups in community health trainings.

Ms. Padmasini Asuri :
She has been active member of SOCHARA and was the treasurer at the time of meeting her. She is professional in nutrition and is very practical in her approach and teaching.

Dr. Rama Rao:
He served as a medical officer and also is member of the Deena Seva Sangha, a Gandhian organisation established in 1925. His spirit even at this age of 82 was very inspiring.

Dr. Thelma and Dr. Ravi Narayan:
They were in search of an alternative paradigm in health and hence moved beyond their institutional boundaries of teaching in a medical college. They co-initiated CHC as the expression of this search.

Dr. Sudarshan:
Dr. Sudarshan who is now the Vigilance officer in the Lokayukta worked in the B. R. Hills with the Soliga community for number of years and is known for his outspoken approach against corruption.

Other people who I met or had conversation with are Dr. Ravi D'Souza, Dr. Paresh Kumar, Dr. R.L. Kapur, Mr. Mohammad, etc.

Centre for Community Health: The members of SOCHARA gave useful ideas and concepts which later on helped formulate the concept note on the CCH. It helped towards clarifying issues and confusions, identifying areas of concern which required further study and identify grey areas which required deliberation. (Vide …)

IMPRESSIONS AND LEARNING EXPERIENCES

- The dedication and conviction to do something that they believed in
- The genuine concern for people
- The indomitable faith and conviction in people oriented development and heath care
- In spite of all the odds the optimism that is seen in their lives and work

2.3 LEARNING EXPERIENCES FROM VISITS

As part of the feasibility study undertaken by CHC for the Centre for Community Health (CCH/ALC) which followed the formulation of the concept note and a presentation at the Annual General Body Meeting in Sept. 2005, the following institutions were visited from among the short listed ones.

October, 2005:

- Centre for Social Medicine and Community Health CSMCH, JNU (Delhi) (Dr. Imrana Qadeer, Dr. Ritu Priya, Dr. Rama Baru, Dr. Mohan Rao, Dr. K. R. Nayar)
- Centre for Advocacy and Research (CFAR), Delhi (Ms. Akhila Sivdas –.Journalist & Coordintor)
- PEACE, Delhi. (Mr. Anil Chaudhari and team)
- Dr. D. Banerji, (Nucleus for Health Policy and Planning-NHPP), Delhi.

November, 2005:

- Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai (Ms. Padma Deosthil – coordinator, Ms. Amita Pitre)
- Centre for Studies in Ethics and Research (CSER), Mumbai (Dr. Amar Jesani, Dr. Sunita Bandewal)
- SATHI – Cehat, Pune (Dr. Ananth Phadke, Dr. Abhay Shukla)
- Tata Institute of Social Sciences (TISS), Mumbai (Dr. Ramila Bisht, Dr. Kanchan Mukherji)
- Foundations for Research in Community Health (FRCH), Pune (Dr. Antia, Dr. Shubha/Dr. Rakhal)
- Comprehensive Rural Health Project (CRHP), Jamkhed, (Maharashtra) (Dr. Raj Arole, Ms. Shaila Deshpande and the team, Village Health Workers)
- Institute of Health Management, Pachod (Maharashtra) (Dr. Ahok Dayalchand, Field and Training Coordinators)
- School of Interdisciplinary Health Sciences, Pune University, Pune. (Dr. Anita Kar – Coordinator)

The following text is a brief note on the general learning that one has picked up. The detailed notes on the visits is in the process of compilation which also will have some finer aspects which may not necessarily be included.

A. DELHI VISITS:

1. CSMCH-JNU:

- The Course is recognised by UGC as M.Phil. It is not recognised by MCI. The doctors get a MCH degree and only the other disciplines get M.Phil degree.
- Perspectives: CSMCH has strong roots in the political-economy of PH; very strong on socio-economic and political context of the country and public health;
- Inter-disciplinary approach in teaching, learning and research
- Rigorous course – the first year course is equivalent to a MPh; Second year is for research.
- Pedagogy: Discussions, field visits, seminar presentations, journal clubs, research are used
- Research is also a main focus.
- CSMCH has a very good team of faculty which is multi-disciplinary. The faculty is known for their commitment to the cause, quality of teaching and concern for students.
- In a democratic spirit of functioning, every two years the chairperson is rotating. Hence most of the senior faculty has taken up the administration work.

Comments about CCH:

- ❖ Quite happy about the idea of the learning centre.
- ❖ If planned out in advance, some are ready to give some time as visiting faculty.

2. PEACE- Popular Education Action Centre, Delhi:

- Resource and Training organisation that has the strong philosophical basis of demystifying economics, budgets, etc.
- Train organisations and people mobilised by organisations on the economic policies, changes and facilitates understanding the changes, trends and patterns.
- Strength is transparency, accountability in the organisation, and trainings.
- Like demystifying medicine, demystifying economics has been a good experiment. The organisation has remained small with their approach as facilitators.

3. CFAR- Centre For Advocacy and Research, Delhi:

- The organisation has worked with the media and advocacy for the last 10 years.
- They have also participated in the campaigns related to PH like PNDT Act, discrimination against the HIV positives, gender issues etc.
- Very professional and do consistent work in understanding the working of the media. Being an experienced journalist herself, Ms. Akhila Sivdas has

the inner insight of the media. Hence one of their main job is to work with the 'newsmakers' of the news.

- Media Education also is part of their campaign.

  - They train organisations in issues related to media, how to work with the media, etc.
  - They are willing to train organisations in perspective and capacity building only if the entire organisation including the decision making level cadre is involved.
  - CFAR is willing to collaborate if we want to understand the media campaigns, how the media works, need collaboration in any campaign related to PH etc.
  - Their strength is their professional approach to work..

B. MAHARASHTRA VISITS:

4. CEHAT, CESR, SATHI:

- After almost 10 years working, the organisation has grown big with difficulties to function as one unit. Hence the year 2005 saw the emergence of 3 independent institutes(units) but still linked to Anusandhan Trust. The three units are autonomous, self-organised/administered but are linked to Anusandhan Trust for legal and financial purposes.
- This division/trifurcation went through a process of two years of discussions and debate in the context of Organization Development.

Learning factors:

a. Experiments towards democratic, transparent and non-hierarchical functioning; structures created for democratic space is worth studying: Concept of the 'Working Group' (WG), power and accountability to 'Project Incharges' (PI) who in turn have to work with their own team keeping in mind the principles of democratic functioning, accountability and transparency , etc. The issue to be considered is how to ensure that the staff has much stake and responsibility in the organisation, rather than being only employees.
b. Institutionalisation of ethos: The core-group though are now divided into three units, are present in all the three, hence a continuity with change is assured. The transition, though akin to a major surgery, has survived the crisis with almost all the people staying on and the next line of leadership from among staff slowly being geared take over the leadership in a phased manner.

c. Research based action, rigour in research and demonstrated action projects have been part of their work.

d. Trainings: Areas of strengths are developing modules, trainings, research on private sector, health financing/budget, violence, human rights. The trainings conducted, some of which have been accredited are,

- Health and Human Rights Course (2005, 15 days, accredited by TISS)
- HHR: Faculty (module on health) for the pol. Sci. dept of Mumbai University
- Law school Pune has started a course on 'domestic violence': Cehat is participating as faculty for the health part.
- Paralegal training: with ICHRL (2 days)
- Feminist Counselling: for victims of violence and grass-roots level workers
- Studying budgets: for professors, activists, Panchayat members etc.

Comments about CCH:

- Very happy that a rigorous exercise is undertaken like this to talk to people and to make a study. Hardly any does it these days.
- Very enthusiastic about the idea. Open for collaboration in terms of exchange of personnel, resources, etc.
- Centre is a need:
    - To promote people with perspectives
    - To promote alternative PH
    - To work even at policy level for government and mainstream medical people
    - To put together concerted efforts to get people with certain kind of perspectives
- Certificate would be necessary: A tie up with a deemed university/open university would be good.
- Multi-layered course is required: fellowship for some; targeting teachers in medical college; voluntary sector; reach out to people who think differently; research and training on the pvt. Health sector; also to evolve new strategies and courses with the requirements of issues (e.g. domestic violence)
- CHC has an established credibility to do the job.

Suggestion: Define the role clearly: Why we do certain things, Why we don't do and What we can't do (very important to keep the focus amidst varied expectations)

5. TATA INSTITUTE OF SOCIAL SCIENCES, Mumbai

T.I.S.S. offers two years masters course in Hospital and Health administration and a Diploma in Hospital Management. The selection for the former is done as per the practice of the institute with entrance exams, Group Discussion and interviews. The latter is however is like a open schooling course conducted in the week ends and flexibly structured.

- **Masters in Hospital/Health Administration** is generally perceived as a management course for hospital and health programs: Corporate hospitals oriented.
- Modular based, rigorous masters level program and is a applied course aimed at giving skills required for program management in public health

programmes: It goes beyond the boundaries of PSM/CSM: Imparts skills to PH practitioners: Management skills, MIS

- Very strong on methodology: Quantitative, Qualitative, Operational research, systems research, epidemiology, advanced epidemiology
- Internships: 5 weeks of internship in each of the 4 semesters each amounting to 6 credits. : The placements are in Urban NGO, Urban Public Hospital, Rural health NGO and Directorate of Health Services (Sub centre to State Headquarters of health system)
- No MCI recognition to the course so far. The Jammu and Kashmir State and Mumbai Municipal Corporation recognise the course..
- **Diploma in Hospital Management**: Is a modular course for which classes are held in the evenings and week ends. It is also a modular course which gives a certificate for six months completion and diploma for a one year completion. The time period to finish the diploma is five years; there is a flexibility in completing the modules within five years.
    - Govt. departments also depute their staff for this course
    - Some others come in view of VRS and joining INGOs

Pedagogy: Class room lectures, presentations by students, internships, assignments, research report during internships.

Curriculum: Foundational courses for two semesters and specialization for Hospital and Health Administration for the remaining two semesters.

6. COMPREHENSIVE RURAL HEALTH PROJECT, Jamkhed

- Huge and comprehensive programme in community based primary health care.. Now expanded to even beyond Maharashtra.
- **Jamkhed Institute of Training and Research in Community Health and Population** was established in 1992. Courses are offered throughout the year on **Community Based Health & Development (CBHD)**
    - 2 Months course conducted generally in October and November.
    - Aimed at those who are already working (Middle level) or are likely to work.
    - The Fees is Rs.15,000/= (inclusive of boarding and lodging)
    - At the end of the 2 months, a certificate is given and after 8 months of completion of work in the field the completion certificate is given.
    - English language as medium is compulsory.
    - The resource team consists of Dr. Raj Arole, Dr. Shobha Arole, Ms. Connie Gates (USA), the field workers and VHWs.
    - VHWs are also involved in training as resource persons
    - The batches consist of on average 20-25 participants: The foreign students including those from Nepal form the majority of the participants.
- They refer to Alma Ata in their facilitation. But didn't show any inkling about JSA or PHM.

Concerning CCH: Dr. Raj Arole said for those who are interested in learning primary health care a composite course for four to five days could be arranged. He preferred learners coming over to Jamkhed.

7. INSTITUTE OF HEALTH MANAGEMENT, Pachod.

- IHM conducts only short courses (6 days – 15 days)
- Most of the trainings are linked to their projects in child and women' health and from management perspectives.
- Research is a strong component of their intervention which sustains the projects: Baseline Research, intervention and research on impact assessment.
- Faculty are all part of the research projects.
- The VHWs are now called Community Organisers are the lower most research investigators, feeders of data and intervention is done through them. Mostly medical intervention.
- Institute has simple and adequate infrastructure for trainings: from community or grass roots level workers (open halls) to middle level PH staff.

Concerning CCH: Any field based module on health management, Management Information Systems can be worked out with IHM.

8. THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH (FRCH), Pune

- The field experiments at Mandwa, Parinche and now in Ralegan are very innovative projects
- The very strong philosophy that has emerged from these experiments is the enabling People's Sector, people's control of health, making democracy (panchayat raj) active and alive in the community health programmes.
- Trainings: The NIOS (National Institute of Open Schooling) has taken the subject of Community Health Training. The course is of one year and two years duration. Now Dr. N. H. Antia wants also to replicate it in other places. They have well developed syllabus.
- Dr. Antia is very positive about CCH.

9. SCHOOL OF INTERDISCIPLINARY HEALTH SCIENCES, Pune

- It is a MSc in Health Sciences course, headed by geneticist, wherein molecular biology, laboratory based technical learning are the predominant built in aspects of this department.
- Now they are building in a module of Public Health for half the batch which will be recognised by MCI.
- Positive aspect is that it is one of the few departments in the country which is fully equipped with a laboratory for experiments, testing of drugs, food etc.

C. A GENERAL FEEL ABOUT THE VISITS

1. Putting the idea across: The visits served as space to put the idea across about the proposed CCH/ALC to people who had known about CHC.
2. Deeper discussion: though a summary note was sent to all of them, it is only while discussing across the table that the discussants thought about it in details and were able to visualise it.
3. Suggestions and Critique: In the context of the discussion, many gave their suggestions and their visualisations about the concept of CCH which will feed into a broad based conceptualization.
4. Sharpening of the ideas: In the context of discussions there are reflections and questions which will help in sharpening our own ideas
5. Ideas of Networking and Collaborations: Ideas of possible tie-ups, availability of resource persons, making space available for fellows etc. was discussed. Some organisations like Cehat who have more similarities with CHC have shown overwhelming excitement over the idea. They also have suggested towards making it a collective/collaborative venture, an idea which needs further fine-tuning.

The spectrum of the context and strength of the visited organisations gives us a small glimpse of their current status and intervention. Perhaps we can pick up specific learnings from each of these institutions and build them into the *uniqueness and richness* of our own experiences at CHC. CCMCH, TISS and Health Sciences department give the academic contexts with their sensor antennae firmly tuned to the need of the society or demands of health market. But a tangible effect of their output is yet to be felt in the field of Public Health. The Jamkhed and Pachod experiments give micro level realities, however, openness and collaboration with others is a casualty in the process of being very micro-focussed. CEHAT and FRCH somewhere are experiments who have their sensors high and still their roots deep with much openness to social/peoples movements and people's sector. While moving into the CCH we can learn from these varied approaches, their strengths and weaknesses and enrich our perspectives.

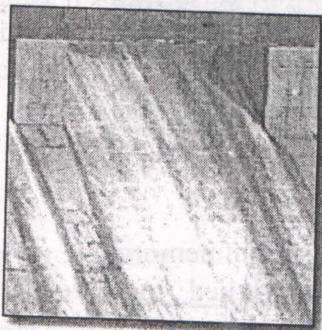
Eddie Premdas

(Submitted to the meeting of the Executive Committee of SOCHARA on 02.01.2006)

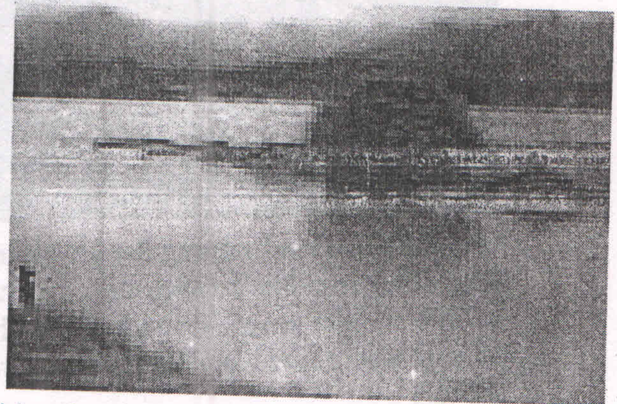
2.4 STORY OF AN UNTIRING STRUGGLE : 20 YEARS OF NARMADA BACHAO ANDOLAN

Background:

Narmada Bachao Andolan is one of the well known and one of the largest mass movements of the people displaced and affected by mega dams. NBA took shape in the context of the Narmada Valley Development Project spread across Madhya Pradesh, Maharashtra and Gujarat. The huge project consists of 28 big dams, 135 medium dams and 5000 small dams on the main river Narmada and its tributaries. While some of the dams have already been built quietly displacing lakhs of people, the issue of big dams and right to life and livelihood of the people emerged as a major issue in the mid 80s in the context of one dam viz. Sardar Sarovar Dam built in Gujarat but submerging 19 huge villages of Gujarat, 33 huge villages of Maharashtra and 196 huge villages of Madhya Pradesh. The official estimate of the directly affected household is 44,000 families in 1980.



Besides the mainstream farmers and the peasant classes the most marginalised and voiceless section that is affected is the various adivasi communities along the banks of Narmada, in the valley of Vindya Satpuras, which is today archaelogically is known as the most ancient civilization in the subcontinent even predating the hitherto known Harappa Mohenjodaro civilization.



The destruction of the SSP does not stop only at submerging the villages on the banks in the reservoir of the dam. There are 10000 families who were surviving on fishing in the command area of the dam who are affected; also there is a sizeable population of 1,50,000 people who are affected by the huge network of canals across Gujarat; nearly 2,50,000 tribals are affected by the wild life sanctuaries which have come up in the name of protecting environment and considered as compensatory afforestation in place of 30,000 hectare of ancient forest that is submerged in the reservoir of SSP. Hence a dam displaces and affects the livelihood of nearly 7 lakh people. From the side of Arabic sea SSP is the first dam on Narmada river. Behind it are equally devastating dams like Maheshwar dam, Narmada (Indira) Sagar dam, Veda, Bhargi etc.

It is 20 years since the affected people are struggling for justice – for just rehabilitation along with raising the questions of 'what is development?', 'whose development?' 'what kind of development?', the political economy of development etc. NBA triggered this debate off two decades ago. While it was a continuous struggle against the bourgeoisie democracy and the bourgeoisie state which cares nothing for the subalterns, the lower classes/castes and the powerless. It was a struggle against the insensitive state to the plight of the affected adivasis and farmers, to the unjust state policies which are biased towards the rich-affluent, the industrial mode of destructive development that is thrust through the throats of people which has been a death-knell for the alternative paradigm of developments, against the upper class controlled media, apathetic judiciary and the anti-poor judicial system, against a violent state….

20th anniversary (1985-2005):

Series of events were organised as a precedent to the 20th year Commemoration of the struggle. In Nimad (i.e. Badwani, Khargone and Dhar districts) motor bike rallies, discussions, protests were held. I participated in the motor bike rally across Dhar and Badwani districts. Dharampuri is an old 800 year full-fledged town which is fully getting submerged. So also Kalghat on the banks of Narmada is a huge settlement which also will be submerged. But the residents are now caught between the devil and the deep sea as they all have taken cash compensation which has now turned out to be pittance. A lot of corruption in disbursing cash compensation has taken place. Prior to this event, on the complaint of NBA 16 officials of NVDA were suspended due to their involvement in corruption in disbursing compensation.

The 20th year commemoration of the struggle was marked by a national seminar on the issue of 'Big Dams, Development and Alternatives'. It was attended by around 300 delegates from different parts of the country. The second day was marked by a huge rally where nearly 8000 people participated asking the state to implement land to land rehabilitation. This demand came in the context of Supreme Court order in March 2005 restraining the government giving cash compensation and making land compensation compulsory. Madhya Pradesh government was busy coercing people to take cash compensation. The dam now is at 110 mts. height. A new slogan was coined in Hindi : " *ek sau das, ab bas*" (110 meters, that's it-no more")

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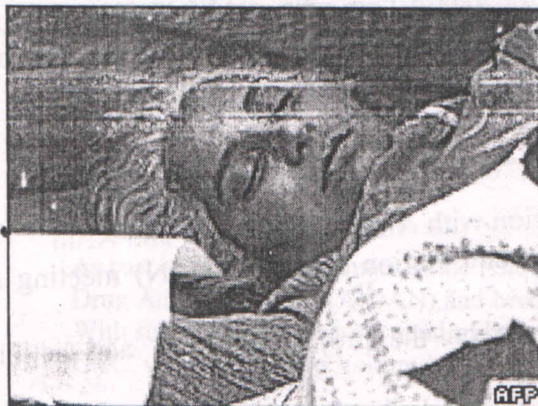
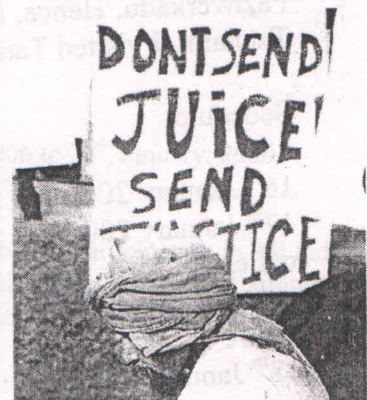
The upper most feelings that were in me were

- A wave of shock in seeing to what extent a state can lie and cheat its citizens
- What is real democracy and is there real democracy in India? It is a rule by the powerful to serve its own class interests. Development projects are pushed through to destroy and annihilate.
- Corruption involved in even in giving cheques was of gigantic proportions. Besides, with the money people had clothes, motor bikes and other goods. No real savings or investments had taken place.
- Meanwhile the grit and determination of people to continue the struggle for over two decades was awe inspiring. The core cadre has greyed and have become old but are still at the fore front of the struggle. Kamalu didi, kaki, ashish bhai, Vankya bhau, Nurji Padvi, Vankya bhai, Vittal bhai, are all faces that come live while one remembers the struggle.





Medha Patkar on Hunger strike demanding rehabilitation to the outstees in Delhi in April 2006

2.5 OTHER FLASHES OF LEARNING

The other learning experiences are flashes that I happen to get through some unplanned/unscheduled visits, regular participation in CHC activities and some workshops that I happen to participate.

- Tsunami – after one year
- Mid year review: Participation in the AIDAN and MFC
- Jan Swasthya Abhiyan: Participation in the Material Preparation Workshop
- Participation in the discussions, strategy meetings, weekly team meetings, special staff development sessions at CHC

1.0 Tsunami – after one year

One of the greatest tragedies to have affected South East Asia in the recent past is Tsunami. In India nearly 7000 people lost lives and lakhs of people lost livelihood. However I had never had a chance to visit Tamil Nadu and the affected parts. CHC too had participated in the relief phase and later as part of the involvement in the rehabilitation phase had continued involved in Chennai and Pazhverkadu. Hence, for a preliminary feel of the lives of people after one year of Tsunami, I visited Tamil Nadu.

Schedule:

16th January 2006 : Discussion with Amir, Asha, Satya and Arun
17th January 2006 : Pazhverkadu Action Network (PAN) meeting at Loyola college

Discussion on the project proposal and action for the future
18th January 2006 : Visit to Pazhverkadu, the second biggest salt-water lake in India after Chilika. Visited the offices of PAM, Bhoomi, Cartitas, MSS.
Also attended the sessions conducted by Satya, Asha for the Students' club members (college students)
19th January 2006 : Fellows discussion on Cuenca Declaration at the CHC office at Balamandir. In the afternoon visited the Kargilnagar and the semi-permanent shelters built by PAM (People's Action Movement) and Karunalaya.
20th January 2006 : Visit to Srinivasapuram and the Marina Beach/Seashore which was affected by the Tsunami.

Observations and Learning Experiences:

- My first and firsthand visit to the area gave me a feel of the disaster and its impending impact even after one year.
- Learnt about Chennai NGO Coordination Council in which Mr. Rajendran was involved on behalf of CHC. And also about PAN which was facilitated by CHC staff Amir Khan.

- New experiences about the inter community dynamics in the fisherfolk communities of Pazhverkadu lake. The issue of prawn-picking women was new to me: their kind of work which requires to be in the lake for over 6-7 hours and earn a little at the end of day.
- The catalyst and facilitation philosophy was followed here for a year. It was instrumental in getting the otherwise mutual-distancing NGOs in Pazhverkadu. The PAN was an exciting experiment. The students of different villages in the islands were mobilised. It was a positive experience.
- The quality of the houses built by PAM in Kargilnagar was not up to the quality. The substandard houses, though semi-permanent, were leaking during rain, as was told by people. It raises the question of accountability of NGOs. Who are NGOs accountable to? To people or to the funding agencies or to the State or to no one?

2.0 AIDAN and MFC Meet at Vellore

Venue: Vellore Date: 26th January, 2006 to 28th January, 2006

Introduction:

As part of the mid-term meet of the fellows of our batch, participation in All India Drug Action Network (AIDAN) and Medico Friends Circle (MFC) was arranged. With some historical background of both these collectives by Dr. Ravi Narayan at CHC, we proceeded to Vellore.

Learning Experiences:

- The most striking was the simplicity and openness of the group. Quite committed, passion filled and demystified group. True to their name it was a friends circle.
- Though many of us were new, still we were welcome to their core team members.
- I observed the AIDAN core team meet which discussed the issue of convener, resignations and some conflicts. The maturity with which they handled the issue with honesty, frankness and not hurting others was very inspiring.
- The consistency in their effort on issues that they were passionate about is something to be noted.
- Most of the MFC friends are the present Jan Swasthya Abhiyan – It shows the contribution of this friends circle to the community health movement in the country.
- Without having any organisational structure still MFC is alive and is with energy, is an unusual phenomenon. It made me understand that if individuals are committed and convinced a dream can be made to happen and be kept alive.
- It was a very positive atmosphere encouraging each other and energising each other. I came back with a lot of fire in my heart and ideas in the mind. One of the ideas is that CH fellows could be the future critical mass on certain issues. This idea needs to be cross checked with others and how and what of it needs to be worked out.

3.0 JSA: Material Preparation Workshop

Venue: Navspoorthi Kendra, Bangalore
Date: February 24 & 25, 2006

About 25 members of Jan Swasthya Abhiyan gathered in Bangalore for the Material Preparation Workshop in view of the proposed National Health Assembly II in February 2007. It was a useful occasion to interact with people with different disciplines who are concerned about people's health.

The meeting was attended by selected individuals from within JSA who had volunteered to give time for the preparation of the campaign material on the issue of 'defending peoples' health'.

An elaborate discussion took place on the issues to be taken up, theme of the campaign, the problematic and limitations of using rights language, the different booklets etc.

Learnings:

- The spirit of concern for the victims of today's development that was the connecting factor
- The differences of opinions and stands and yet the will to work together on a common platform
- Spirit of voluntarism and participation, seriousness and depth of discussions. The meeting consisted of activists, medical practitioners, university professors, youngsters, activists etc.
- It was a beautiful exercise of collective working, taking collective decisions and responsibility.
- There are issues which need to be addressed which I thought people could give more time to, such as the organizational matters. Many times the campaigns are not effective due to organisational malfunctioning and organisational set up (network) does not get built because there are no effective campaigns taking place which enthuse people.

4.0 Participation In CHC Team Meetings

One of the great advantages of being stationed at CHC was everyday was a different kind of learning by observing and participating in what was happening at the venue of the organisation.

1. Staff Meetings: The internal staff meetings of Wednesdays was an occasion to understand the organisational dynamics of CHC. On most of the Wednesdays I attended the meetings whenever it was possible. The management of the systems, the line of decision making, the methods of conflict resolutions, planning and review etc.
2. Informal Discussions: Discussions with mentor, Dr. Thelma Narayan, with Mr. S J. Chander and Mr. Naveen was also on an ongoing basis.

3. Sessions at CHC: Mr. Chander conducted two sessions on life-skills. It was useful to understand the philosophy of life-skill education.
4. Orientation to Centre for Social Action project staff: The project staff of community development project at Hoskote (part of Christ college) came for a day at CHC for orientation. Along with Mr. S. J. Chander I was the resource person to animate the sessions. It was also a new experience to prepare the material and to discuss about the Community Health concept.
5. Staff Development Workshops: From January 2006 Dr. Ravi Narayan started the staff development workshops for the CHC technical team – viz. S. J. Chander, Mr. Naveen and Mr. Amir Khan. On January 13 we worked out the three month plan for learning which was then termed as 'open learning sessions' which was then changed into 'staff development workshop'. The areas identified were
    a. to understand the historical evolution of the community health movement in the country
    b. to understand the history and evolution of CHC.

6. The personal clarity that emerged in me was that I should concentrate on Social Movements, Health and Human Rights.

SECTION 3

Source: Community Health Cell

LEARNING BY DOING

Trainings, Orientations and Workshops conducted during CH Fellowship

1. **Jagrutha Mahila Sanghatan (JMS), Raichur**
2. **Inputs at the Orientation to the Batch of Fellows: Understanding Society (Social Analysis) and Health and Human Rights**
3. **Orientation on CH to staff CSA field projects, Hoskote:**
4. **Right to Food Security : HCCRHP, Hanur (Kollegal, Chamarajanagar District)**

3.1 JAGRUTHA MAHILA SANGHATAN (JMS), POTHNAL, RAICHUR

JMS is a collective/union of women agricultural labourers in the drought prone district of Raichur in North Karnataka, struggling for their socio-political and economic rights. JMS strives towards being a symbol of empowerment of rural women through mobilizations for respect, basic rights and dignified existence and simultaneously promoted initiatives for economic self-reliance.

The trust through the Sanghatan is primarily involved in five areas

a) Facilitation of the building up of JMS into a vibrant agricultural labourers Union looking into wider issues of wages, minimum and equal wages, public distribution systems, employment guarantee, atrocities against dalits, violence against women, domestic violence etc

b) Education Rights of children from the dalit communities who are engaged in child labour

c) Health Rights through the work with community bare foot doctors and making state health programmes function effectively.

d) Livelihood reconstruction with units for neem, bio pesticides, terracotta jewellery, herbal medicines, livestock development etc. Agricultural reconstruction through initiation into organic farming, water and land development programmes etc

e) Ensuring access and rights from the Government for basic rights like, BPL cards, pensions, housing, electricity, sanitation, Panchayat and local governance issues like corruption and right to information

<u>Thoughts from the women/people at JMS . .</u>

- We understand that the marginalization faced by the vulnerable /marginalized communities (esp. dalits, adivasis women, workers in the unorganized sector) are caused by multiple factors but crucial among it is the systematic denial of access control and ownership of resources necessary for sustenance.
- Within all such communities women are further oppressed through a series of inbuilt structures values and roles which undermine a life with dignity.
- Unequal division of labour, control and exploitation of sexual and human rights, denial of equal rights of property and wages .Horrendous violence perpetuated on the person like rapes, domestic violence and terror to contain women is evidenced more and more.
- That the new economic policies being pursued by the government only further aggravate such process and increase the control of capitalist forces at all spheres.

The political, social and economic apparatus of this nation serve as instruments to expropriate and exploit the labour, and meager resources held by the dalits, adivasis, workers in the unorganized sectors etc, the earth plundered for unbridled profits at the cost of survival of indigenous communities.

Towards resistance and alternatives:

- That resistance processes needs to work towards reversing the above said hegemony. It needs the sustained organizing, mobilization and alliances of all affected communities at various levels for a long time.
- That alternatives needs to be created at local levels by the building up of people controlled institutions and organizations through the leadership and creative involvement of communities themselves.
- Such work needs to look into the larger question of access, control and ownership of resources; crucial among them is the **land** question. Resources already within the community's grasp must be augmented and appropriation of common property / natural resources by poor communities needs to be systematically taken forward.
- That true social transformation is only possible when communities of oppressed are able to experience freedom and dignity at personal levels and such a process means working also at the levels of individual and communities for change in the value systems and negation of the ideology and principles of oppression and unbridled profit.
- That such transformative process has to be attempted through democratic and effective intervention strategies which understand the adage that ***"people struggle to live and not live to struggle"***.

We believe that we need to start the creation of societies we want to live in

'those who loot – shall be banished
those who labour – shall eat
a new Society – has to be built
who shall build that new society – we shall build that new society'

History of JMS

- The mobilization of women agricultural labourers began in 2000 as a group of youngsters who were involved with Narmada Bachao Andolan and other people's movements wanted to work with Dalit communities addressing the issues of women and socio-economic and political rights.
- The basic perspective was two-fold: Oppressed Caste (dalits) and marginalized gender (women). The strategy was also two-fold: Sangharsh and navnirman (resistance and alternatives). Sangharsh meant struggle for basic socio-economic-political and cultural rights as dalit women and navnirman meant creative reconstruction activities in livelihood, dignity, education, health, land, and other basic issues like water, sanitation, housing, state facilities etc. the underlying line was the understanding of perspectives of caste, class, patriarchy, gender, ownership-access to and control over resources.
- Mobilisation began slowly by organizing them into sanghas in each of the villages and slowly addressing the issues like domestic violence at home, cases of rape, caste atrocities, wages etc.
- In the process of equipping women to respond they understood that it was necessary to challenge the values and premises where communities see oppression as normal hence a series of trainings on caste, class and patriarchy, causes of poverty, land and wage questions etc were conducted.
- At the same time they held local protests in the Panchayats, organized women to participate in *gramsabhas*, worked to access basic facilities from various governmental sources etc. Organized struggles conducted on various issues such as atrocities on dalits, rapes and violence on women, minimum wages, labour rights etc.
- Then came the phase where they were faced with droughts for 3 years and crisis in the agriculture sector, failing health standards and declining educational opportunities etc.
- Responded by starting work on land development, community health initiative by training barefoot doctors, started training groups to produce terracotta jewellery, neem fertilizers, bio pesticides etc.
- Understanding that such efforts take time to be up scaled into self sustaining units for larger number of people. They turned our attention to the larger issues facing the landless and marginally landed communities.
- By three years of work it became clear to us that in accordance to our vision of building up of people controlled institutions and organizations our focus has to be in unionizing the agricultural labourers.
- Started the process for registration of the ***Jagrutha Mahila Krishi Kooli karmikara Sanghatan*** as an agricultural labourers union.
- All the seven team members moved out from Vimukti (a charitable Trust run by the Capuchin friars) and become full time workers ***(Karyakarthas)*** for the JMS union. 4 women volunteers from the sangha joined as full time coordinators ***(sanchalakis)*** in taking leadership of the union activities.
- **Navnirman Trust** was registered in 2004 to support the effective functioning of JMS. The board of trustees was constituted with legal provisions for community representation.
- Meanwhile JMS started the processes of organizing wider community of agricultural labourers and successfully campaigns at the issues of low wages , employment guarantee, demand for the ban on paddy harvesters, rectifying BPL lists, proper running of PDS shops. Intensive campaign was conducted in 100 villages. Massive struggle was conducted in front of the Deputy Commissioner office, Raichur.
- District administration responds with banning harvesters, ordering for re-survey in the district, labourers identity cards given to bona-fide labourers and such.

- The Sanghatan through a series of meetings identified its priority areas for the immediate future. The continuation of the process of resistance and alternatives were discussed at various foras of the organization. Various requirements and suggestions given by the team of ***karyakarthas*** and ***sanchalakis*** were put forward to the board.
- The board after deliberations asked the team to prepare plans and make contacts with possible local group/individual contributors to further the work put forward as the aspirations of a community of hope.

Keeping the vision of socio-economic and political empowerment of the marginalized, the group has taken up small tasks towards this larger goal by animating the Dalit Women. The strategy that is adopted for this is both **Sangharsh** (Struggle) and **Nirman** (Reconstruction).

All the work, whether in the area of organizing Dalits, women's mobilization by way of organizing women towards issues of economic sustenance and livelihood or mobilization of child labourers and the drop outs by alternative educational curriculum or the taking up of process to ensure minimum subsistence viz. land and water all are rooted on the principle of Rights, based on the People's (of the marginalized) Access, Ownership and Control of life sustaining resources, supported by the freedom and opportunities to make relevant and meaningful choices.

Situational Analysis

Raichur district, which is now known as the rice bowl of Karnataka has a long and checkered history. Over the centuries it has been part of the empires of Vijayanagar, the Adil Shahs of Bijapur, the Marathas, the Nizam of Hyderabad, and latter part of the reign of Mysore has seen being neglected politically and economically. Raichur has been predominantly known for its dry and harsh climactic conditions. Yet, it is home to a variety of crops, medicinal plants, minerals and an abundance of river sources. At the northern end of the district passes the mighty river Krishna and its southern boundaries passes the Tungabhadra both flowing eastwards into the state of Andhra Pradesh. Five taluks that is Deodurga, Lingsugur, Sindhanur, Raichur and Manvi formed the district of Raichur with an area of 5559 square kms and a population of 13, 51, 809(Hand book of Karnataka 2001 pg 83)

The district of Raichur falls in the Deccan plateau, has predominantly black cotton soil and agriculture is the primary basis of production and employment. . The western portion is noted for alluvial soil while the eastern portion contains predominantly red soil. The major parts of the district are dry lands. Rains are scanty, 602 mm being the district average. The Government of India classifies the district as hot, dry, semi-arid area. The western portion of the district is plain country, bleak in aspect and scanty in vegetation, whereas the eastern portion is undulating with a few hillocks and scrub jungles. The fact that these lands were historically highly productive is understood by the fact that the Nizam administration taxed the black soil areas of the district higher than other areas due to its high fertility. The general slope of the land of the District is from Northwest to South East and hence a large number of rivulets and streams flow into the Tungabhadra. A dry climate and an extremely hot summer, lasting from mid February to early June, characterize the district. Three taluks, Sindhanur, Manvi and Raichur of the district came under the command area of the left bank canal of the Tungabhadra reservoir.

Context of the work

According to the World Development Report (1999) the district of Raichur stands abysmally low, lower than the sub-Saharan African countries. The literacy rate of the District is 35.96 percent. It has the lowest literacy rates for the whole state. The literacy rate for SC/Sts is 21.25% of which male literacy is 31.87% and for females it is 10.61%. Of the illiterates, the major chunk is of the dalits, of whom women are at a dismal low level as afar as education is concerned. However the overall literacy rates given are confusing whereby some statistic brought out by the State of Karnataka show the literacy rate of Raichur district as low as 25.78 per cent. It is a common experience in the villages that not more than 5 per cent of the women in the dalit community are literate. 47.6 percent of all workers are landless agricultural labourers and 31.6% are cultivators. The district of Raichur falls at the bottom of the Human Development Index rating (inclusive of health, education and gender disparities) not only in the whole state of Karnataka but is among the worst in the world[1]. This area is politically neglected and the government administration gives hardly any attention to social infrastructure, transportation, etc. The villages have hardly any access to convenient transportation. Bicycles, bullock carts, tractors and occasional buses are the modes of transport. Many people foot their way for miles together. Except for a few villages exposed to the mainstream, others have the oppressive social, economic and religious structures. Hence, the Scheduled castes have primarily remained economically backward, socially segregated and existentially powerless. The region had seen the emergence of strong dalit movement in the mid eighties and early nineties due to the organizing of educated Dalit youth primarily in the universities and in villages on issues of untouchability, atrocities against self-respect, struggle against traditional village feudal lords and sporadic instances of land struggles. It is widely accepted that the movement has now been severely fragmented and in many cases unable to respond in the pro-active way it had a decade ago.

The lands holding are highly skewed 31.6% of people involved in agriculture are landless (Human development index 1999). 43.7% of all workers are agricultural labourers, with women being large part of that. Ruled by the Nizam of Hyderabad for a long time and through the Jagiridar systems caste groupings a powerful tool for social existences. Large land owning castes and other intermediary castes had a vice like grip on the conditions of the poor. Caste issues have a long history connected to resource holdings. The condition of women and dalits with regard to violence and social indicators are pathetic. Regional disparity is highly evident when one takes the developmental activities in the region. Hence it is no surprise that the human developmental indexes of Raichur district are compared to being lower than sub Saharan African countries by the human development report of Karnataka 1999.

Social Scenario

- Social system highly stratified- visible forms of untouchability highly prevalent, characterized by no entry into public places like hotels, temples etc. Discrimination at sources for water like taps, bore wells.
- Lack of basic necessities like shelter, electricity.
- Lack of adequate education facilities.
- Health facilities are wholly inadequate, exorbitant charges, increase reported in diseases like TB, gastroenteritis, stomach ulcers, skin disorders, gynaecological disorders, deaths due to AIDS. Malnutrition and anemia rampant among almost all women.

Within this, the conditions of SC/ST communities are horrible and degrading to the existence as humans.

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[1] (Human development in Karnataka 1999/progress in human development

Political Scenario (of dalit communities)

- Ineffective community leadership, because representation in local governance bodies subdued and overshadowed by the presence and rule of upper castes.
- Struggles against untouchability and processes for political emancipation fragmented. Fragmentation in ranks of Dalit group and general lack of credibility for Dalit sangha groups within local communities.
- There is a general disenchantment with 'token struggle politics'.
- Questions of women marginalized, issues of violence rape, questions of equal rights and wages, questions of property and unequal division of labour silenced.
- Women seen as easy groups to be mobilized for SHGs and savings activities. Women's groups have become co-opted, a cheap source for rallies and committees. Facilitating the withdrawal of the government from essential services.

Emergence and consolidation of caste based groups another feature. The main focus is to corner the share of proportional benefits and work on issues the particular castes are concerned with. Such caste based caucuses in effect strangle the movements of people cutting against caste boundaries.

Economic Scenario (special focus on Agricultural sector)

- Large communities of landless/marginal farmers increasingly feel themselves being wiped out of the mainstream process of participation in the local and national economy.
- Agriculture sector is facing a complete collapse with traders and middlemen expanding at the expense of farmers.
- The agriculture scenario is characterized by low returns, rising prices of inputs/ spurious inputs, high rate of interest for private credit, unavailability of credit, erratic water and rains, high incidence of pest and pesticide use and reducing yields.
- The agricultural labourers are caught in the web of poverty and despair for survival, increasing shortage of work, real time decrease in wages, large scale migrations in search of employment, rampant poverty, foods needs unmet.
- Rise in the cost of essentials, inequality in land conditions and lack of political will to deal with the land question.
- Major factor has been the loosening up of pro farmer controls and diversion of subsides on seeds, inputs and fluctuating market prices.

Emergence of an excess of traders, companies and middleman stifle the aspiration of people dependent on agriculture for survival.

The Government

- The withdrawal of the govt. from the social sector is happening in a planned and meticulous way creating a disastrous and volatile situation in the rural sector.
- All kinds of schemes in the social sector are siphoned off or are made ineffective by the brokers/contractors/ bureaucratic/politicians mafia

Projects for basic necessities are stifled.
Large scale corruption at all levels of governance is a reality.
In effect the poor and vulnerable communities have no option to lead a normal life.

The civil Society

- We live in times when the civil society movements are systematically fragmented by neo liberal forces. The unrest in the society tempered by NGOs whose work border on charity or in effect .creates a semblance of hope in communities that things will change. NGOs have become pacifiers of people.
- Extremely difficult for movements to function in such an environment, people engaged in survival issues daily find no immediate result in the processes of struggles undertaken by most of these bodies.
- There is a marginalization of issues of dalits, women, violence, labour, local governance etc.

Indeed the new millennium are really difficult times to have a strong vision and a practical plan for social transformation when the forces of capital subsume all other aspirations of nations, people and communities.

3.2 INPUTS AT THE ORIENTATION TO COMMUNITY HEALTH FELLOWS

Sessions:

Session 1: Understanding community, systemic analysis and the process of marginalization
Session 2: Assertion, Casteism (caste discrimination) and Communalism
Session 3: Rights, Human Rights and Public Health

Focus and objectives:

- To understand the societal systems/structures/systemic marginalization
- To understand equations of power relations 'intra community' & 'inter' community
- To understand resources and power relations (Accessibility, Ownership & Control)
- To know issues: Social change/transformation, resistance, development, empowerment
- To recognize value frame work : Equality, Equity, Social Justice, freedom, democracy, participation, democratic revolution, State, etc.
- To understand caste discrimination, communalism in the framework of Indian constitutional ethos.
- To understand the concepts of rights and Human rights and the interlinkages with public health

Tools:

- **Discussion**
- **Visual Documentary**
- **Case Studies**

Session I:

TOWARDS UNDERSTANDING THE COMMUNITY/ SOCIAL MOVEMENTS

Understanding social structures and systems:

ORGANIZATIONAL SYSTEMS			MEANING SYSTEMS		
Social	Economic	Political	Religion	Culture	Ideology
Units of Systems of Organization	Ec. Resources –	Decision making, administration, justice, redressal	* god, spiritualities, * Rituals	* Behavior * Socialization * Knowledge systems	* Value system: good/bad, * Political ideologies
Caste Class Race Clan Ethnicity Patriarchy	Production Distribution Market/ Exchange Profit -------------- Ownership, Access & Control, Tools & processes of production	Community State Admin. Revenue Judicial Vigilance	god/goddesses/ deities festivals temples rituals	Social norms/mores Morality Good/Bad Right/Wrongs Superior/ inferior	Capitalism Socialism Feudalism democracy

THEORETICAL SKETCHING OF MARGINALIZATION

	ORGANIZATIONAL SYSTEMS			MEANING SYSTEMS		
	Social	Economic	Political	Religion	Culture	Ideology
Aff-lu-ent	✓	✓	✓	✓	✓	✓
	✓	✓	✓	✓	✓	✓
M IDDLE CLASS						
MAR-GI-NA-LIZED						

PROCESS OF MARGINALIZATION

- **SYSTEMS**
- **IDEOLOGY**
- **PREJUDICES : Jargons and Language**
- **THE DOMINANT - THE DOMINATED divide**
- **JUSTIFICATION**
- **MARGINALIZATION : = VIOLATION**
- **OPPRESSION: SYSTEMIC AND/OR SPECIFIC**
- **VIOLENCE: SYSTEMIC/ENDEMIC OR EXTERNAL/DIRECT**

Session 2 :

COMMUNALISM, CASTEISM AND ASSERTION

Towards Understanding Concepts:

Secularism:

- Western concept: Separation of State and Religion
- Indian Concept: Different – to be seen in ethos of the Constitution and 'Secular' Spirit and the "Assertion to Rights" by the marginalized: Dalits, Minority, Women

Indian Constitutional ethos:

- Equality
- Equity
- Economic-social-political justice
- Rule of Law
- Pluralism and Diversity respected
- Tolerance: Ethnicity, gender and other political opinions
- No Majoritariansim

Fundamentalism:

- Religion based
- Caste based
- Ethnicity based: Color, Region
- Fundamentalism is against "change" in structure and against any "assertion" for change (by dalits, adivasis, women, the marginalized in general) of the established system.

IT IS ALWAYS 'AGAINST' THE "OTHER"

Communalism :

- Caste based, Male-power based, 'Aryan' race based, religion based
- Target of Communalists are those who are committed to the values of "Indian Constitutional/secular Ethos" (who fight for gender rights, dalit and tribal assertions, sexual minority rights, etc. which actually question the status-quo and challenge the system)

Session 3:

RIGHTS, HUMAN RIGHTS AND HEALTH

Concept of Right :

- Entitlement v/s privileges
- Emergence of Nation State : recognition of citizenship and rights – moving forward from the feudal set up
- State= Guardian/dispenser of citizen's rights
- Rule of Law is Basic

Human Rights :

- **'All are born free and equal in dignity and rights' (UDHR)**

Features of Human Rights:

- Rights being "Human" – fundamental principles of humanity is absolute
- Universal
- All are equals
- Individual and State relationship: State has to ensure HR
- HR: beyond the 'boundaries of States'

Categories of HR:

1. Civil and Political Rights
2. Economic, Social, Cultural Rights
3. Solidarity Rights – 'yet to emerge'

Public Health (PH) and Human Resources (HR):

PH: Takes into account health of the populations; ensuring conditions in which people can be healthy

- WHO definition of Health stresses on "Well being"
- Alma Ata: Health is a Social Goal
- Human Rights and Public Health: both are complementary approaches to 'well-being'
- focus on the actions of the "State" for well-being
- Violation of either – 'impact each other' for mutual disadvantage

3-fold relationship between PH and HR:

- Health Policy/Program has impacts on Human Rights
- HR violation has impact on health and public health
- HR ⇔ PH dialectics: "Conditions" for well-being

3.3 ORIENTATION TO COMMUNITY HEALTH

Background Note on Hoskot e Project of Centre for Social Action:

Centre for Social Action (CSA) is the field action project of the Christ College, Bangalore and is located at Hoskote, about 50 kms. From Bangalore city and falls in the Bangalore rural district. The project is going on for some years now and the need had arisen to orient the staff towards community health.

The work so far:

The project is going on in 14 villages in Hoskote Taluka (Bangalore Rural district). A community Health Nurse is there: ANC/PNC, immunization, health check up for children below 16 years age, medical check up for children from 0-5 age group, awareness program on health related issues and reproductive health is undertaken. Training also on First Aid is given to them.

Their main concern: How to take it forward? Community Women can be training (like a TOT program) so that they can train other women.

Issues of Concern:

- Understanding Community Health
- Issues that Community should take up
- CHW training is part of the program
- Health programs: What kind and how

Hence, an orientation to community health was organized by CHC to them on the 3rd of January, 2006.

Venue : CHC
Date : 03.01.2006, Tuesday
Facilitators : S.J. Chander & Premdas

Participants :
The Project Staff and VHWs from Hoskote – CSA project
Project Officers 2 : MSW/MA level
Field Coordinators 4: MA/BA graduates
CHWs (women) 5 : 8th std. min. (married women – from villages and not employees of CSA)

Objectives :

- To build perspectives, broaden understanding of Health.
- To understand the framework and concepts of Community Health.
- To facilitate an action plan for Community Health work in villages.

Contact Persons: Ezekiel: 7921667/9845239261
Antony: 25536280 (CSA) 9341233112
e-mail contact: csachrist@yahoo.com

Participants in a Group Discussion – discussing about future strategies

SCHEDULE:

Sessions	Duration	Topic of Discussions	Facilitator
Session I	10.00 to 10.45	**Introduction :** • Participants • Topic • Setting the tone & framework	Chander Premdas
10.45 to 11.00 TEA BREAK			
Session II	11.00 to 1.00	**Understanding Health :** • Basic concepts : Community, Disease, Medicines, Health. • Broader concept of Health	Premdas
1.00 to 2.00 LUNCH BREAK			
Session III	2.00 to 3.00	**Understanding Community Health :** • Dominant Health care system, Paradigm Shift, Levels of health care, Primary Health Care and Community Health • CH : Promotive/ Preventive aspects Role of Health workers	Chander
Session IV	3.00-3.45	**GROUP DISCUSSION: Exploring and planning for community health intervention and processes.** Group 1: the Village Health Workers/women Group 2: The POs and Field Coordinators	
3.45 to 4.00 TEA BREAK			
Session IV	4.00 to 5.00	• Exchange of group discussion ideas • Summarizing, • feedback, • discussion on follow up action	Premdas & Chander Dr. Ravi N.

Reflections:

1. It was a very good thing to bring together the project officers, staff and the community represented by 6 women. The community and the project staff represent the insiders – outsiders dynamics. The orientation was pitched in at a level to bring them to the common plane of thinking i.e. community health. So the process of thinking together was a positive step.

    - This was evident that in the morning the project staff were talking in a "outsider" tone. But as the day progressed they also gave a lot of space to women.

2. The entire group had a lot of openness to learn and to understand. This was a positive point of the group.
3. The group, especially the women seem to have understood the concept of health and community health. In the sharing of expectations session they expressed the desire to know about some diseases, how to treat etc. but by noon they themselves told that more than treating malaria they would rather want to be those who will prevent malaria, T.B., fever, etc.
4. As they themselves have been working for sometime now (3 years), women said in the group discussion that they have taken number of collective actions. i.e. demanding a bus to the village, asking for a school teacher for the local school, reviving anganwadis, etc. The staff also said they are doing number of projects such as drinking water (borewells), nutrition, so far a Community Health Nurse was doing ANC/PNC, immunization etc. Now the challenge was put before them how to integrate them into a COMMUNITY HEALTH process, and how to add the community part. The group discussion was good in the sense that it helped bring the community views and project staff's views together. A suggestion was given to make this like a charter for their own reference.

The women identified the issues as,

- With the help of the Mahila Sanghas they will clean the sewage so that mosquitoes do not breed in their villages. (In one village they came together and weeded the parthenium from the compound of the school to provide good environment to the children in the school)
- They will work and demand for a toilet for every house
- They will raise the issue of housing for every poor person (beginning with their sanghas)
- They have enormous drinking water problem. This issue also they will take it up with the state and CSA.
- Some women want to demand for milk-collection centre in their village so that they can get milk for their andganwadi children and also some can sell milk to that centre.
- Some women said they themselves will apply (some have already applied and they will press for) for a ration (PDS) shop, to get better quality grains.
- They will raise the issue of health care with the PHCs. If the doctors do not come they will go to the Taluka Health Officer and complain. They will also give application/complaint on the non attendance of ANM.

- They will demand for a teacher in the school as there are shortage of teachers in every school.
- Some villages there is no space for the Anganwadis. They said they will take up the issue.

How they said they will do this?

- They will discuss this in their sanghas, mahasanghas and convince other women about the need to work on the community health issue.
- They will also request for the help of CSA.
- They will collectively take action on the above.

This confirms the overall understanding that women are more aware of their situations. They also became aware of health as right. But they are not able to articulate it in the 'elitist jargon'.

5. By the end of the day all the women had already spoken and participated. The project staff too were very comfortable in discussion.

From the CHC's point of view:

- It was an opportunity to conduct the orientation together – Everyone took part directly or indirectly.
- For me (Premdas) and Chander it was an experience of working together which needs further reflection.
- Due to a good amount of ground work and preparation, the inputs went on well. And the group also seemed to have benefited from the orientation.
- Materials in Kannada was used and also distributed to the participants.

Follow Up:

- The CSA group has been asked to write the report
- They have been asked to go back, reflect together and get back to us.
- Mr. Ezekiel will get back to us on the further aspects of their need and training.

3.4 RIGHT TO FOOD SECURITY - REFLECTION ON RIGHTS

RIGHTS AT THE GRASSROOTS

People's Perception of Rights

Perspective building on rights and right to food security

Venue:
Hannur, Kollegal Tq., Chamrajnagar dist., Karnataka.

Background:
Holy Cross Comprehensive Rural Health Project: The project is located the villages of Kollegal Taluka of Chamrajanagar district, with its centre at Hannur, a growing small town, at the foot of Male Mahadeshwara hills. Project began about 9 years ago (1997) with Sr. Dr. Aquinas as the initiator of the process. Presently they are having the intervention in 72 villages with various programmes. The present ongoing projects are

- Training Village Health Workers
- Awakened Social Health Activists: for girls between 15-20 years of age
- Bridge Education programme for the child labourers: a residential programme
- Vikas Voluntary Vahini (VVV): Groups of small and marginal farmers
- Watershed and Environment Programme

Chamarajanagar district was carved out of the Mysore district in 1991. It borders the states of Karnataka and Tamil Nadu and the thick forest and the remoteness of the villages inhabited by many tribals such as Soligas is the speciality of this district. Far removed from the mainstream and neglected by the mainstream politics as it is in the border, the district also known for its low HDI. Hence I thought it was necessary to spend some time with the people of the villages when Dr. Vinay, the CHC fellow of the previous batch who is the coordinator of the project invited me.

Module I: ORIENTATION TO RIGHT TO FOOD AND FOOD SECURITY

Objectives:

- To give perspective about the rights, right to life and right to food security
- A general understanding of the scene of deprivation of food and nourishment across the globe and our own country
- Right to food campaign in India:
  - PUCL case in the Supreme Court in the year 2000, Rajasthan
  - National Rural Employment Guarantee Act, 2005

Sessions	Topics/Issues	Methodology
	Introduction: 15 minutes	Song Slogans
Session I: 45 minutes	**Concept of Rights** • Welfare state • Citizens • Entitlement & Guarantee • Safeguarded by law/Constitution.	Pictures Examples Discussions Poster
Session II: 45 minutes	**Concept of Food Security** Understanding Global politics Indian scene	Discussion Posters
Session III 45 minutes	**Right to Food Campaign in India** • MKSS • PUCL v/s Union of India: Case • Orders How can communities participate, e.g. • ICDS • MIDDAY MEALS	The campaign Poster Discussion
Session IV 45 minutes	**National Rural Employment Guarantee Act** • Main features • Rights of People • Discussion	OHP Discussion

The Discussion:

Discussion I: Right is an Entitlement, Guarantee:
Concept of Rights: What do they understand by Rights
Examples

Discussion II: Source of Right:
Traditional
State can make law: e.g. reservation for women, property rights for women

Discussion III: Rationale of this Right: RELATIONSHIP
e.g. students and his/her teacher, children and parents, husband and wife
State and the citizens relationship

Discussion IV: The power to claim/demand your right : the power to 'question'
Examples

The Person who is Entitled/Guaranteed. Entitlement : Citizen
The person/entity that is liable to dispense the entitlement: State
Bargaining power: right to demand / to claim / to question

Discussion V: Right to Food Security

The Schedule of the trainings

Date	Venue	Target group	Estimated Number	Participants' history	Expectations
6th Feb. 2006 10 am -1 Pm	Holy cross CRHP Hanur.	Women SHG Members	70	SHGs that are two yrs to seven yrs old. Hanur cluster has 27 SHGs. These 27 SHGs are formed into federation. Federation is 2 yrs old	Right to food
7th Feb 2006 10 am – 1 pm	Shettally (30 km away from Hanur)	SHGs & 3 VVV club representatives	80	-SHG members come from 17 SHGs (2-7 yrs old) that is also formed into federation and it is also 2 yrs old. These SHGs are from very back ward villages specially in terms of transport, health and education. - VVV (Vikas Voluntary Vahini) is farmer's club (all men) promoted by CRHP with the assistance of NABARD. Number of members in a club is 20. Members are between the age group of 25-35. They take up village devt. Activities. VVVs are 1-2 yrs old.	Land right also Other than "Right to food".
8th Feb. 2006 10 am- 1 pm	Holy Cross CRHP. Hanur	3 VVV clubs	50	1-2 yrs old VVV clubs.	Right to food
9th Feb. 2006 1 day	Satvidya Integrated Rural Education Centre for working children, Prakash-palya.	Adolescent girls ASHAs	24	95% of the girls are scheduled caste. Qualification : 7th to PUC	Preferred topics attached
10th Feb. 2006 10am.- 1 pm	Holy Cross CRHP. Hanur	VHWs	40	Group of illiterate and literate women (>7th class) 6months- 8 yrs old VHWs	Right to food

Reflection: People's perception of Rights

In the preliminary discussion with people about their understanding of rights many aspects came out which are quite important to take note of. *Hakku* means *adhikara.* While both look like synonyms the word *hakku* denotes a legal sense and *adhikara denotes* a more social sense of power, ownership, right of entry, right to participate in the discussion etc. People explained this in different life-situations: Two people are discussing or talking and a third one intrudes irritatingly, then the retort will be 'what *hakku* you got here?'. In a meeting or a discussion in a group if a stranger moves in and gets into an argument while asked to vacate the place the punch line would be 'do you have *adhikara* to talk here?'.

It is also 'power' over someone or something. The 'adhikara' to correct, punish, to scold a student or a child.

People have very clear perception of right regarding to land, property or ownership of assets. E.g. Father's property should go to 'sons'. If the father doesn't give it to them or gives it away to his brothers' children, or if they lay claim after his death on different grounds the son can go to the court for legitimate share in father's property.

Source of this right: The people are very clear that this right comes from tradition (sampradayikavaagi bandide) – from time immemorial. If girls have any right on the property? Most of them said 'NO'. Very few said that they have read that now girls can claim share in the property.

A teacher has '*adhikara*' to chide, advise, scold his/her student. But another person, though professionally teacher, doesn't get this right over that particular child or student. A parent has power over one's own child to correct and to punish and not on some one else's children. The source of this adhikara is the RELATIONSHIP that is shared between the student and the teacher.

Components of right: hakku means 'sigalebeku' (ought to get) or 'maadlebeku' (ought to do). Sense of obligation is very evident. On the part of the person who is entitled he/she ought to get and on the part of the party that is the dispenser the obligation is to guarantee and to dispense. The obligation part of guarantee/entitlement stems from the fact of tradition or a law (kaanoonu). It is 'samvidhaana' (constitution) in the case of the country/State.

Approach I:

With women, VVV it began asking their perception of the understanding of rights

Approach II:

with Ashas, began with

- What do they know of the country – India: the responses were: it is a rich country, there are many poor, big country, India got independence from Britishers in 1947 etc.

- Analysis: Freedom?: what's the meaning and do people have freedom: Freedom means to understand what is good for oneself, to have knowledge and awareness and to have the POWER to DECIDE. How many have the power to decide their own life, their destiny, their education ..e.g. women, Dalits, child labourers, etc.
    - How many have real freedom?: the response was only for 25%. The rest 75% do not have the freedom.
    - Rights: When we speak of rights we speak of the basic rights of the 75% of the population: we call them oppressed, weak, backward, lower, the deprived, the cheated etc. The other 25% too have rights. But we do not speak about them as they have not been deprived of it to some extent.

Approach III: Health Workers

- Health: what does it mean: Is there relationship between health and nutrition/food
    - If people do not have proper food to eat, if they starve who has to provide them? They said: Government
    - Why? Because- they cast vote, they pay tax (*kandaya*), they are born in this country, they are citizens.
    - That they can ask/question = they have right to ask, claim, demand, to struggle.

Training Module II: PANCHAYATI RAJ INSTITUTIONS

9th Feb. 2006 ASHAs in Prakashpalya: This training was conducted for the ASHAs at the Sadvidya School. Awakened Social and Health Activists (ASHA) it is a residential course for 10 months exclusively for the adolescent girls. Course is divided into 3 trimesters. Every trimester has nine workshops. During the 2nd trimester's W.S. on "Society and Culture"- Social Institutions were covered except **"Panchayathiraj"**.

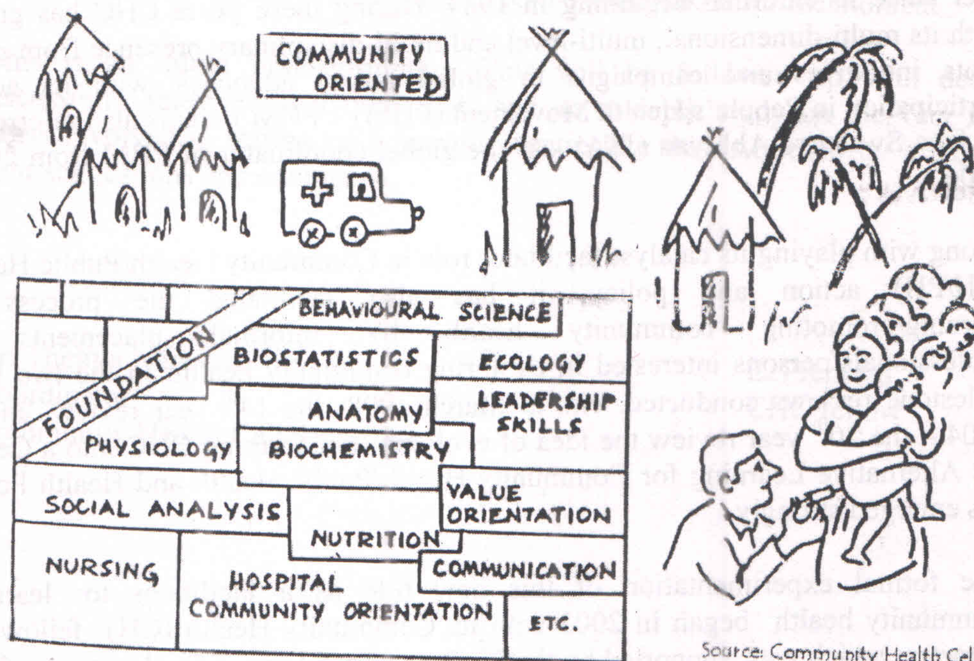
Objectives :

- To explain the aims and objectives of Panchayat Raj Institution
- To understand the history of PRI
- To understand the traditional Panchayats and the PRI as envisaged by 73rd amendment
- To understand the structure of the Panchayat institutions
- To understand the critical issues concerning the Panchayats

Session	Topic	Method
Session I	Introduction General discussion • Democracy and power • Politics: Electoral – non-electoral/People's politics • Decentralisation • Social Justice/Equity • Participation	OHP POSTERS DISCUSSION
Session II	**Understanding Panchayat System in India** • History • Traditional • 73rd amendment	
Session III	The three-tier structure of the Panchayat The functions of Panchayat	
Session IV	Women and Panchayat	
Session V	General Discussion on People's Power • Gram Sabhas • Annual Budget Plan making process • Jama Bhandi • RTI act Any other general discussion	

Section 4 :

NOTES, ANNEXURES AND ATTACHMENTS



Source: Community Health Cell

Annexure 4.1:	**Regarding the Concept of Centre for Community Health (CCH)**
Annexure 4.2:	**Learning visits to various Community Health Organisations**
Annexure4.3 :	**Orientation to Community Health – The training material**
Annexure4.4 :	**Orientation to Right to Food Security – The training Material**
Annexure 4.5:	**Preparation of Campaign Material for NHA II – Rights discourse and booklets of Jan Swasthya Abhiyan (JSA)**

Annexure 4.1.1

AN INTRODUCTORY NOTE ON THE PROPOSED COMMUNITY HEALTH LEARNING CENTRE (CHLC)[1]

Community Health Cell (CHC) which is a unit of the Society for Community Health Awareness, Research and Action, has invested 21 years in the field of Community Health/ Public Health Action, Research and Health Policy Advocacy ever since its informal beginning in 1984. During these years CHC has grown with its multi-dimensional, multi-level and multi-disciplinary presence from grass roots initiatives and campaigns to global policy advocacy with its active participation in People's Health Movement (PHM) – PHM India is also referred to as Jana Swasthya Abhiyan (JSA) - as the global coordinator of PHM from 2003-2006.

Along with playing its catalyst/facilitator role in Community Health/Public Health (CH/PH) action and policy, it has also facilitated the process of learning/promoting community health by informal placements of professionals/persons interested in exploring community health. In the two key-milestone reviews conducted, viz. in March 1998- the 14th year review, and in 2004 – the 20th year review the idea of evolving transforming CHC into a Centre for Alternative Learning for Community Health/Public Health and Health Policy has emerged strongly.

The formal experimentation of this new role as a facilitator for learning community health began in 2003 with its Community Health (CH) fellowship program, which was supported by the Sir Ratan Tata Trust. The objectives of this fellowship program are,

- To promote life options in CH by offering a semi structured, placement opportunity in CHC, in partnership with selected community Health projects;
- To strengthen motivation, interest and commitment of persons for CH;
- To sharpen analytical skills and to deepen the understanding of the societal paradigm of CH.

During the period of 2003-2005, 6 medical professionals, 12 social science professionals have been part of CHC as CH fellow interns. Most of them have continued to work in the field and/or have opted for further studies in CH after the fellowship program.

The feedback of the CH fellowship participants and the recommendations from the review of CHC have strongly suggested the need for the formalization of this learning CH program through the Community Health learning centre. Now CHC is at a stage of formalizing this process and also evolving the Community Health Learning Centre.

CHC consider this growth as part of the collective growth of the public health initiatives and peoples health movement in India.

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[1] CHLC is the proposed Community Health Learning Centre of Community Health Cell (Bangalore) for Community Health Training & Research, Health Policy and Advocacy. It is also referred to as Alternative Learning Centre at this stage.

CHC have planned for a participatory evolution of this concept to turn it into a reality. CHC shall look forward to your participation in this process by way of your valuable ideas/ association/suggestions. To visit, study and learn from the persons/pioneers in CH/PH, existing CH/PH centres in the country and to evolve a participatory idea (strategy) and pedagogy towards realizing of this proposed CHLC is one of the major tasks that CHC has undertaken for the moment.

This is an initial brainstorming. This will be followed up with detailed discussions/ interviews/personal visits and an in-depth study on the very many facets involved in setting up a learning centre like this. Attached is a page for your suggestions and comments.

Dr. Thelma Narayan,
Coordinator
Community Health Cell, Bangalore

E. Premdas
CHC fellow

Annexure 4.1.2

TOWARDS
THE CENTRE FOR COMMUNITY HEALTH (CCH)
A Note on the
basic concept, dynamics, dialectics and dilemmas

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1. Abbreviations used:

CH	-	Community Health
PH	-	Public Health
PHM	-	People's Health Movement
JSA	-	Jan Swasthya Abhiayan
JAA-K	-	Janarogya Andolana - Karnataka

2. In the discussion under each section,

SUGGESTION will mean suggestions made by the respondents, and PROPOSAL will mean a general finding of the study

3. N.B.: What was referred to as ALC/CHLC in the earlier concept note is referred to as Centre for CH (CCH) in this draft

4. Summary statement appearing at the end of discussion in each section is a verbatim quote from a Public Health professional respondent who is not a SOCHARA member.

TOWARDS
THE CENTRE FOR COMMUNITY HEALTH (CCH)
A Note on the
basic concept, dynamics, dialectics and dilemmas

N.B.: What was referred to as ALC/CHLC in the earlier concept note is referred to as Centre for CH (CCH)in this draft

1.0 INTRODUCTION AND BACKGROUND

The evolution of the concept of the CENTRE FOR COMMUNITY HEALTH (CCH) is located within the development and flowering of the ethos of community health (CH) in CHC and its partners/team/ associates/SOCHARA. The beginnings of CHC is in a team of people who were looking/searching for alternative paradigms in Health and outside the mainstream bio-medical model. The **philosophical principles of search** that emerged in pursuit of this alternative paradigm were,

- Subaltern paradigm
- Catalyst approach

The subaltern paradigm, a search for an alternative paradigm in health has grown into a CH/PH philosophy, resulting in the strengthening of the CH movement in the country by supporting those who are in the field. The subaltern social paradigm was also used in research, advocacy and intervention in sub-national, national and global health related policy.

The catalyst approach has in itself a political standpoint not to be alternative service providers, but to positively strengthen the people and their capacities in the CH movement. Consequently, networking with govt., NGOs, individuals, marginalized communities in the past two decades, has resulted in a larger alliance for CH, health, JSA and PHM. The proposed CCH is to train/prepare younger generation professional to support and promote the alliances and to be able to respond collectively and creatively with people to newer challenges.

A range of activities/interventions have emerged from these standpoints. They have resulted in involvement in 'community' – from grass roots level to global 'community'- consisting of individuals, groups, organizations and the State itself as the 'field' for intervention. This has defined the image and tasks of CHC, promoting CH movement by grooming people for community health. Providing a platform in this cell for people to launch into CH/PH was also an important task consciously done, informally/non-structurally though. In this direction, the Community Health Fellowship Scheme (CHFS) launched in 2003 was a further step in the same and the task of promoting people to CH was taken further in a more systematized way. The idea of institutionalizing the experience so as to pass it on to others has been emerging time and again in different fora of CHC. In the 2004 a committee was formed (see next page) to think and discuss about this task to sharpen the views and to propose strategies for the same.

While a small SOCHARA team provided stability to this process, a number of people who were in similar search have joined this process and have moved on. Directly or indirectly CHC has been a part of the network to promote the CH movement in the country for the last two decades by way of intervention, preparing/orienting people for CH/PH, being part of the wider peoples' health movement, advocacy and policy always keeping the interests of the marginalized and vulnerable communities at stake and with a dream to make the 'health for all' vision come true.

The historical milestones that one can refer back in this journey are

- 1986: The philosophy of CH was spelt out as a collection of axioms of CH (Red Book)
- 1990: First review: Internal and External
- 1991-92: Registration of SOCHARA, the Society for Community Health Awareness, Research and Action.
- 1998 : Internal and external review & discussion on papers on 14 year report on Management, Training & Research.
- 1999: Involvement in the first People's Health Assembly preparations and subsequently People's Health Movement.
- 2003: Community Health Fellowship scheme begins.
- 2004: External and internal review(20th milestone of CHC)

The important policy statements that this concept of CCH derives its spirit from are,

- Alma Ata Declaration (1978)
- People's Charter for Health (2000) (Global and Indian) which emerged in the context of People's Health Assembly I
- Mumbai Declaration (2004) evolved in the context of WSF 2004
- Cuenca Declaration (2005) – PHA II

1.1 The Rationale And The Evolution Of The Concept

Context

In the general setting of the ethos of CHC, the Community Health Fellowship Program was undertaken in 2003 to focus on the task of harvesting the potential of young and/or experienced professionals to promote the CH movement in the country. The experience that is derived from this experiment forms the immediate context from which the CCH has to move on. There were many young professionals who came earlier, experienced and moved on into the CH movement. The CHFS was another step in further institutionalizing and organizing the learning contexts. The questions such as how long the fellowship will continue, will it continue in the same form, is it feasible to have it in the present form are still to be reflected upon. However, the spirit and nature of the fellowship forms the part of the Centre.

This issue was discussed in the AGBM of SOCHARA in Sept.2004 and a committee was formed to work on the issues relating to the further institutionalization of this experience, with a tacit mandate to suggest formally to

reshape CHC, if need be, in the background of the 20th year review that was conducted by Amar Jesani.

The committee members are:
Dr. Ravi D'Souza, Dr. Sunil Kaul, Dr. Mani Kaliath, Dr. Sr. Aquinas, Dr. Pankaj Mehta and Eddie Premdas

A three-day workshop was organized at CHC from 26th – 29th April, 2005 to further reflect on this issue and was attended by the SOCHARA members, current and ex-fellows, pre-fellows and CHC team members. Eddie Premdas, SOCHARA member and a member of the committee opted to give time to the process of conceptualization and feasibility/modality study of the proposed CCH, so that the process could be taken further, hence this draft of the conceptual note.

1.2 Methodology of the Study

Task: Developing A Participatory Conceptual Note:

Objective:

- To develop a participatory conceptual note by facilitating discussions among SOCHARA members, CHC team members and other professional and field-based CH activists
- To facilitate the process of sharpening of ideas and of developing clarity regarding the task that is proposed, its implications;
- And to identify areas still needing further reflections.

Timeframe: July – September 2003
Methodology: In view of making this exercise participatory and locating it within the historical ethos of CHC the following 'tools' were employed:

Discussions and Consultations: Professionals, Persons involved in trainings,
Personal/Telephonic Interviews with SOCHARA members
Mailed Questionnaires to SOCHARA members
(Focus) Group Discussion with ex-fellows
Discussion with present fellows
In-depth discussion with CHC team members
Discussion with the Core-CHC team

PHASE II:

Task 1. A Detailed Study on the 'Feasibility' of this Concept:

This study will be done by Dr. Thelma Narayan (Coordinator CHC) and Eddie Premdas (CHC fellow) with the support and participation of CHC team.

The objectives of this study are,

(1) to study the feasibility of the proposed CCH, by visiting and learning from individuals and groups who have experience in running educational/training institutions for Community Health, public Health, and health services
(2) To investigate and study the modality of this centre by focusing on the pedagogical and organizational aspects of the Centre for CH and develop
(3) To discuss and propose suggestions on the operational aspects of the CCH.

Timeframe: Sept. – Dec. 20005

Methodology:

Learning Visits to different Centres of Education in CH/PH, social movements in India, places in need of CH intervention like Tsunami affected areas;

- Achutha Menon Centre and Sri Chitra Tirunal Institute of Medical Sciences and Technology, Thiruvananthapuram;
- National Institute of Applied Epidemiology, Chennai
- RUHSA/CHAD – CMC, Vellore
- TISS Mumbai & TISS Rural Campus, Tuljapur
- CEHAT Mumbai, Cehat-Saathi & Centre for Studies in Ethics and Research (Anusandhan Trust)
- Foundation for Research in Community Health, Mumbai/Pune
- Child-In-Need Institute (CINI), Kolkotta
- All India Institute of Hygiene and Public Health, Kolkotta
- Institute of Health Sciences, Pune
- Dept. of Social Medicine and Community Health, JNU, Delhi,

Interviews & Discussions with CH activists, professional PH personnel, alternative training centers, etc.

Task 2: Developing the Pedagogy and Curriculum of the Centre
Task 3: Documentation: The process documentation of the feasibility/modality study and the findings of the study and recommendations

NOTE: Parameters for comments: In summarizing the discussion or in putting together the divergent views the following concepts are kept as guidelines:

- Weight & Value of the Idea/Concept
- Need for further exploration/study due to the non-availability of adequate information and lack of expertise to give detailed inputs now
- Critical Factor of Key Human Resources available to transform this concept into a reality
- Availability of other resources: Finance, Infrastructure, etc.
- Dialectics of either/or & both/and

2.0 CONCEPT OF CCH

2.1 Concept

An attempt was made to capture the spirit of the first 'heart level' reaction of various people to the very idea/concept of the Centre. **Invariably, everyone in the following category has affirmed and expressed in various positive terms the need , relevance and appropriateness of such a venture.** There thus seems to be a broader mandate, beyond that already given by SOCHARA members, the external evaluator and the SOCHARA team. People have also seen it as a logical flow of CHC's ideology and work without seeing it as one of the programs. Some have given a word of 'caution' at the 'upscaling' given the nature of 'cellness' of CHC.

IDEA	SOCHARA	FELLOWS	CHC TEAM	PROFES-SIONAL ASSOCIATES	ANY OTHER REMARKS
Value	Positive/ Good	Positive/ Good	Positive/ Good	Positive/ Good	
Relevance	Relevant	Relevant	Relevant	Relevant	
Need	Needed	Needed	Needed	Needed	
'CHC's role	Timely	Can and should	Can	Good thing to structuralize/ take it to higher level	Logical progression of CHC to 'higher' level
Critical Remarks	Too much investigation is not required. If within the policy and you feel it is good, 'just do it'				A participatory approach was used to develop the idea

2.2 Importance: Idea of Centre Is Important

- Current Scenario: In the changed scenario in the country where PH is being given more attention and importance and schools of PH are being strengthened and established;
- Fill the gap: There are vast needs in the society and this centre should address "groups/needs/courses" not available at present, supported by an 'excellent library/reference centre'

Issues Emerging:

While most of the people have assumed/presumed the need for such a Centre, some individuals have also raised important issues regarding:

the needs assessment of such a centre;
clarification regarding the understanding of CH;
the 'alternativeness' of the centre.

Caution:

Assess the need, focus objectives towards meeting the needs, realistic assessment as regards setting objectives/resources to meet these needs. Also assess the results/impact so far and keep in mind : what impact/results are you trying to produce?

It should not be merely an **'additional'** centre

- Is there a need expressed from people's movements; primary health care sector; medical and health education sector?

For introspection:

- The definition/broad based understanding of Community Health is required
- What is 'alternative' about it?- needs further discussion and clarity.

2.3 Value Framework:

The one concern that has come up in the discussion is that will the spirit and value framework of CHC - which is BASIC - be carried over to this Centre or will it grow into an institution devoid of all that is BASIC. This was a great concern expressed even while linking it to the issue of Human Resource to translate this vision into reality. How is the transition or growth be looked at? Some have given some philosophic guidelines:

- **Basic stand/perspective** is the perspective of the weak, marginalized, the vulnerable. Without compromising this BASIC stand, we should look for modification in approach in terms of upscaling, receiving funds, etc.
- **Bottom Line**: The challenge of the Centre is how to link the charismatic/non-formal with more systematic, scientific & effective approaches and methods. It should have ALTERNATIVE approaches to learning. How to keep alive and pass on the spirit of adventure, risk taking and determined commitment to make health within the reach of the masses, to help develop strategies to organize, concretize the masses in the dual context which is a mixture of optimism/opportunity and pessimism. The optimism is seen in the current context i.e. Health for all Now!- a slogan which has engineered the global health assemblies and the increasing awakening of the policies towards the social (non-bio medical) determinants of health. The not so encouraging context is the privatisation and commercialisation of health care resources in the wider context of privatisation and corporatization.

Caution And Concern:

It has been expressed that it should not be another addition to existing centres, and it should be truly alternative in its vision, approaches and strategies.
Besides, 'quantity' is not enough, it should impact the common/marginalized person whose 'health' is at stake today.
Question of upscaling: As the number increases the effectiveness reduces!

2.2 Objectives/ Purpose:

- To promote the CH philosophy and action
- To train people who are working in the community to make them become 'human resources' in CH (to strengthen committed people to CH)
- To pass on the lived experience/to help professionals make CH a vocation/way of life/commitment

- To be an 'educational centre/institution' for the attitude formation, knowledge building and skill development (rather than a 'training' centre)
- To keep the 'CH movement' and spirit alive
- To build analytical capacity and create capacities for networking advocacy and policy

Summary Statement:

> *"Institutionalization of the CH internship is a good idea. The positive experience you have of creating CH activists must be taken to a higher level. As you are looking at different skills, research, policy advocacy, CH training, etc. you must look at different levels and methods of capacity building. So your courses should be flexibly designed – having a basic orientation module to facilitate deschooling or unlearning and opening of minds, followed by specialist modules for persons depending on how and what they want to pursue as a career"*

3.0 PEDAGOGY :

By pedagogy we understand for the present the principles of, approaches to and methods of learning, or in simple words HOW TO LEARN.
In continuation with the positive approach to the concept of the Centre the persons who responded, have provided important pedagogical principles largely emanating from their own experiences. They might be considered seriously as ALTERNATIVE approaches and further used in articulating the Pedagogy of the Centre.

3.1 Principles

Self-Learning: Learning to Learn: 'Self Learning' – experience based learning/learning from books/other people
Self-motivated, self-directed, guided, responsible with less outside control but with guidance
Group learning: to be made use of extensively
Participatory/collaborative learning: Collaborative vs. competitive learning: Small group learnings, learning together to be encouraged to promote spirit of collaboration
Personalized learning: Individual growth focused : Individual should be given freedom to enable the person to learn in the areas of his/her liking/interest (eg health financing, food & nutrition, water supply and sanitation, HIV/AIDS, tuberculosis, malaria, etc.); facilitating individual for reflection, self-assimilation, internalization and personalizaiton
Learning through Mentoring: Mentor is a preceptor, philosopher, guide, friend, not a teacher.
Creative and flexible learning - Not a rigid structure: but basing on a basic framework
Field based learning: Learning through involvement/doing
Exploratory learning
Open-ended facilitation

3.2 Approaches to & Methods of Learning

1. Problem Solving & Analytical learning: Enabling the learner to analyze critically the problems and solve them and learn from the experiences in the field and to translate them into concrete 'action' (to meet the needs of people)
2. Value based learning: All humanitarian values to be upheld and they have to be in built into learning
3. Case Studies: to be used extensively (CHC has a large collection of reports of real life experiences from all over India in their documentation centre)
4. Talks & Demonstrations: Discussions, dialogue (talk with) should be used to learn CH/PH with all those who are passionately involved in CH/PH.
5. Use of Journals: Participants to critically analyze the principles, methodology, discussion, findings, their relevancy, conclusions of the article- (different people may see the same thing differently. All discussion should be in the context of community health)
6. Research: should be part of learning – research in all aspects of Health including Health Policy; results to go to concerned people
7. 'Learning Visits': Learning (and not mere observation) Visits to the field (places like Gadchiroli)
8. Documentation: Participants to be trained in documentation, ..how to document, to analyze and make it available, so that others can benefit from their work
9. Self-assessment: to assess themselves
10. Involvement in People's Movements, placement with networks

3.3 General Principles:

It should be a flexible module with an 'individual' focus
It should increase motivation and also skills and capacities
There should be basic theoretical framework, pedagogy, efficient faculty & resources
Both theory and practice: more practice and small inputs of theory
Horizontal sharing and theoretical framework: makes a good context to work
Learning Strategies: they should be informal and unstructured
It should have a generic component with applied specific situations – a little more structured
Basic framework, reading list, introductory perspective building sessions, then leave it open

Issues Needing Further Clarification

Areas/issues that are emerging which need further definition and clarification are 'field' & 'community'
'Field' – as a context of learning
Community: is the social, political, economic, cultural, ecological entity/constituency

Broad Pedagogical Framework emerging is : A mix of experiential and didactic learning semi-structured in its content, oriented towards giving values/perspectives/ skills

Summary Statement:

> *"The methods and pedagogy must be a mix of perspective building as well as skill and experiential learning. Exposure to real life situations through interning with functioning organizations, case study analysis and other practical methods should form a core part of the learning process. Thus classroom learning and field exposure should alternate frequently, with former providing not only theoretical understanding but also an opportunity to debate and discuss what experiential learning provides.*

4.0 THE ORGANIZATIONAL ASPECTS

(**N.B.:** in the following sections SUGGESTION will mean suggestions made by the respondents, and PROPOSAL will mean a general finding of the study)

While there are many creative suggestions regarding the pedagogical aspects which have come from the vast and long years of experience, the task of 'organizing' this in some sort of structure is emerging as the challenge which needs further discussion and work. **A general consensus is seen cutting across opinions that the realization of the Centre should be a progressive growth in a phased manner, which rationally has two points in the process, viz. the initiation phase and final phase.**

Initiation Phase: This phase is seen as a little more formalization of the model of fellowship scheme with a little more number, but conscious introduction of the course and the pedagogical principles.

Final phase: The discussion regarding this has thrown open the dialectics and the dilemmas.

Nature of the Centre: Accreditation v/s autonomy

Nature of the Course: Formal – Non-formal dialectics v/s non-formal only

Participants: freshers v/s 'field' based

Faculty: QCEC v/s HR availability

(QCEC = Qualified, Competent, Experienced & Committed)

Facility/Infrastructure: Requirement v/s 'Structure maintenance'

4.1 Nature of the Centre: Accreditation V/S Autonomy

4.1.1 'NO' Affiliation: quite a few have strongly expressed that affiliation should not be sought after:

The disadvantages are,

- Constant monitoring/change/ restructuring not possible which is

sine-qua-non in Centres like this
- Does not give space for flexibility and openness (DKS)
- It is a 'conundrum' – flexibility/imaginativeness does not exist

Suggestion:

It is an autonomous centre which issues diplomas/certificates (like the erstwhile IIMs)

Affiliation to be explored:

- Formal affiliation might be required for the sake of CREDIBILITY (with a university or appropriate institution)
- ACCREDITATION gives added value to the course/the experience one has gained (not only for employability but even when a person goes back to the community after a course)
- To replicate CHLC model elsewhere
- In the long run, some sort of ACCREDITATION might be necessary

4.1.3 Recognition/Linkage

- RECOGNITION: Recognition rather than affiliation to be explored – by involving the university personnel/staff into the program
- Course needs 'public' recognition not only by the academic institutions but also by organisations and people.
- LINKAGE/TIE-UP: with national/international institutes/ universities to be explored.

1.1.1 Other Responses – Open Ended

- GRADUAL: Affiliation can gradually 'emerge'
- OPEN UNIVERSITY type affiliations: more flexible
- DISTANCE EDUCATION mode is another possibility for exploration

CONVERGENCE	DIVERGENCE	CRITICAL Factors
Centre should have freedom, flexibility & autonomy Qualitatively high professional standard Recognition: Either on its own strength or through linkages, public recognition is necessary	Dangers in affiliation of taking away all freedom v/s explore those kind of possibilities which retain freedom and give recognition	Quality Critical 'QCEC' Human Resources Requirements in affiliation in terms of faculty and course structure and requirements

Proposal:

A further detailed study is required regarding each of the options and to explore which one is more appropriate

Progressive upscaling is a viable idea keeping in view the following factors

It will not put the sudden pressure of roping in HR with a sense of urgency without giving much time to reflect if they fit in;

It will provide time for experimentation of different ideas at the organizational level: to weigh the pros and cons of the experiment, to introduce ideas and concepts and to evaluate them

Other factors such as NRHM, the other PH institutes that might come up, etc. will have to be taken into consideration in time.

3. Plan in phased manner for another 5 years : It can be planned to be a full-fledged course of 2 years in the next five years. The first phase of the first three years to be seen as experimentation, building of resources and learning. This would be an informal phase. The second phase from the 4th year could begin with a full-fledged 2 year course, building on the experience of previous years, with a plan to make it a accredited course in the next two years, and meanwhile developing many other courses to make the centre multi-sectoral, multi-faceted and inter/multi-disciplinary.

4.2 Nature of the Course:

Nature of the course is linked to the nature of the centre. The question of affiliation/ accreditation will mean more of formal course while keeping autonomy of the centre would mean more flexibility. The suggestion has been to explore the possibility of retaining the autonomy (implies freedom to structure the course) and finding possibilities of linkages/recognitions. As regards the nature of the course is concerned, by and large the consensus emerging is that it is related to the nature of participants and the duration of the course which needs to be specified. **However, most of the people suggest that it should be a mixture of both Formal/Regular (for some) and Non-formal/Ad-hoc (for some more). There are also a few strong opinions saying it should be only Non-Formal.**

FORMAL/REGULAR COURSE	
NATURE	**PARTICIPANTS**
Diploma to PG Dip.: Starting as 12 month course ---18 month programme ---24 month full fledged PG Diploma course	Graduates of any discipline recognized by any body
PG course	(not only) medical professionals; nurses, others in professions which have implications on health; persons working with people (NGO-Non NGO), government persons
Gradually building into a MPH course	People who are already working, people with experience, govt. health employees/officers
NON-FORMAL	
Semi-structured course, if at all certification needed, then with a diploma	For all the above
SHORT TERM /AD-HOC	
NATURE:	
Orientation Programme: for 3 months (might be extended upto 6 months)	Who are already engaged in PH like Health officials, VO, etc.
Adhoc courses (trainings, capacity building programs regarding the health factors/issues etc.)	People in agriculture, animal husbandry, in pesticides related work etc.

The factors in consideration are

Formal:

The Centre should qualitatively stand on par with any university in its rigor and professional involvement

Has an award of diploma/PG diploma/MPH in the scheme

Only Non-formal: (more than one responses) unstructured course **if required only with a diploma**

Those who seek degrees can avail of other universities leading into a Diploma

One year course which is a little more structured (semi) with more emphasis on the experience

CHC does not have resources for Master's program & its sustainability

Un/semi-structured course with a diploma drawing on mentors/inputs from the network of resources is viable and sustainable

It will keep the continuity of the spirit followed so far

CONVERGENCE	**DIVERGENCE**	**CRITICAL INPUTS**
Qualitatively high and professional course Both for fresh professionals and people in the field Some sort of a 'degree' it should have Short term and long term courses: Multiple layered(2-3 weeks/3months/6months/2 years) A Modular core course for the continuing participants and a short term course for others	Both formal & ad-hoc v/s only unstructured/non-formal	Critical HR Requirements in formal in terms of faculty and course structure and requirements

4.3 Curriculum:

The word 'curriculum' denotes the content of learning – WHAT TO LEARN- to be provided to the learners. The scope, depth and intensity are intricately linked to _who_ are the participants, the _duration_ and the _end_ of the course.

There are certain guidelines/principles which have been suggested in this regard. In addition, some have also given the basic courses which could be part of the curriculum. (annexure)

The content of the course should depend on the 'end' of the course: what objective you have in mind

Bottom up approach: keep first and foremost the community in mind

Broad list of readings/references

Core reading list

Proposal:

The Centre could have both formal courses with predominantly formal curriculum which forms the basic course content for the long term course as well as informal/short term courses with appropriate/modified/adapted course content.

Further Task: Curriculum needs to be developed for a formal/long term course and for other informal/short term/orientation courses

Summary Statement

> *"Any good learning must be at least a two year process with another half year for putting into practice what you have learnt (as internship or supervised practice). Accreditation of some kind, whether degree or diploma is important because then the CCH model would have an opportunity to grow in other places also get recognition. Yet it must have build in flexibility and adaptability so that it does not become a degree for the sake of degree and for this there must be a built in dynamism and feed back system for the course to continuously evolve by getting the learners to determine how and what they should learn in consultation with those who facilitate the learning process"*

4.4 Other Academic Considerations

4.4.1 Award of Degrees:

This discussion has thrown up a debate which basically has to be located in the value frame work of CHC/CCH and it is linked to the question of 'WHO' are the participants. It is also linked to the nature of course: formal or non-formal. The opinions are that if the participants are seeking a degree for the sake of degree, then they can approach other institutes who offer it. If they are freshers seeking direction, degree is not the most important priority. If participants are people already working (as in NGO/govt.) 'some sort of certification' would be enough.

Suggestion:

India is more and more becoming an 'informal market': Therefore the quality of the course should be considered more important than any degree.

- An academic board to be constituted to award any certificate/degree

4.4.2 Participants

4.4.2.1 Who

Principle:

The target group should be clear. If they are too vague/diverse then it is difficult to teach

Convergent View:

- Graduates of any discipline
- Motivated learners (spirit of Guru-Shishya tradition)
- Should be volunteers to learn, where rigid structures are not required for imposition
- Not those who seek degrees for the sake of degrees

Divergent view: It should be for people with experience of working. Float arounds may not work. Hence link up with organisation and help them with better work efficiency by giving the staff theory, knowledge. Freshers may absorb a lot without internalization. They need to be given a short term orientation course.

Proposal: As the fellowship program was meant towards guiding the young and tapping their potential to promote CH movement, the young could be kept as an important component of the learners. Besides, without being exclusivist, keeping the principles of group learning/horizontal learning people with experience who want to explore the avenues of CH should also be welcome. This will add richness to learning, hence a mix of both motivated young, seeking experience and experienced persons, seeking direction of CH could be a balance that needs to be struck.

4.4.2.2 Admission-

Suggestions:

Selection panel for admission is suggested

A structure for admission to choose those persons you want to match with the objectives

Pre-entry testing to assess: personality, interest, suitability, motivation etc.

4.42.3 Eligibility Criteria:

Suggestions:

Motivation and Commitment

Aptitude/inclination towards the marginalized

Value of commitment to People & CH

4.4.2.4 How Many:

Suggestions:

Start with only 10 then gradually increase.

The number of 'final' phase to be fixed later.

4.4.2.5 Fees

Suggestions:

No fees – it should be free: One can never meet the needs of the institution by way of fees. The principle should be : " I got my education free, so give my services free"; we provide the seats and the learner does not buy it.

Charge the govt. employees

Some fees may be charged lest it should be seen as 'valueless' course

Scholarships & fellowships for the needy to be explored.

4.4.2.6 Assessment:

Self assessment: Ongoing self-assessment with regard to one's growth, attitudinal change, acquired skills is important.

Formative Assessment: It is continuous, ongoing assessment to promote learning and growth of the person – not a penal or performance assessment

Summative Assessment: All faculty (inclusive of mentors) are involved in this and the complete aspects of a learner's growth are taken into consideration

Suggestions:

- Research/projects/assignments can be part of assessments
- Field based research: On social aspect of health/medicine (Must)

4.4.3 Duration: Currently the fellowship program is for 6 months. The discussions have suggested the final course as 2 years. The duration at the initiation phase needs to be discussed further.

Suggestion & Proposal:

A one year course is viable to start with along with short term courses (like present fellowship program)

Questions needing further Clarification:

- Will the fellowship program continue in its present form, with its component of financial assistance?
- Will it be sustainable to give grants to all?
- Will it merge with the predominant program of the centre or will it run parallel?

4.5 Resources and Sustainability

4.5.1 Faculty

In the course of discussions across, this has emerged as one of the most crucial and important factors, where people had no definitive answer 'who' is but gave suggestions in principle. The necessity is conceived not so much in terms of individual 'professional performers' but in terms of a good team with a team leader who has the vision of this centre and who can take this team along. *This is pointed out as an area of great concern.*

Principles:

Persons of Competence, Quality, Experience and Commitment

Fulltime/part time/visiting/honorary faculty may be considered

Work experience is a must: those who have lived/worked experience in the field

Facilitator of learning

Faculty should work – should have 'one foot in the community'

Suggestion:

CHC has a large network of people : Make a compendium of these resources

A few core/essential staff, a small number of administrative staff and large number of visiting faculty in different areas of specialization is needed. Appointing/getting a commitment from the visiting faculty would be more cost-effective.

"Key Human Resource is one of the most critical factors for the Centre's growth and sustainability"

4.5.2 Facilities

There is a unanimous understanding in all the responses that minimum resources, infrastructure or otherwise are necessary and also a strong emphasis and understanding is shown by SOCHARA members that 'what is required is the 'absolutely simple and minimum/optimum and not the grandiose-maximum'

- Minimum good facilities: better class room, library, space for group sharing/sessions
- Hostel facility: for the participants
- Absolutely simple infrastructure

4.5.3 Sustainability

Along with Human Resource, sustainability -financial/non-financial- is pointed out as the other area of most concern.

Suggestions:

Explore the govt. grants/govt. buildings/infrastructure

Pvt. funds/affiliations

Collaboration with the govt. should be encouraged

Faculty should be able to generate funds through research and other projects

Corpus

Scholarships and subsidies for the students

Fees should not be seen as maintaining an institution and they can never maintain an institution.

People coming from government sector, NGO sector may be charged fees

"Finance Is One of the Kay Factors For Sustainability"

5.0 THE FUTURE: SOCHARA CHC AND CCH

A specific question regarding various aspects covering the role of CHC in the future, SOCHARA and its role in the future, the linkages of CCH to CHC/SOCHARA and if CHC should completely transform itself into CCH was asked. Three models have evolved in the discussion which are referred to as Model A, Model B and Model C. While Models A and B have slight difference, Model C is suggesting the contrary, if not for a radical change, at least for the future.

5.1 Models regarding the SOCHARA-CHC-CCH dynamics:

Model A: One Single Organic Unit:

Sochara, CHC and CCH forming one single organic entity, with internal autonomy to CHC and CCH under one umbrella of SOCHARA is suggested to be the model.

In this model,

SOCHARA will continue to be the policy making, principle setting registered society & it will have two wings viz. CCH & CHC with the objective of promoting CH.

CCH: Educational program, including research. It should have its own management system: one head, board of advisors, faculty to facilitate

CHC: CH Service (Action) Program, including awareness creation

Both (not all from each unit) form part of the governing body/general body of SOCHARA

Each wing will have its own executive, under the governing Body/General Body of SOCHARA, with separate appointments and functions.

No merging of both. CHC should not be lost, CHC should not 'transform' into CCH, lest its function be lost. Both can grow simultaneously; both are valuable.

The centre while can be a part of SOCHARA but it should have autonomy in management and it should be widely represented, wider than the core team involved in CHC now.

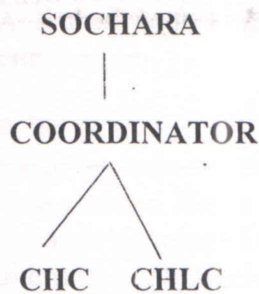
CHC in the future:

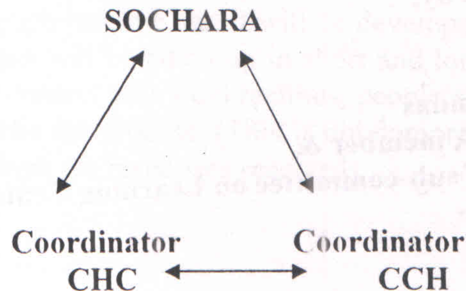
- retains its non-formal structure committed to strengthening people's movements
- continues to make its contribution to PH policy
- becomes field-practice for the Centre
- Continues as meeting point for people to make choices in life, for interactions, discussion, debates, to promote a CH movement, against the commercialization of health sector
- It has now acquired an international linkage with policy and PHM which should continue while keeping the perspectives of the masses and the marginalized. The international dimension should continue
- Intermediary in training and policy development
- Continues the catalyst/facilitator's role

Centre

- Adds educational dimension to the work/erstwhile CHC
- For the Alternative approaches to CH
- Has a potential to expansion and will require autonomy
- It might in future grow into a formal institution
- Provides formal curriculum
- It can also be registered as a Trust

It should be near the community (suggested: a rural community)





Model B:

CHC continues as it is now with CCH being added as one of the programs.

Model C:

CHC should completely evolve into the centre. It is also expressed by a few SOCHARA MEMBERS, but to be done in a gradual process. There is no need for two units or CHC having its separate identity.

<u>Comments And Proposal</u>:

Whether it should be one or two will depend not only on aspirations but also on practical concerns like persons to have that vision, capacity and to carry the process onward. These practical considerations should be given enough 'weightage'. The important question shall be the viability , given the context of Bangalore. The availability of HR being a big question, how can the two separate units be managed? The progressive growth concept and the dynamics of 'initial phase' and finality can be kept as parameters in the discussion regarding this. While retaining CHC in its current form, its action in CH (like Tamil Nadu: Tsunami), policy, JAA-K, etc the Centre of CH can be given shape. The autonomy/independence of the Centre can be the end-point of institutionalization of the Centre.

6.0 TOWARDS REALIZING THE TASKS:

The above draft is thought to be a reference point for further discussion and debate regarding the dialectics and the dilemmas. It makes a point of progression from the planning workshop of April 2005 in the sense of crystallizing fluid, broad and wide ideas. Secondly, certain rationalization of these ideas in terms of principles and guidelines is attempted here. This is hoped to be a tool for refining ideas regarding the Centre.

Further tasks: A tentative model of the Centre will be conceptualized regarding its vision, mission, objectives, etc. developing guidelines for its learning trajectory and curriculum. ***A small team of resource persons from SOCHARA and outside maybe mandated to do this at the Sept. AGBM.***

Facilitated by,

Eddie Premdas
SOCHARA member &
member of sub-committee on Learning Centre

7th Sept., 2005
CHC, Bangalore

Annexure 4. 1- 3

A list of topics and subjects that were suggested as part of an evolving curriculum

A list of topics and subjects that are suggested as part of an evolving curriculum are given below. This is not a comprehensive list. It will be developed further and systematized. Some of these topics will be taken up in short and long courses. A dynamic approach keeping close contact with field realities, people's perspectives, alternative approaches will underlie the process. (This is not comprehensive or in sequence but just a compilation from the responses received).

Part A:

Public Health definitions:

- Communicable/infectious diseases
- Non-communicable diseases
- Water, sanitation, nutrition.
- Mental Health
- Disasters and Health
- Occupational and environmental health.

Epidemiology: types of diseases that happens according to agro-climatic conditions, causes of disease transmission

Disease control programs and approaches

Health system/sector: public, voluntary, private; partnerships.

Understanding the underlying determinants of health: gender & health, women's health & empowerment; social and economic determinants; culture and health.

Health Promotion

Health Administration

Communication for health

- Inputs on pedagogy, lesson planning, methods of learning,

Understanding community : Community dynamics

- Socio-economic and political structures
- To understand the felt needs & real needs of community

Monitoring , Evaluation and report writing

Research methodology and how to conduct research

Understanding systems of indigenous health practices

Part B:

Health Policy Process and action

Social Analysis/understanding society

Sociological and anthropological approaches to health – an introduction

Human Rights and Health

Behavioral science

Community Organization & Development – organizing community, group processes

People's Health Movement (Charter, structures and approaches of the movement)

Annexure 4. 1-3

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Part A:

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Communicable/infectious diseases
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Health system/sector: public, voluntary, private; partnerships.
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Health Promotion
Health Administration
Communication for health

Inputs on pedagogy, lesson planning, methods of learning,

Understanding community : Community dynamics

Socio-economic and political structures
To understand the felt needs & real needs of community

Monitoring , Evaluation and report writing
Research methodology and how to conduct research
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Part B:

Health Policy Process and action
Social Analysis/understanding society
Sociological and anthropological approaches to health – an introduction
Human Rights and Health
Behavioral science
Community Organization & Development – organizing community, group processes
People's Health Movement (Charter, structures and approaches of the movement)

Constitution of India, Health as a Human Right, (National and International instruments, covenants, agreements – UNDHR, UNESCR, CEDAW – etc.
Political Economy of Health,
Managerial inputs (how to manage a health programme, finance management, material management, resource management etc.)
Optional courses: depending on need: e.g. post-disaster relief, rehabilitation and development.

The core content should involve:

Some subjects are suggested as core subjects for the course.

Understanding health systems: health resources (public/private) in a community, their relationships, etc.
Tools to understand health problems: social, epidemiological (survey, PRA, etc.)
Problem Solving Techniques:
Management Issues
Training/teaching methods (health workers, community leaders)
Health as a universal, fundamental human right, community participation, etc.
Primary Health Care.
social demography, etc.

Dr. Ravi D'Souza: Some of these subjects and areas would include:-

*History of Public Health in India.
*Industrial and Occupational Health.
*Disaster Health Management.
*Health Policy and Planning.
*IT (Information Technology) and its application to Public Health.
*Health Care of Special Groups (eg. tribals, migrant populations).
*Clinical medicine and public health.
*Non-communicable ("lifestyle") diseases.
*Nutrition, Malnutrition and Health.
*Costs of Health Care.
*Geriatric and Mental Public Health.
*The drug industry and its influence on public health.

The core content of the curriculum should include the **determinants of health** (social, political, economic and occupational especially), in addition to the points already mentioned in the concept note.

If it is for the govt. doctors/health workers: giving them skills and knowledge: Health management, supervision, monitoring, how to prevent diseases…

Module Based approach: take one module, go to the field then come back
Trimester based approach: basic input is given and then learner spends one trimester in the field

Annexure 4.2 :

LEARNING VISITS TO VARIOUS COMMUNITY HEALTH ORGANISATIONS

Introduction:

As a part of my fellowship I had two fold task to do: one, I wanted to explore and learn for myself more about community health projects, perspectives that have been built up in various organisations and the working of different organisations. This took me to various organisations, academic institutions, projects etc. Two, as part of the perspective building and feasibility study for the CCH my task was to look for critical information that would help shape CCH.

Learning Visits:

Objective:

- To make a feasibility study for the proposed Centre for CH by visiting different centres in the field of CH/PH in the country
- To understand the organisational and administrative aspects of these organisations, their impact and contribution to the CH.

Some questions for exploration while visiting the Centres:

What is the philosophy and approach of the organisation?
Where are they pitched as far as CH/PH is concerned in the country?
What are the trainings they offer? The organization, management and sustainability of the program: HR and finance
The strengths and expertise of the organisation
Collaboration and linkages in terms of the Centre- to explore their willingness and ideas
What are we looking for: System Managers or Process Facilitators, alternative service providers or political conscious people;
Political/ideological position: Should be take any position or open position

1. ANUSANDHAN TRUST/CEHAT (united):

Philosophy: There is a large amount of health research and there are also democratic organisations/structures. Cehat was an experiment to fill the gap between the two: i.e. to build an institution and to run it democratically. To build a core group and to build leaders was the running line (mandate) in the organisation.
Main streams of work are **RASA**: Research, Action, Services and Advocacy
In 2004 December, evolved themselves into three distinct entities but being part of the Anusandhan Trust, carrying forward the same ethos:

Sathi (Cehat), Pune: Action
Cehat, Mumbai: Research and Action
CSER (Centre for Studies in Ethics and Research): Research in Ethics

1.1 SATHI, Pune :

SATHI (Support for Advocacy and Training to Health Initiatives) is the action-centre of Anusandhan Trust evolved from CEHAT. The SATHI team originated in

1999 as part of CEHAT and after working for more than 6 years as an action-team in CEHAT, from 1st April, 2005, has developed into a full-fledged action-centre of Anusandhan Trust with headquarters in Pune, whereas CEHAT would specialize as the research centre of Anusandhan Trust, with headquarters in Mumbai.

Goal and Strategy:

SATHI envisages a society, which has realized its right to health and health care. To move towards this long-term goal, SATHI's strategy is to contribute as a team of pro-people health professionals, to the movement, initiatives towards such a society, by focusing on the aim of realization of health and health care as a fundamental human right.

Activities:

A. Collaborative programme with four people's organizations in Maharashtra and MP
B. Participation as a rsource group at local, regional, national level in the advocacy and initiatives for health rights, specifically for right to health care as a fundamental human right.
C. Training on health rights and in Community Health Initiatives
D. Action-research
E. Publications – Preparation and publication of relevant training and advocacy material to complement this work
F. Library and Information Service
G. Other Projects: like project on standard treatment protocol

1.2 CEHAT Mumbai:

Learnings:

a. Building a democratic institution to build leaders was the mandate and they worked towards it in the past years.
b. Democratic structures built in the functioning. In principle strived to be an egalitarian, non-hierarchical, transparent organisation
c. More of a staff owned and staff *'onused'* organisation: ('Power and accountability' A. Jesani)
    i. Concept of 'Working Group'- It is elected body of the staff = parliament of the organisation. It is consisting of both the administrative staff and researchers. While co-ordinators is appointed by the Trust, the WG also has a very strong and almost equal say in the functioning and administration of the organisation. Organisationally co-ordinators' accountability is not only to the Trust but also the WG. Reciprocally also the responsibility on the staff to be accountable to the organisation and to shoulder the burden of the decisions.
    ii. Project In-charge (PI): PIs are responsible for the management of the project. To work within the democratic ethos of the organization with the staff. All the co-workers

give evaluation ("Dictatorial PIs cannot function for long"). Project monitoring is done by the WG.

iii. Onus on the staff: If staff say that the salary is low and is to be upgraded, then the answer is get funds (by way of research projects or innovative proposals) so that everyone benefits (the lowest to the highest)

d. Cehat supposed to be having very good 'staff-friendly policy'. (copy is given to AO)

e. Space for differences of opinions (but also end up in endless discussions, meetings, fights etc.)

f. Research based action; rigour in research; demonstrated action projects

g. They have their "own" space: they see it as their strength

h. The core-group consists of 7 and the total staff are 35 (10 admin incl.). The transition has survived the crisis. People have stayed on. The staff are becoming the co-ordinators now (Jan.1. 2006). The gap between 'stalwart' co-ordinators and staff has reduced.

i. Trainings: Areas of strengths are developing modules, trainings, research on private sector, health financing/budget, violence, human rights.

Health and Human Rights Course (2005, 15 days, accredited by TISS)

HHR: Faculty (module on health) for the pol. Sci. dept of Mumbai University

Law school Pune has started a course on 'domestic violence': Cehat is participating as faculty for the health part.

Paralegal training: with ICHRL (2 days)

Feminist Counselling: for victims of violence and grass-roots level workers

Studying budgets: for professors, activists, Panchayat members etc.

j. Still project-driven organisation, staff on contract; no core funds yet.

Comments about CCH:

Very happy that a rigorous exercise is undertaken like to this to talk to people and to make a study. Hardly any does it these days.

Very enthusiastic about the idea. Open for collaboration in terms of exchange of personnel, resources, etc.

Centre is a need:

To promote people with perspectives

To promote alternative PH

To work even at policy level for government and mainstream medical people

To put together concerted efforts to get people with certain kind of perspectives

Certificate would be necessary: A tie up with a deemed university/open university would be good.

Multi-layered course is required: fellowship for some; targeting teachers in medical college; voluntary sector; reach out to people who think differently; research and training on the pvt. Health sector; also to

evolve new strategies and courses with the requirements of issues (e.g. domestic violence)

CHC has an established credibility to do the job.

Define the role clearly: What we can't do, Why we don't do, why we do certain things. (very imp.)

1.3 CSER, Mumbai:

Insights of Amar Jesani:

Cehat was started as an interface between movement and academics. It was supportive to the movement as in itself it was not a movement. The democratic ethos of the movements and the management part of the organisations is combined together. Cehat aimed at providing support through research with a long term goal to support the movement.

Institutions have stakes. Pass on as much as power to professional staff and provide them space to grow. Working group is a reflection of this ethos. It is a body with power and accountability.

Research and training is to be rigorous as any academic institutions; it should be scientifically rigorous.

Trainings to be well conceputalized, each module to be desiged together, to be rigorous. The standard should be higher than the academic standard of university and movement.

Standard and Quality are very important for sustainability. Quality will always attract people.

Those who have differences, be liberal with them. And those who are critical be liberal and allow the process to go ahead, have a review.

Quite excited about the idea. A few good PH groups/NGOs - a council of 3-5 people- can give accreditation. In 5 years it will be recognized. CHC through Ravi and Thelma have generated a enormous amount of good will. Only they have the resource to get others together. Quality and standard should be of high standard.

We should pool/pull our resources together – say 20% of time and resources to make it work.. To sustain the infrastructure: break even point is 40% utilization. We need reasonably good infrastructure – simple and modern (technology is cheaper now): meeting place and accommodation.. We should be able to get some infrastructural grants. For sustenance we should look for some grant for maintenance and raise the rest. Some stability and other part of dynamism is good.

We should get commitment from funder for 10 years: Explore people like HIVOS. Agenda should be ours.

Corpus is not going to work as the interest rate is so low.

Staff: Efficiency + Quality + discipline + professionally equipped. For others have fellowships (eg. Activists). Do not make them staff.

Average life of staff should be at least 3-5 years. Facilitate going the s/he becomes our 'advocate'.

Raising funds should be the responsibility of the staff by developing good proposals. It will also make them more responsible and self-confident.

Salary: people should get good salary at least the govt. standard. The Research faculty should get university standard. In the increase, there should be

approximate increase for all. The staff should work towards the raising the money.

Sustainability is financial and HR.

HR: Doctor should not be the criteria. Humanities/SS/SW are also good for PH. Epidemiological work is a joint work. SS and doctors do equal contribution. (Achuta Menon 2 of 7 are medical background and 5 are non-medical like demographers, statistician etc.). Even Cehat has less doctors.

A Good MPH course should have issues like Health policy, medical sociology, bio-statistics, gender, bio-ethics.

Cehat's Staff policy: PF , gratuity, medical security, accident policy, insurance for cash handling, maternity and paternity benefits.

Appropriate salary is good.. Gross security is bad. Good mix of security and effort on their part to get money is ideal.

Staff retention: Money is only factor in leaving. Other important factors are what is their role in the organisation, autonomy they experience, satisfaction in what they do. Leaving is a complexity.

The professional career and commitment should gel with the organisation. There should be space for gelling in the organisation. In NGOs we should be realistic. Don't demand too much. What you are contributing is so much. What you expect: To do good work and expertise. Lifestyle, political stand is a bonus. Realistic working out of expectations is required.

Create a role model of institutions rather than of individuals. Role model of institution will attract right kind of people; then individuals will fit in.

Building Staff:

- Send staff for seminars
- Publicly representing institution in high profile work by staff builds their confidence. Instead of society people the staff should do it. CHC has earned that place, the institution should be represented.
- There are personal goals of the individuals. Norms should be worked out to recognise these
- The work of the staff needs to be recognised. Develop institutional methods to do this.

CHC: Theoretically Society is the doer and CHC is only functional. But in practice, CHC is doing everything. Everything came from CHC. But all these ideas are made the ideas of the Society.

Society should be care taker, dispute resolver.

In CEHAT: very few left because of money. Some went as consultants to funding organizations and rewrote their funding policies.

Co-ordinator has separate salary: 35,000/=. Highest in staff is about 25,000/=. Presently search for coordinator is on. Padma is the next coordinator. Vacating the chair is the most important thing. No one should have permanent interest in the Trust.

Restructuring Cehat: It was 2 years long exercise. There was a huge tension between researchers and activists. Administratively separation has helped us.

2. TATA INSTITUTE OF SOCIAL SCIENCES, Mumbai

Met Dr. Kanchan Mukherji and Dr. Ramila Bisht

Masters in Hospital & Health Administration:

History: MHA (Masters in Hospital/Health Administration) department began 11 years ago, in 1993. Prior to that the Extra Mural Studies (EMS) dept. conducted a survey and had started a hospital administration diploma programme in 1989. Later Yesudian with the grants received from Ford Foundation for four years built it up into a department. While starting the department along with hospital administration a batch of health administration was also started. The course is recognised by UGC.54

- MHA aims at training intermediaries, not grass roots level workers
- Applied course aimed at giving skills required for program management in public health programmes.
- Modular based, rigorous masters level program in health/hospital management
- It goes beyond the boundaries of PSM/CSM: Imparts skills to PH practitioners: Management skills, MIS
- Very Strong on methodology: Quantitative, Qualitative, Operational research, systems research, epidemiology, advanced epidemiology
- Internships: 5 weeks of interniship in each semester amounting to 6 credits. Hence a total of 24 credits (5 weeks x 4 semesters)
  - I sem: Urban NGO
  - 2nd sem: Urban Public Hospital
  - 3rd Sem: Rural health NGO
  - 4th Sem: Directorate of Health Services (Sub centre to State Headquarters of health system)
- No MCI recognition to the course so far.
- The Jammu and Kashmir State recognises the course for promotion. BMC also accepts the course.

Diploma in Hospital Management:

- Classes are conducted in the evenings and week ends
  - Modular course
  - Six months certificate course
  - One year diploma course
  - Time period to finish the diploma is five years; there is a flexibility in completing the modules within five years.
  - Govt. departments also depute their staff for this course
  - Some others come in view of VRS and joining INGSs

Pedagogy: Class room lectures, presentations by students, internships, assignments, research report during internships.

curriculum: Foundational courses for two semesters and specialization for Hospital and Health Administration for two semesters

Critique:

- Critical thinking on Public Health and perspective take a back seat in the course
- No link with the alumni
- Hospital Management is considered prestigious as it is feeding the prestigious, corporate hospitals. Though health management students are supposed to join health organisations or national programmes, that is not assured.

Restructuring of TISS:

A Major exercise of restructuring TISS is happening now and decisions have already been taken to give a new shape to TISS from 2006. Accordingly the MHA department will be under the School of Health System Studies which will have four centres viz.

- Centre for Social Science and Health,
- Centre for Health and Development.
- Centre for Health System development and
- Centre for Public Health and Epidemiology.

There is a lot of uncertainty regarding the outcome of this restructuring and opinions are divided even in the process of this major exercise of restructuring. Hence what shape MHA dept. will take is not very certain. By and large the presumption is that the restructuring is market oriented, and if it is so, the School of Health Systems Studies might end up in producing more market/corporate hospital management type professionals. If the Centres are seriously planned, then there might be a scope also for grooming Social Science based PH professionals. But the interviewed faculty themselves had opinions otherwise looking at the existing capacities of the department.

3. COMPREHENSIVE RURAL HEALTH PROJECT, Jhamkhed

The visit to CRHP Jamkhed consisted of group discussion with the Village Health Workers – VHWs - (women), field visits where I could see the primary health care in practice, visits to demonstration farms, visits to watershed areas, interviews with Dr. Raj Arole, Ms. Shailaja (administrator and coordinator of trainings), field coordinators and training resource persons.

Training Of VHWs:

CRHP has trained more than 200 VHWs in 200 villages. Visit to the centre for trainings every week was a routine and now they come once a week and spend Wednesdays as their training input days. Some VHWs are new (3 to 5 years) and the rest are more than 5 years in the field. Yamunabai, Pushpasudha, Leelabai, Sakkubai, Dhokubai and others spoke spontaneously about cleanliness, tetanus, vaccination, diarrhoea, anaemia, breastfeeding, vitamin A deficiency and blindness, taking of weight, spacing of children and using different kinds of contraceptives, leprosy, childrens' care and protection, health educaton, watershed, rearing of cow/sheep etc. Some of the VHWs can be called 'wounded or healed healers'. E.g. Sakkubai herself is a leprosy patient who is now healed and is working as a VHW. Yemunabai has conducted at least 800 deliveries as far she can remember.

The rationale: The CRHP also has highlighted another issue which has largely been neglected very often: i.e. the illnesses of poor people. The illnesses of the poor are food and micronutrients deficiency (hence you need farms, not hospitals and vegetables and not medicines) and, environment (clean water, clean housing etc.). The dialectics of India v/s Bharat ('Elite island v/s the true republic of India'-Aroles) is very real today. 90/100 deaths of the former are due to illness like heart disease and other life-style disease. But 70% deaths of the poor are related to lack of food and unhealthy environment they are forced to live in, of which 60% deaths are totally avoidable. To meet this challenge you don't need doctors and nurses. With the fraction of the cost of the education of a nurse or doctor (i.e. Rs.500/month) you can train health workers and the health challenge can be faced.

An experiment basing on this rationale as demonstrated by of Jamkhed has the following to convey:

Totally illiterate women became barefoot women doctors to give health education. They give health education to people and also health care. About 2000 local health workers are trained in Ahmednagar district. Also through VHAI about 1,00,000 women are trained in health. They have now reached out to other areas – the tribal areas in Maharashtra, Andhra Pradesh etc.

Pedagogy:

Dr. Raj Arole elaborately explained the underlying principles of the training of women as VHWs.

Women as Village Health Workers: Women are fast learners and especially issues related to health is part of their life. Besides, women share their knowledge, time and resources. Being health workers is also part of their empowerment: it increases their social status, respect, they are sought after by others, and they heal.

Demonstration based trainings: Grass roots level training is different from elite learning. Women learn from concrete examples, imageries, demonstrations rather

than abstract ideas. apart from many teaching aids and models which are used, goat heart, intestine, 3 Dimensional things are used. Laboratory is also used to show blood samples, blood testing.

Demystification of Myths medical hegemony: Medical profession thrives on myths and mystification of medicine. Commercialisation of medicines destroyed the concept of health and technology dependency has destroyed the primary health care. Instead of primary health care government promoted medical care. However, in the training here, women are taken to the laboratories, they attend minor surgery like hysterectomy, appendicectomy,

Problem based teaching: Unlike the classroom mainstream teaching where the knowledge is stored (bank deposit concept), the teaching is linked to the immediate issues like suicide, violence and death, the socio-political issues surrounding that event etc.

Perspectives: Only 50% time is spent on technical training and another 50% time is spent on perspectives of social issues. Why I am poor? Why as a women I suffer humiliation? These are the questions that are posed for analysis. Social issues/social causes take precedence over the technical causes. 'If there is social justice IMR will go down to 1/10 of what it is today; we need social conditions for application of health inputs'. It is a valued based perspective of the marginalised. "Knowledge without values is dangerous, it can be detrimental to the society" says Dr. Raj Arole. "Knowledge is also like a double edged knife – it can either cut your throat or the shackles of poverty".

Exposure:

Generally all the teaching and training looks down upon the women or reinforces the image of women as inferior. Hence, the training VHWs was an empowering tool to counteract the traditional image and to give status and dignified image to women. The strategies used were,

Everyone respects the VHW.

She is praised and complimented even for a small eff...

Dignity of Dalits:

- Generally Dalits are denied access to water sources. During famines and droughts they are the ones who get affected first as even the existing water sources dry. Hence during the famines, borewells were dug in the Dalit colonies in 200 villages and the high caste people had to go to their colonies to get water.
- Community kitchens were made and children of all castes were made to eat together. Ingenious methods were devised to make the children play together by tying ribbons of different colours to their heads and they were grouped by the colour of their ribbons, clothes etc.
- The Dalit and Maratha women cooked together and ate together
- When they came for trainings, blankets were stitched together and all of them were made to sleep under the same blanket.
- Blood samples were taken out from each one of them and they were shown the blood in the laboratory and under the microscope. They were asked to identify the blood of Harijan's and that of Maratha's. They were also shown the heart of the goat in the lab and were explained that human heart has no affiliation to any caste.
- When the income generation schemes were launched, the goats and cows were mixed up and they were asked to identify the animals of low caste and of high castes.
- When the foreign visitors came (both blacks and whites) the villagers were made to understand that there are different kinds of colours, races among human beings.

VHWs are partners: The VHWs are considered and given the status of partners …they have high respect and stake in the health work and in the hospital. Hence women are not paid any remuneration. One can't expect her to be fully a volunteer all the time. However, indirect methods of supporting her are consciously evolved. VHWs are helped to get loans from banks where CRHP stands as guarantees, CRHP itself gives them loans on a priority basis, they are given priority in any IGPs, their children are helped in education etc. In their health work their reference to the hospital is given utmost priority, their phone calls in emergency are seriously taken, they can just walk into the hospital bypassing the queue, etc.

The VHW is considered a bridge between the community and medical doctor/health worker. She is representative of the community, chosen by the community and is accountable to the community. Hence she brigs the questions from the community to the doctor. She needs to be a partner in this venture of empowering communities, she needs that space to express what people can do and what the health worker can do.

The strategies used in empowering the VHWs

- Organise them: the VHWs chosen by and from the community are made comrades and one of their issues is taken (e.g. child care) to mobilise them.
- Information dissemination: Information is given on every aspect that promotes health – water, agriculture, sanitation, etc.

- Skills: Weighing a child, treating diahorea, pneumonia, bronchitis, B.P. etc.; classes are also take to improve their own financial position. Indirectly it improves their health.
- Finding social issues: They identify doctors in determination of sex, doctors in unnecessary hysterectomy, mystifying medicines, violence, caste, dowry, etc.
- Value of group well being: sharing, caring is also instilled. If one has to be healthy, all have to be healthy
- Support groups in villages: Men's groups, farmers' clubs, SHGs are created and are made a support group to the VHW in health work. She also teaches them in small business, SHGs, leprosy work, HIV/AIDS, etc.
- Integration: Health work is integrated with the development work. E.g. good nutrition means to have a good water. Women have planted 50 lakh trees, they have been part of watershed programme, 200 tube wells have been laid. A farm also is there for the demonstration where water-harvesting, vermiculture, chicken-dairy rearing, value added farm and agricultural products are produced. Women also have been taken to police stations, jails, DSP's office, court room, airports, 5 star hotels,, "to break the myth and mystique" about everything.

Hospital with a difference: Hospital is also a place where women are trained. It basically caters to the needs of the poor. It is also used as a tool for health education and empowerment. Generally the poor access the hospital for a reason that is unique. The relatives have to take care of the patient and do all the work that they can do that is expected of a maid or nurse such as keeping the bed pan, taking out the urine bag, administering tablets/medication at regular intervals. The relatives/attenders are also to clean the ward and keep it clean. The upper caste who are caste and purity-pollution conscious do not come to the hospital.

The identity of Dalit Women asserted – Addressing Gender and Caste through Health: The compounding factors of the irrationality of caste and idiocity of illtreating women is found in the community of Dalit Women. As Dr. Raj himself acknowledged in a private conversation the unstated yet underlying thread of the work in Jamkhed is 'empowering dalit women' and through them the Dalit communities.

Jamkhed Institute of Health Management

The objective of CRHP is to work with the poor and marginalized people and enable them to achieve acceptable level of health through the primary health care approach. Through this approach people are enabled to improve their health. The emphasis is on empowering people and working towards achieving equity and integration for all health services. In order to share our experiences gained over the years **Jamkhed Institute of Training and Research in Community Health and Population** was established in 1992.

Courses are offered throughout the year on **Community Based Health & Development (CBHD).**

Diploma in **Community Based Health & Development (CBHD)**

The Diploma Course in **CBHD** provides the participants relevant need based and experiential learning in the various aspects of Community Based Primary Health Care, Rural Development and Appropriate Technology

The objectives of the CBHD course are to:

1. *Acquire a clear understanding of Primary Health Care and Community Development.*

2. *Learn practical skills to effectively manage projects for the urban and rural community.*

3. *Develop the skills necessary to make Community diagnosis, write a program proposal, generate resources, develop tools to monitor and evaluate projects*

Information about the course:

- 2 Months course conducted generally in October and November.
- Aimed at those who are already working (Middle level) or are likely to work.
- The Fees is Rs.15,000/= (inclusive of boarding and lodging)
- At the end of the 2 months a certificate is given and after 8 months of completion of work in the field the completion is given.
- English language as medium is compulsory.
- The resource team consists of Dr. Raj Arole, Dr. Shobha Arole, Ms. Connie Gates (USA), the field workers and VHWs.
- VHWs are also involved in training as resource persons
- The batches consist of on average 20-25 participants:

Dr. Ghorpade: Dr. Ghorpade is an ayurvedic doctor who is also now a trainer. He summarised the principles of health work:

Motivation
Community Participation
Health Education

The three are summarised as *"to find out community resources for their own development is the concept behind health empowerment"*

And the approaches to health work are,

Integration
Equity
Empowerment

4. INSTITUTE OF HEALTH MANAGEMENT, Pachod.

Ashish Gram Rachna Trust was established in 1979 and IHM is the unit of this trust to implement its programmes of health and development in rural areas and urban slums of Maharashtra.

The objective of IHM is the holistic development of the individual, family and community and is deeply committed to the upliftment of marginalised communities. It strives towards the health and development of women and children and is done through organising and mobilising communities toward self-reliance and sustainability.

IHM Pachod is also one of the premier community Health programmes that started in the early 70's. Presently the intervention is active in 72 villages under 3 PHCs. In 27 slums in Pune also there is intervention going on.

Community Organization:

The Village Development Committee (VDC) elects woman who used to be called Village Health Worker earlier and the now the nomenclature used is Community Organiser. For every 1000 population one CO is selected. The COs and the VDCs are trained in an ongoing manner.

Remuneration: The COs are given remuneration of Rs.500/- through the VDCs. The COs also dispense medicines. The low cost medicines of Primary Health Care level are given to them. are allowed to sell them with a margin. They seem to be getting around Rs.1200/= a month in total.
The COs are given intensive training for 1 ½ months and the every week inputs are given. Supervisors and field coordinators also visit them and discuss with them.

Main activities:

- **a.** Research: Academic and Intervention Research
- **b.** Training
- **c.** Programme Implementation
- **d.** Policy advocacy

Strengths:

Management Information Systems (MIS) – every household is divided on the basis of the SE scores that is developed. Every individual also is numbered. Every two years the household survey is updated. The MIS helps in monitoring and reporting.

Mobile Team: 6 ANMs and 2 doctors: ANM visits the village every fortnight and doctors visit the village every month. What is done by PHCs like the ANC/TT is not repeated but RTI and such other things are done by this mobile team.

Demography, CO, PME (planning, monitoring, management and evaluation) : is the common component of every programme.

Training Programs:

Research:

The objectives of the research are

To use information for planning, monitoring, implementation and evaluation
To conduct special research assignments of WHO/UNICEF
To use research for training and policy advocacy.

Researches conducted:

1. Social Mapping: to find out the socio-economic status of households: a detailed survey of 300 households was conducted.
2. Research in Women in Reproductive Child Health: to get the benchmark on the status of women
3. Abortion
4. Community Perception/attitude on the utilization of services
5. Health needs of Married adolescent girls
6. Nutrition and Gender Initiative Stud

5. FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH (FRCH)

The Foundation for Research in Community Health (FRCH) was established in 1975 as a public trust and is recognised by the government as a national scientific and industrial research organisation. Its aim is to promote the concept of health rather than illness care based on the principles of the pioneering report of the Joint Panel of the Indian Council of Social Sciences and Medical Research (1981). The experience of FRCH shows that about 85% of health and illness care can be undertaken by an appropriately trained local women. Their impact as the grassroots level in health as well as their capacity as effective teachers has been well documented. The women health workers have participated in the training and testing of the training modules.

The Growth with experiences:

Mandwa Project: (Alibagh Tehshil)
Women were trained as health workers. The basic perspective was demystification of medicine and the transfer of health knowledge to women. With for years of intense work communities were able to achieve a lot through these health workers.

Malshirus (Pune dist.): Indian Council of Medical Research project was undertaken on the efficacy of health education,. It was used to improve the demand of people for health services. However services did not increase between the intervention group and control group. (ref. People's health in People's hands)

Pariche (Purandar Taluka):

Standard training programme for health workers was established
Health workers were given referral services
Referral service was a small hospital
Women got advanced training as health workers
This experience slowly grew into a course in NIOS.

Gram sakhi (1 year): basic health worker course
Sahyogini: The health worker becomes a teacher and trainer and clinical training is provided to her
NIOS: it is a 2 year course
I year: 48 contact days in one year
4th standard as the minimum requirement
II year: Clinical inputs are given
Health workers teach other owmen
These modules are printed and curriculum is framed.

Ralegan (Pune Dist):

Concept of people's participation in the health work
Involvement of Panchayat Raj Institutions
Using of Right to Information Act

Based on this experience FRCH has devised various courses for several levels of such a Community Health Care System at Parinche, Purandar Taluka, Maharashtra.

1. Grassroots health worker without certification (15-30 days)
2. Community facilitator (3 months)
3. Orientation to middle and senior level personnel of multisectoral organisation and institutions (3-5 days)
4. Courses certified by the National Institute Open Schooling for health workers
   a. Grade I : Gramsakhi (1 year)
   b. Grade II : Sahyogini (1 year)

6. INTEFDISCIPLINARY SCHOOL OF HEALTH SCIENCES

The Interdisciplinary School of Health Sciences is one of the 44 departments of the University of Pune. The vision of late Prof P V Sukhatme (Padmabhushan), the School was established in 1989 through funding support from the University Grants Commission (UGC). The UGC was Chaired during that period by Dr Manmohan Singh, current Prime Minister of India.

The School has now evolved into a premier teaching institution in the field of Health Sciences. The goal of the teaching programme is to train manpower, primarily students with an undergraduate degree in the biological, social or clinical sciences to work in the field of public health. The curriculum has a unique interdisciplinary approach, with an emphasis on learning through extensive field work.

The School offers two Masters degrees :

-- Master of Public Health(MPH) leading to a public health and epidemiology specialization and
-- Master of Health Sciences leading to specialization in biological sciences related to health and disease, with primary teaching focus on human molecular genetics, recombinant DNA technologies and their applications to human disease diagnostics, vaccines. genomics of infectious agents etc.

With many shared courses, the objective of the Health Sciences curriculum is to ensure that students from a biological sciences background and with laboratory skills in microbiology, biochemistry, genetics and molecular biology have sufficient community exposure and are aware of the diseases of public health importance and of the public health priorities of the country, whilst public health students from non-biological disciplines are made aware of the recent technological advances in bio-medical sciences.

The School also offers a Masters programme in Dietetics.

Master in Public Health course

Background

The University Grants Commission under its Innovative Programme scheme has provided a grant (sanction no.F.14-62/(Inno./ASIST) to establish a Master of Public Health (MPH) degree as a two-year full time post-graduate course. This revolutionary decision heralds the first ever MPH programme in Indian Universities, with the University of Pune as a pioneer institution.

Goal of the MPH programme

To develop human resource with expertise in the field of public health and epidemiology, who can ensure comprehensive health development of the community and better quality of life;

To create good advocates for launching public health movements;

To promote the understanding of the need to integrate social and cultural factors and determinants into the practice of public health;

o develop qualities that encourage the development of innovative and alternative approaches to meet the varying local needs of communities;

To train students in health services/systems research in order to encourage this as an integral part of health administration/management.

Objectives of the MPH programme

1. To prepare **public health practitioners** having the :
   - knowledge and skills of community diagnosis
   - ability to design strategies to enhance community health
   - skills to implement intervention programs

skills to develop public health policy
knowledge to evaluate the impact of public health policies on community health
leadership skills in public health administration

2. To evolve public health as a discipline in Indian Universities, with these departments having the objective of training **public health researchers** who will produce data for planning public health policies

Skills and Competencies to be imparted

Public health management
Public health research
eaching skills
eadership skills

Career opportunities

The MPH programme will provide career and employment opportunities for students in national and state Government health organizations, with advocacy groups; voluntary health organizations, in research and academic institutions and in international organizations including donor aid agencies.

Eligibility

The course will be open to students with an undergraduate degree in biological, clinical and social sciences.
B.Sc. (life sciences, nursing, pharmacology, dietetics), B.A. (Anthropology, Sociology, Psychology, LL.B, Journalism), MBBS, BAMS, BHMS, MSWNumber of seats : 10
Fees : As per rules of University of Pune

Teaching and evaluation

MPH is offered as a two year full time course. Students need to complete 100 credits in order to obtain the Masters degree. 75 credits are compulsory from the School. Remaining 25 credits can be taken from any other post-graduate department of the University of Pune, (those courses which are under the University credit system). The two-year course is organized into four teaching Semesters. Each Semester consists of 15 weeks of teaching. One credit hour is equivalent to 15 hours of teaching There is one hour of assessment for every 4 hours of teaching. Assessment may be in the form of evaluation of long/short written answers, multiple choice questions, presentation, term papers, assignments etc.40% of assessment is done during term so that there is continuous evaluation of the student, 60% assessment is done at the term end examination (held around May and November respectively).

Internships: One of the key teaching/learning components of the MPH programme will be internship rotations. The MPH programme will function in close association with the government health services and non-governmental organizations (NGOs). Rural residency during internship is a compulsory requirement.

7. JAWAHARLAL NEHRU UNIVERSITY

CENTRE FOR SOCIAL MEDICINE AND COMMUNITY HEALTH

Interviews and Discussion regarding the courses their institutions offer, its impact with regard to Public Health and their views about Centre for Community Health.

7.1. Dr. Rama Baru And Dr. Ritu Priya

JNU: University set up, functional framework is preset, mainstream institution, CSMCH is set up with an alternative vision of PH.

ACCREDITATION – AUTONOMY: needs to be sorted out. Even JNU does not have recognition of MCI. If you need accreditation then one will have to fall within that framework and it will decide the nature of students.

GOAL of the institution:
Look at the discipline and boundaries of PH in the Indian context.
Focus on the poor
Policy formulation in India for the poor
To be interdisciplinary

Composition:

Faculty: 50% Medical + 50% social sciences/allied
Students: 1/3 medical + 2/3 other sciences (roughly)
Courses: MPhil and MCH

Selection:

Preset system:

Entrance written test- Questions on contemporary issues, applied concepts, ability to argue one's position, short essays.
Interviews: IV gives a fair sense of their stands, judgement, motivation, perspectives

Students: Range of students: some wanted to do PH, some who have worked and come, some with the idea that PH is a good career option, from medical background and others from socio-psychological and anthropological work.
Alumni: There is no formal system of keeping in touch with them. There have been long term associations with faculty, some have come back as examiners. Most of the faculty are the students of the department. (Third generation – now there are 4 layers. The second is not visible).

TEAM Building and processes:

Most of them are products of the Centre itself. RB:

Dr. Banerji - who had experience in PH played a great role with his overpowering personality. Dr. Imrana Quadeer, a pediatrician by profession joined 6 months

later than him. Dr. Ramlingswamy Others imbibed the spirit and yet critically understanding the issues and perspectives. Now, as the seniors in the background there is a 'equal'/horizontal leadership. Every two years the chairpersonship of administration rotates. All, except the two junior faculties, have headed the department.

Team unity: Option to break up/out is less. The working relationship is defined. Earlier small group of 4. Now it is 9 members. There are different groupings for different works. It is "structured and peculiar" (RB). Other centres it is less cohesive. There is a mandate which everyone believes in and 'cohesiveness' is a great strength.

Factors influencing cohesiveness:

- Mandate which everyone believes in.
- Difference of perspectives is respected: they range from marxism to liberalism. There is space to disagree. Discussing constantly, and continuously working at it
- Core teaching program is accepted as of highest priority and emerging issues are discussed –this is the nucleus of the centre.
- Interdisciplinary composition helps one learn from one another, recognize the "other" expertise, find the fine balance, helps 'cross-learning', helps in 'vision' the program as per the need. It helps in redefining what you teach (eg. Sociology teaching is different from as done in a sociology department) and helps one unlearn and relearn.
- Team teaching – the teaching is linked to each other. Students can make linkages from one subject to the other.
- Faculty meetings: decisions are taken, views are shared. Earlier once in two weeks now once in a fortnight.
- Recruitment and grooming: the faculty is recruited and all the faculty members have a say.

Being within JNU: No total autonomy yet flexibility and space
Impact: Ideas were initiated and they have been disseminated, passed on to the others;

Individual space and Center:

Alliance with others – networks and movements: this is done individually and as a center. To engage with or not, personal commitments and whether it is representative of centre these are debated and discussed. But information are shared with the team.
Rama Baru: From a Medical Social Work background, got into some radical social work, but wanted to move beyond individual focus. The dilemma whether to teach or to work with grass roots is still there.

Pedagogy and curriculum:

How do you teach doctors social science theories and principles and how do you teach public health to other disciplines was a constant challenge and that dynamics itself has given rise to innovative pedagogy. Basic curriculum is there. But various perspectives are built to understand that there are many ways of looking at the world, and not just one. Social science subjects are taught to break the boundaries. Certain courses are taught separately, at different pace.

- Discussions based on reading
- Didactic teaching: Each course has some lectures.
- Tutorials based on readings
- Interactive sessions
- Group work/readings
- Critical reading and discussions: It makes sessions lively
- Interaction among group members
- Guided discussions
- Separate courses: Social Science students have 2 semesters of course work and 2 semesters for research. MCH course has three semesters of course work. They do their field work in the holidays.
- Field trips

"Student faculty committee" is a democratic structure where all issues related for course work and planning (except financial issues) are discussed. Useful feed back is given

Curriculum:

Evaluation:

- Continuous: Short term paper and long term paper
- Feed back and improvement
- End semester exams based on reading
- Viva voce

Field experience should be necessary for students.

Challenges: Nurture the next generation who are not from this institute in itself is a challenge (there are two new faculties - the ethos/atmosphere is new)

- Keeping the dialogue on: to engage or not to
- Constantly working at differences,
- Selective engagement with organizations

SUGGESTIONS FOR CCH:

delineate the role, goals and objectives – this will define the curriculum
Building faculty: this should be done as a focussed effort and will define the team.
Multi disciplinary team:
Core/committed individuals involved in a consultative core (only depending on external faculty will be a disaster. E.g. hospital management course in Administrative Institute of India – ended in a failure)

It cannot be done on a modular basis. Cannot sustain. Each one comes and says as one likes and proper linkages and perspectives cannot be formed.
Take really time off to think and form the team

Brain-drain:

There has not been many cases of persons leaving. Some have moved into other department. But only about 2 have left for elsewhere, not only due to the money factor but also because they were not very comfortable with the ethos/perspectives of the center. People have stayed on because of perspectives and due to their personal choices. The team also makes sure to select such persons in the selection process. This is as for the present. One cannot be sure of the future generations.

7. 2. Dr. IMRANA QUADEER (Professor Emeritus)

"While CHC is doing already teaching part, why does it want to institutionalize it?"

Dr. Imrana joined the centre with its inception in 1971. She was a paediatrician by profession, but in a search to do what was more meaningful.
Beginnings: In 1971 CSM started as a nebulous program. Diverse team but very small. Dr. D. Banerji, Mrs. Ramlingswamy (Psychology) and Dr. Qadeer.

Processes of CSM and CHC:

- CSM team was brought together exploring substance, evidence and logic in PH. Objectiv was to create data base and to create new perspectives in PH. Mainstream PH had been medicalized. Eg. Hygiene, sanitation etc. was not figuring out in this perspective.
- At CSM conceptualization and research has evolved from teaching processes.
- By involving in national planning, research, attempting to generate awareness and knowledge base among students and articulation of what we consider PH.

CHC's processes are different. After involving in actual doing now you are coming to academic teaching, thus carrying the understanding of what is actually happening in the field of Public Health.

CSM's Rationale:

There are two approaches to PH.
One, to create PH practitioners at the district, CHC and PHC level.
Two, Policy planning, understanding systems, conceptualization on PH.

CSM tended to do the second. Stress on policy planning to give shape to PH, to ground PH practice in clear concepts. If perspectives are clear, skills can be acquired or learnt.
Social dimension is primary to PH . Hence CSM department was set up in the School of Social Sciences.
Critique of PSM: PSM departments were supposed to give social dimension to PH. But they miserably failed as they were located in and were dominated by the bio-medical model and set up. PSMs also were set up when there was no way to go the US, as they wanted PH professionals.

PH defining and redefining: Today the challenge is to get together and define what is Public Health and in doing so use the tools of PH like epidemiology. However, it's only a tool and tools should not destroy concepts.

Methodology:

For doctors to think socially is difficult. Questioning of bio-medical framework is difficult for them. They take about 3 – 4 months to understand the new language and they become enthusiastic by then.

Achievements:

- That we've lasted in JNU for so long is a big achievement. (Everyone was so skeptical as to what these doctors would do here in the social science department)
- We didn't have anything, no data base, no theory on PH. The challenge was to develop it.
- Social Scientists did not consider doctors as theoreticians
- It was a centre for social policy. It had an interdisciplinary approach and started with a problem.
- Giving shape to the content was another challenge. It needs a bigger group than what is now.

Students: Some students come, explore and go back to their place. Some are in medical sociology and anthropology. Some have gone into teaching in PH (like TISS), some are in organizations like WHO. (This is actually worrisome) Many students are in the NGO sector. INGOs also pick up students for their liberal image. However, the comforts diluted concepts. In the larger organisations one has no say.

Faculty: The Faculty of CSM are the students of the Centre. (except 2).

Selection: 70% marks for written paper and 30% for perspective and attitudes.

Group dynamics:

They have developed open rules for group function and individual conducts.

Having procedures and common understanding. Procedures of collective working should be spelt out, should be known to everyone.

Ensure that people participate in the processes, communication to all should be done.

Working group methods: Methods of promotion is generally competition and merit based. However it is not enough. What is a "merit" in a group? What is the amount in responsibility? these are taken into account.

Investing in the Centre and Students: It also should be a shared notion. E.g. teaching responsibility and guiding students is the most important and this needs to be clarified.

Collective responsibility, no competition, respecting differences, common shared field work, building in certain commonalties….

In CSM, the chairperson responsibility rotates every 2 years.

There are fortnightly meetings of all: All communications are given and issues/involvement are shared. Decisions are taken there. Ideological differences can be handled, personal differences are difficult o handle

Project earnings go to the centre. It has been invested to build up the department.

Differences:
The Center respects differences. Differences are accepted

RECOMMENDATIONS FOR CCH:

Integrity of the group
Commitment to the idea
How much the members share the objectives – shared responsibility: No master-worker relationship.
A lot of money need not be invested in big researches. A lot of data is already available and it needs to be analyzed, interpreted.
Challenge is make small researches and ask big questions. "You ought to be doing this".
"Begin with right people, put ideas in place and have a group of students. Building should be the last thing on the agenda".

- Inter-disciplinary group

Dilemma: Whether we should engage or critique from outside. The idea that one can join big organizations (WB) and make a change there is worrisome and impractical. In the big organizations these are a small player and have no much say.
"Tell Ravi that it's good to start a center with these perspectives"

Miscellaneous: The chairperson is of the rank of professor. However, during Dr. Imrana's time when she had finished two terms she refused for the third term and she suggested this idea of rotation of the chair. The rotation is only in this centre in JNU.

7-3. DR. K.R.NAYAR

Social Scientist and since 28 years is linked to the department.

PEDAGOGY:

Interdisciplinary approach and Dichotomy: The dichotomy between the social science (M. Phil) and MCH (Medical) is not desirable and forms a fragmentation of the course. It should be avoided. PH requires a unitary approach and not a divisive one. The logic of this approach is still not understood properly. We have tried to rectify it by having some common courses. E.g. epidemiology, an important course is not taught to the SS students.

At present, the SS need more health inputs, they feel inadequate and uncomfortable. Only doctors get more SS inputs.

(Pune School of Health Sciences: But it is mainly bio-medical/science framework and very little of SS)

Present approach goes against the interdisciplinary approach. Evidence shows that there are about 28-30 medical doctors who have done Phd and about 200 SS who have passed through.

MCH and MPhil: MCH is not recognized by MCI and UGC.
MCH:
9 credits research – do it in their December and summer breaks. They go back to their places for data collection. UGC now wants to term MCH into MPh.
SS: Research is equal to 6 credits.
They have common exposure to rural areas which is conducted.
Semesters:

I Semester:
Core courses are taught in the first semester. Joint teaching
There are 3 sections: RM, SS issues in CH and SS towards integrated approach. The last binds together the Core subjects which is required for PH.
There are written exams.
MCH have 3 semesters of course work and SS have 2 semesters of course work.

2nd semester:
Optional courses are taught in the second semester. Concentration on specialized areas, and focus on the individual interests.
Journal club. Students come together. It is a very innovative way of learning. They pick up articles from current journals and understand the theoretical approach. They present 6 articles and 5 articles they ready and give comments.
There is a seminar on any theme. It is an extensive review on a particular theme which they take forward from the first semester synopsis to the seminar to the dissertation.

Curriculum: Faculty meets to upgrade reading. There is bias towards the public sector in the course work. The private sector aspect is not yet dealt with. For each subject there is a course in charge.
SS:

Each course is taught by more than one teachers. SS teachers also come together for seminars.
Lectures
Discussion
Group work/group presentation

Students: Strength is of perspectives and conceptualization. Students are in NGOs and teaching. The weakness is in techniques/skills/tools like the quantitative aspects.
Are students able to influence the system? "Not thought of so far.."

TEAM:
Each one has a personal portfolios: like documentation, computers, field work, perchasing.
Chairperson is like an executive officer.
Perspectives dominated the Center.
Now it is a more democratic functioning. There are opportunities for others to say/voice their opinions.
Dr. Banerji: whether is instrumental in building the Center? "doubtful". He didn't want to recruit more faculty with the fear of diluting faculty. However, all team composition is like a curve. Some percentage are good and some are average. He surrendered about 15 posts.

(NRHM: article in EPW, No.4: regarding the conflicts)

7.4. DR. MOHAN RAO

Faculty in CSMCH. Associated with the Centre for the last 18 years.

Placed the CCH initiative in the trends that are visible in the country.

1. Institutional Collapse: there is a vast network of Public Health Institutions in the country. But their academic base is shoddy. No efforts are being done to strengthen these institutions. Why are they in bad shape is a question which needs to be answered. It is better to strengthen these institutions rather than weaken them.
2. Anti intellectual traditions: Even in PHA the talk is about grassroots matters. NGOs do small researches. Everyone is speaking about evidence based data when there is no system of collecting data. In the Primary Health Care 1952 collection of data was important but not followed or kept up.

Therefore, CHC has been a good bridge between medical education and activism. This should be confirmed. CHC's efforts at rethinking medical education, ethics are all important. Hencae taking positions, PH learning is important. (There are 9 medical colleges in Bangalore. CHC should be available to them)

3. Academic content and recognition: Students want IMCA recognition. MCI wants to impose only PSM syllabus and very less of social science which is accepted by Achutamenon Centre. Hence they got recognition. When students come from the govt. health services they face problems in their promotion. This is in spite of being in JNU, an established university. Hence CHC should rethink on this.
4. Donor driven agenda: e.g. of DANIDA who wanted to strengthen "in service training" to strengthen PH training. They offered 2 posts to CSM to produce critical PH faculty to NIHFW. However, CSM asked them to establish the posts in National Institute of Health and Family Welfare. DANIDA refused. This might become a big hurdle. *Critical mass in PH will come in institutional strengthening.*
5. Critical Mass of People/faculty: Even CSM is struggling to get good faculty though thre are many applications.

Center for Community Health should be,

Bridge between medical colleges, activism and Public Health
Strengthening the personnel in the Health System/Services is very important and it should form the part of the Centre
ANM schools are being shut down. They need strengthening.

Banerji…
We need more people to build the critical mass of people…we need systemic cure for systemic deficiencies. For influencing health policy we should work long term and building critical cadre for PH is very important. Banjerji gave away many posts. He was not the right man to build the Center.
Collaboration: for short term courses CSM+CCH can collaborate.

Students of CSM…
Some are inservice doctors and they are making a difference. Those who have joined NGO sector – we do not have the same feeling (like oxfam). They have not even been involved with JSA.

7. 5. DR. DEBABAR BANERJI (Founder member of CSMCH, retired)

Articles: Politics of Rural Health (EPW, July 23)
Medical Graduate from Kolkotta
At the age of 20, revolted against the medical education, the way it is taught.
AIIMS, Ist batch of Physiology
Then worked in Himachal Pradesh on a govt. project in Chamba District for 2 years.
National Tuberculosis Institute from 1959 for 5 years. Formulated the National TB program.
Then also with National Institute of Health Administration.
Then was invited by the VC of JNU to head the CSM. Upto 1990 with CSMCH.

Aims and objectives of CSM:

To build the alternative body of knowledge
To build a faculty
Education of students
Research
Involvement in the PH activities in the country
Motto/mandate was to make medical and health services meaningful to the people of India particularly the unserved and underserved. Everyone in the department had to be within the manadate.

Rationale: PSM was destroyed . When the departments began, the intellectually inadequate and the rejects became the heads and professors of PSM. Hence CSM was conceived as alternative to PSM. PSM was not built up. It was suppressed by the dominant groups. Medicine is part of health. Hence the aspects of social medicine and community health. The alternative is not medical sociology but social sciences in health.

Faculty: they themselves had to do good work
Most of the faculty is "in bred". The dominant culture is in bred.
"Non breeding is worse than in breeding. In breeding was far below expectations"
The guidelines are

Commitment to the mandate
Hardwork
High degree of intelligence

(You can't be committed and do light work. Very committed and who do hard work are useful)

Inter-disciplinary: for SS students MPhil was offered (earlier social work was not considered)
For Physicians it was MCH: now it will be termed as MPH.
Interdisciplinary approach cultivates interdisciplinary thinking and it is a major strength.
Researches: Health behavior studies in 19 districts (3 from Karnataka): It is a longitudinal study also anthropological and sociological.

Students and their response: Students carry the spirit in international bodies. They have also diluted the spirit. Something remains with them. It is a good system but doctors have difficulty.
MCI does not recognize CSMCH MCH.
MCI demands thesis first and then the course work. CSMCH did not compromise on this.

(We want mad people to come, who are ready to take risks, work for the poor)

Curriculum:

Common subjects which form the basic core is a must: Organization of Health Services. Application of SS in Health, Research Methodology. CH cannot be dissected. Eidemiology, statistics, SS, RM in CH, CH programmes in India, MCH programmes, nutrition, Rural health services, hospital administration.......One must have an overview.

(Verticalization of faculty is not good???)

PHD: Center also had one or two nursing students They also should get pHd like doctors. Prakashamma from Hyderabad was a MSC nurse and did her PHd here.

Curriculum and program is changing; new epidemiological studies are inducted. Faculty needs to be agile to respond to the changing scenario.

SUSTAINABILITY:

- Minimum expansion.
- It should be something substantially alternative.
- Resources: If St.John adopts, it will be good idea. Funds from church institutions can also be accepted. It is better than of Tata's
- Question of Critical Mass: RN/TN and who else?

Critical Mass: Team work could go on. Complete freedom of thinking to others. Encourage them to criticise (If the leader is insecure and not confident he will become authoritarian)

Learn and criticise

Openness of mind should be there.

- Build documentation
- Centre should give rigour

Recommendations:

- Unless you have competent faculty don't have subjects)
- Get bright fellows as th faculty. They can develop themselves.
- Sub-critical mass can develop competence. But that is not complete.
- Reach a stage and build into a diploma. Get recognized by any university.
- Start as a short course then one can go for doctorate.
- Faculty has to develop. The two 'narayans' have to think hard
- Centre gives rigour. Go through the rigour.

What is the research output of CHC?

Task force report can be used as health systems report

Malaria and TB study.

Need not be published but bring out high quality material: Thelma can write a book on her thesis

Broad based publications and sound scholarship. Charters can be an academic document.

Why CHC is doing this? The reason can be found as a counter thesis to PSM.

Are you happy/satisfied: as a teaching career – NO. Fulfilment in my own way: As a scholar by my work. Where I miserably failed is in building up faculty and students. I would have loved to do much more than what we are doing now.

Subjects: Macro economics and health, Health economics are important.

8. CENTRE FOR ADVOCACY AND RESEARCH (cfar)

Organizational Challenges:

To pass on the vision in an institutional way. Now cfar is at a stage which requires an institutional frame and systems which are proactively hierarchical.

Person building the vision tends to create institutions but asks: I've done much, hoe do I sustain the vision: the contours become more challenging

What I handled earlier – money, structures, interest, money is now grown 100 percent more. So you become outdated, change, challenge of the current: these are like "chasing rainbows". Handling these is a big challenge Money is a small factors

- Building capabilities
- Human Resources: Who value money in development/who only exploit money/opportunities or those who want to turn money into value addition

- Another biggest challenge is Institutional challenge: principle is professional partnership, to partner the venture: take the vision to create the channel, to strengthen the capabilities, to turn the vision into task.
    - Need: people in quest, mode of search
    - There are host of fragmented efforts
    - There are no answers but only 'referencing': you cant replicate the existing models but you can only look at them as 'reference' points

To turn vision into reality we need a team of people. Keeping them, building them, vision setting is important. Institution is not mortar and bricks. Capabilities and leaderships are to be built.

Media: is a specialized domain. Alternative media is a 'creative sphere'. Media is not just about producing, raising issues, not just about creatives. CFAR looks at the processes, products, consumers using media, building public opinion. It s about positioning oneself by talking to the person writing, influencing institutional opinions, talk to the consumer who is reading; not the content alone but how the content is used, how the invisible side is managed.

Media is a conglomeration of many processes: taking position is with regard to every dimension like research, dialogue, content dimension…understanding this multifaceted reality and intervention in influencing specific domain was the task.. e.g. sex selection, HIV (what mindsets people have got like person writing, speaking, institutions that manage delivery etc.)

Organisation's current scenario: 93-2005 were the years to build this knowledge, now even at the district level…

Now creating partnerships, transitional phase of building capabilites, building institutional frame, moving to some form of consolidation, dissemination, proliferation: for this the institutional frame is required to continue to explore. A dynamic and flexible framework where individuals matter

There are people who are good, efficient but don't fit in and can't work in a team. There are others who want to stabilize. Stress is between these two. Sustainability requires a harmony between the two: tolerate people like us and listen to others.

We have to create organizational systems, partnership mechanisms, and conflict resolution mechanisms, create synergy. People's intentionality is important. There should be also space for those who want to come and go.

Realization that not media discourse but stakeholders in this discourse are very strong. They tend to be didactic, opinion formation tends to be too simplistic, caught up in the packaging of product and not the content. There are other commercial and other motives. Now understanding media as a vehicle, one has to effectively partner with media, with the users of media, organizations and mechanisms in between to create right discourse. There are many spaces. Content framing is not being taken seriously.

To this to happen – if we multiply media advocates even at the community level, multiply expertise, knowledge, passed on dedicated spheres. Multiplication replications to be passed on with capabilities and creating skilled leaders to take this forward.

Operational aspects:

- Discouraged consultancies –
- Within the institution : profit for the corpus is built up for sustainability by way of trainings, research, strategy building exercises (client servicing)
- Present involvement: HIV, sex selection

HIV: Media discourses on sexuality, alternative sexuality, denials, to break silences, mental health, physical health.

Media they frame it in problematic manner, they send messages. User has inhibitions. E.g. image of man: toublesome cocktails_ young man wants to be a macho, performer and is under pressure. The media fails to caputre the pulp of the real models. Media is unable to communicate, caputre the inner world like determination, ...the message fails.

HIV stake holders such as drug users. The efforts with stake holders, documentng, building media skills, to build effective strategy, to understand the victims as a marginalized cmmunity, forced to live as a closeted existence. The survival enhancing processes, counselling etc. imp.

9. *PEACE- Popular Education Action Centre , Delhi:*

Resource and Training organisation that has the strong philosophical basis of demystifying economics, budgets, etc.

Train organisations and people mobilised by organisations on the economic policies, changes and facilitates understanding the changes, trends and patterns.

Strength is transparency, accountability in the organisation, and trainings.

Like demystifying medicine, demystifying economics has been a good experiment. The organisation has remained small with their approach as facilitators.

CONCLUSION: A General Feel About the Visits

Putting the idea across: The visits served as space to put the idea across about the proposed CCH/ALC to people who had known about CHC.

Deeper discussion: though a summary note was sent to all of them, it is only while discussing across the table that the discussants thought about it in details and were able to visualise it.

Suggestions and Critique: In the context of the discussion, many gave their suggestions and their visualisations about the concept of CCH which will feed into a broad based conceptualization.

Sharpening of the ideas: In the context of discussions there are reflections and questions which will help in sharpening our own ideas

Ideas of Networking and Collaborations: Ideas of possible tie-ups, availability of resource persons, making space available for fellows etc. was discussed. Some organisations like Cehat who have more similarities with CHC have shown overwhelming excitement over the idea. They also have suggested towards making it a collective/collaborative venture, an idea which needs further fine-tuning.

The spectrum of the context and strength of the visited organisations gives us a small glimpse of their current status and intervention. Perhaps we can pick up

specific learnings from each of these institutions and build them into the *uniqueness and richness* of our own experiences at CHC. CCMCH, TISS and Health Sciences department give the academic contexts with their sensor antennae firmly tuned to the need of the society or demands of health market. But a tangible effect of their output is yet to be felt in the field of Public Health. The Jamkhed and Pachod experiments give micro level realities, however, openness and collaboration with others is a casualty in the process of being very micro-focussed. CEHAT and FRCH somewhere are experiments who have their sensors high and still their roots deep with much openness to social/peoples movements and people's sector. While moving into the CCH we can learn from these varied approaches, their strengths and weaknesses and enrich our perspectives.

Annexure 4.3:

ORIENTATION TO COMMUNITY HEALTH:

4. Charateristics of the Paradigm of Community Health

ಸಮುದಾಯ ಆರೋಗ್ಯ ದೃಷ್ಟಿಕೋನದ ಪ್ರಮುಖ ಅಂಶಗಳು

ಮುಖ್ಯವಾಹಿನಿ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆ	ಸಮುದಾಯ ಆರೋಗ್ಯ ವಿಚಾರ
ಆರೋಗ್ಯ ಸೇವೆ ವೈದ್ಯರು "ಕೊಡುತ್ತಾರೆ"	ಜನರಿಗೆ ಪ್ರಮುಖ ಸ್ಥಾನ – ಜನರಿಂದ, ಜನರಿಗಾಗಿ ಮತ್ತು ಜನರ ಆರೋಗ್ಯ. ವೈದ್ಯರು ಮತ್ತು → ಜನರು ಸಂಗಾತಿಗಳು
ಯೋಜನೆ, ಯೋಜನಾಧಿಕಾರಿಗಳು ಮತ್ತು ಸರಕಾರದ ಅಧಿಕಾರಿಗಳಿಂದ ಪ್ರಾರಂಭ	ಜನರು / ಸಮುದಾಯದಿಂದ ಪ್ರಾರಂಭವಾಗುತ್ತದೆ – ತಮ್ಮ ಆರೋಗ್ಯದ ಸಮಸ್ಯೆ ಮತ್ತು ಅವಶ್ಯಕತೆಗಳನ್ನು ಗುರುತಿಸಲು ಅವರಿಗೆ ಸಹಾಯ ಮಾಡುತ್ತದೆ
ಔಷಧಿ ಮತ್ತು ಡಾಕ್ಟರುಗಳ ಮೇಲೆ ತೀವ್ರವಾದ ಅವಲಂಬನೆ	ಸ್ವಾವಲಂಬನೆ – ಪ್ರಮುಖ ಸೂತ್ರ ಆರೋಗ್ಯಭರಿತ, ಸ್ವಾವಲಂಬನೆಯ ಮತ್ತು ಸುಸ್ಥಿರ ಸಮುದಾಯಕ್ಕೆ ಜ್ಞಾನ ಮತ್ತು ವಿಜ್ಞಾನದ ವರ್ಗಾವಣೆ
ವೃತ್ತಿಪರ ಮತ್ತು ತಾಂತ್ರಿಕ ಜ್ಞಾನ ಉಳ್ಳವರ ಪ್ರಾಬಲ್ಯತೆ – ಜನರ ಮೇಲೆ ವಿಶ್ವಾಸ ಕಡಿಮೆ	ಆರೋಗ್ಯ ಕಾರ್ಯಕರ್ತರ ಮುಖ್ಯ ಕೆಲಸ ಜನರಲ್ಲಿ ಗೌರವ / ವಿಶ್ವಾಸ/ ಆತ್ಮವಿಶ್ವಾಸ ಮೂಡಿಸುವುದು – ಸಾಂಪ್ರದಾಯಿಕ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆಗೆ ಬೆಲೆ ಕೊಡುವುದು
ಡಾಕ್ಟರ್ ಮತ್ತು ಆರೋಗ್ಯ ಸೇವೆ 'ಕೊಡುವವರ' ಅನುಕೂಲತೆಯ ಮೇಲೆ ಹೊಂದಿಕೊಂಡಿದೆ (ಆಸ್ಪತ್ರೆ, ಸಾಗಾಣಿಕೆ, ವಿದ್ಯುತ್ ಶಕ್ತಿ, ಎ.ಸಿ..)	ಸಮುದಾಯದಿಂದ ಬಹಳಷ್ಟು "ಕಲಿಯುವುದು ಇದೆ" ಎಂಬ ದೀನತೆಯಿಂದ ನಡೆಯುವುದು ಕ್ಲಿನಿಕ್ ಮತ್ತು ಆಸ್ಪತ್ರೆ ಅಲ್ಲ; ಜನರು ಇದ್ದಲ್ಲಿ ಅವಶ್ಯಕತೆ ಇದ್ದಲ್ಲಿ ಆರೋಗ್ಯ ಸೇವೆ ಬೇಕಾಗುತ್ತದೆ. ಆರೋಗ್ಯವು ಸಂಸ್ಥೆಗಳಿಂದ ಸಮುದಾಯಕ್ಕೆ ವರ್ಗಾವಣೆಯಾಗುತ್ತದೆ.
ಕಿರಿದಾದ ದೃಷ್ಟಿಕೋನ – ಕಾಯಿಲೆ ಮತ್ತು ಇಂದಿನ ಸಮಸ್ಯೆಗೆ ಪರಿಹಾರ	ವಿಸ್ತಾರವಾದ ದೃಷ್ಟಿಕೋನ – ಕಾಯಿಲೆಯಿಂದ ಆರೋಗ್ಯದ ಕಡೆಗೆ ಗಮನ; ಆರೋಗ್ಯಕರವಾದ, ಆರೋಗ್ಯವಂತ ಜನಾಂಗದ ಕಡೆಗೆ ಗಮನ
ಜನರ, ಸಮುದಾಯದ ಸಶಕ್ತೀಕರಣ, ಜ್ಞಾನ ಮತ್ತು ಗೌರವ / ಆತ್ಮವಿಶ್ವಾಸ ತುಂಬುವುದರಲ್ಲಿ	ಜ್ಞಾನವನ್ನು, ವಿಚಾರಗಳನ್ನು ಹಂಚುವುದರಲ್ಲಿ, ಜನರನ್ನು ಸಶಕ್ತರನ್ನಾಗಿಸಲು ಪ್ರಯತ್ನ ಮಾಡುವುದು. ಜನರೇ ಪ್ರಬಲರಾಗುವುದರಲ್ಲಿ

ನಂಬಿಕೆ ಇಲ್ಲ	ನಂಬಿಕೆ
ಕೆಲವರಿಗೆ / ಹಣ ಇದ್ದವರಿಗೆ ಮಾತ್ರ ಸೀಮಿತ. ಬಡವರನ್ನು ಕಡೆಗಣಿಸುವ ವ್ಯವಸ್ಥೆ	ಬಡವರು, ಅವಶ್ಯಕತೆ ಇದ್ದವರು, ಮಹಿಳೆಯರು, ಅಶಕ್ತರಿಗೆ, ಶೋಷಿತ ಜನಾಂಗಕ್ಕೆ ಆದ್ಯತೆ ಮಹಿಳೆಯರು – ಪುರುಷರು, ಎಲ್ಲಾ ಜಾತಿ-ವರ್ಗದವರು ಸಮಾನರು ಎಂಬ ನಂಬಿಕೆ. ಜಾತಿ/ಲಿಂಗ/ಧರ್ಮ ತಾರತಮ್ಯ ಇಲ್ಲದೇ ಸಮಾನತೆ/ಸಮಾನ ಅವಕಾಶದ ತತ್ವಾಧಾರಿತ ಕೆಲಸ
ಆರೋಗ್ಯ ಸೇವೆ ಮಾರಾಟದ ವಸ್ತು ಎಂಬುದಾಗಿ ಪರಿಗಣಿಸಲಾಗಿದೆ. ಹಣ ಇದ್ದವರು ಮಾತ್ರ ಪಡೆದುಕೊಳ್ಳಬಹುದು	ಸಾಮಾಜಿಕ ನ್ಯಾಯ, ಸಮಾನ ಅವಕಾಶ, ಅಶಕ್ತರಿಗೆ ಆದ್ಯತೆ(ಸಮತೆ)ಯ ತತ್ವಗಳಿಗೆ ಪ್ರಾಧಾನ್ಯತೆ. ಆರೋಗ್ಯವು ಜನರ ಹಕ್ಕು – ಈ ಮೂಲ ತತ್ವವನ್ನು ಅವಲಂಬಿಸಿದೆ.

ಸಮುದಾಯ ಆರೋಗ್ಯವು ಕೇವಲ ಕಾಯಿಲೆಯನ್ನು ನೋಡುವುದಲ್ಲ; ಅನಾರೋಗ್ಯದ ಮೂಲ ಕಾರಣಗಳು ಅನಾರೋಗ್ಯಕ್ಕೆ ಕಾರಣವಾಗುವ ವ್ಯವಸ್ಥೆಯನ್ನು "ಸ್ವಚ್ಛ"ಗೊಳಿಸುವತ್ತ ಪ್ರಯತ್ನ ಮಾಡುತ್ತದೆ

- ಬಹಳಷು ಕಾಯಿಲೆಗಳು ಬಡತನದ ನೇರ ಉತ್ಪನ್ನಗಳಾಗಿವೆ (ಕ್ಷಯ, ನಿಶ್ಯಕ್ತಿ)
- ಶೋಷಣೆ : ಉಳ್ಳವರು – ಬಡವರು
- ಅತಿ ಆಸೆ, ಲೋಭ / ದುರಾಸೆ
- ಭ್ರಷ್ಟಾಚಾರ
- ಸಂಪನ್ಮೂಲಗಳ ಸಮರ್ಪಕ ವಿತರಣೆಯಲ್ಲಿ ಅನ್ಯಾಯ.

ಸಮುದಾಯ ಆರೋಗ್ಯವು ಈ ತತ್ವಗಳನ್ನು ಅಳವಡಿಸಿಕೊಳ್ಳಬೇಕು...

1. ಬಡತನ ಮತ್ತು ಅನಾರೋಗ್ಯದ ಮೂಲಭೂತ ಕಾರಣಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳುವುದು
2. ಸಮುದಾಯದ ಶಕ್ತಿಯ ಮೇಲೆ ನಂಬಿಕೆ ಇಟ್ಟು ಕೆಲಸ ಮಾಡುವುದು
3. ಜನರ ಕೌಶಲ್ಯ ಮತ್ತು *ಸಮುದಾಯದ* ಜ್ಞಾನವನ್ನು ಅರ್ಥಮಾಡಿಕೊಂಡು, *ಸಮುದಾಯದಿಂದ* ಕಲಿತು, *ಸಮುದಾಯದಿಂದ* ಪ್ರಾರಂಭ ಮಾಡುವುದು

4. ಸಮುದಾಯ ಬೆಳವಣಿಗೆ/ಸಶಕ್ತೀಕರಣವು, ಸಮುದಾಯ ಆರೋಗ್ಯದ ಅವಿಭಾಜ್ಯ ಅಂಗ

23. ಜನರ ಹಕ್ಕುಗಳನ್ನು ಎತ್ತಿ ಹಿಡಿಯುವುದರಲ್ಲಿ ಮತ್ತು ಜನರು ತಮ್ಮ ಹಕ್ಕುಗಳನ್ನು ಕೇಳುವುದತ್ತ ಸಮುದಾಯವನ್ನು ತಯಾರು ಮಾಡುವುದು

23. ಅನ್ಯಾಯ – ಭ್ರಷ್ಟಾಚಾರವನ್ನು ಕಿತ್ತೆಗೆಯುವುದರಕಡೆ ಪ್ರಯತ್ನ ಮಾಡುವುದು

23. ಸಮುದಾಯ ಜೀವನದಲ್ಲಿ ಇರುವ ಆರೋಗ್ಯಕರ ಜೀವನ ಶೈಲಿ / ಸೂತ್ರಗಳನ್ನು ಎತ್ತಿ ಹಿಡಿಯುವುದು.

Annexure 4.3.1

ORIENTATION TO CH – Training Material

Case Study: ಆರೋಗ್ಯ ಮತ್ತು ಸಮುದಾಯ ಆರೋಗ್ಯ

ದೃಷ್ಟಾಂತ ವಿಷಯ: ಮಹಿಳಾ ಆರೋಗ್ಯ

ಹಲವಾರು ಸಂಸ್ಥೆಗಳು ಮಹಿಳಾ ಸಂಘಗಳನ್ನು ಮಾಡಿ, ಆರೋಗ್ಯದ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ನಡೆಸುತ್ತಾರೆ. ಶಿಶುಪಾಲನೆ. ಮಹಿಳಾ ಆರೋಗ್ಯ ತಪಾಸಣೆ, ನಿಶ್ಯಕ್ತಿಗೆ ಔಷಧಿ ಕೊಡುವುದು ಇತ್ಯಾದಿಅ. ಇವೆಲ್ಲವು "ರೋಗಸಂಬಂಧಿತ" ಮೆಡಿಕಲ್ ಕಾರ್ಯಕ್ರಮಗಳು. ಇವನ್ನು ಆರೋಗ್ಯ ಅಥವಾ ಸಮುದಾಯ 'ಆರೋಗ್ಯ' ವನ್ನಾಗಿ ಯಾವ ರೀತಿ ಮಾಡಬಹುದು?

ಉದಾ: ನಿಶ್ಯಕ್ತಿ : ಬಹುಸಂಖ್ಯಾತ ಗ್ರಾಮಿಣ ಮಹಿಳೆಯರು ನಿಶ್ಯಕ್ತಿಯಿಂದ ಬಳಲುತ್ತಾರೆ. ಈ ಸಮಸ್ಯೆಯನ್ನು ಕೇವಲ 'ಕಬ್ಬಿಣಾಂಶದ ಮಾತ್ರೆಗಳನ್ನು' ಅಥವ ಟಾನಿಕ್ ಕೊಟ್ಟು ಪರಿಹರಿಸಲು ಸಾಧ್ಯವಿದೆಯೆ?

ಸಮುದಾಯ ಆರೋಗ್ಯದ ದೃಷ್ಟಿ:

ನಿಶ್ಯಕ್ತಿಯ ಸಾಮಾಜಿಕ/ಆರ್ಥಿಕ/ರಾಜಕೀಯ ಕಾರಣಗಳೇನು ಎಂಬುದನ್ನು ಗುರುತಿಸಿ ಚರ್ಚೆ ಮಾಡಿ ಅಲ್ಲಿಂದ
ಮನೆಯಲ್ಲಿ ಎಲ್ಲರಿಗೂ ಪೌಷ್ಟಿಕ ಆಹಾರ ಸಿಗುತ್ತದಾ? ತಾಯಿ/ತಂಗಿ/ಅಕ್ಕ.. ಇವರು ಯಾವಾಗ ಊಟಮಾಡುತ್ತಾರೆ? ಪ್ರತಿ ದಿವಸ ಅವರು ಎಷ್ಟು ಕೆಲಸ ಮಾಡುತ್ತಾರೆ – ಅವರಿಗೆ ವಿಶ್ರಾಂತಿ / ವಿರಾಮ ಸಿಗುತ್ತದಾ? ಇದನ್ನು ಅರ್ಥಮಾಡಿಕೊಂಡು ಕೆಲಸ ಮಾಡುವುದು ಸಮುದಾಯ ಆರೋಗ್ಯವಾಗಿದೆ.

ನಿಶ್ಯಕ್ತಿ ಸಲುವಾಗಿ ಯಾವ್ಯಾವ ರೋಗಗಳಿಂದ ಅವರು ಭಾದಿತರಾಗಿದ್ದಾರೆ? ಕ್ಷಯ, ಬಿಳಿಮುಟ್ಟು, ತಲೆ ಸುತ್ತುವುದು, ರಕ್ತ ಕಡಿಮೆಯಾಗಿ ಯಾವಾಗಲೂ ಚಳಿ, ಜ್ವರ, ನೆಗಡಿ ಮುಂತಾದ ಸೋಂಕುಗಳಿಗೆ ಬಲಿಯಾಗುವುದು.. ಇತ್ಯಾದಿ

ದೈಹಿಕ ಮಾನಸಿಕ ಹಿಂಸೆಯ ಕಾರಣದಿಂದ ಯವ್ಯಾವ ಪರಿಣಾಮಗಳು ಅವರ ಆರೋಗ್ಯದ ಮೇಲೆ ಬೀಳುತ್ತವೆ? ಇದಕ್ಕೆ ಯಾವ ರೀತಿ ಪರಿಹಾರ ಕಂಡುಕೊಳ್ಳಬಹುದು? ಮಹಿಳೆಯರ ಜತೆಯಲ್ಲಿ ಕುಳಿತು ಅವರ ಆರೋಗ್ಯದ ಮೇಲೆ

ಪ್ರಭಾವ ಬೀರುವ ವಿಷಯಗಳ ಬಗ್ಗೆ ಚರ್ಚೆ ಮಾಡುವುದು. ಅವರನ್ನು ಕಾಡುವ ಪ್ರಮುಖ ಆರೋಗ್ಯದ (ಶಾರೀರಿಕ, ಮಾನಸಿಕ ಇತ್ಯಾದಿ) ವಿಷಯಗಳ ಬಗ್ಗೆ ಚರ್ಚೆ ಮಾಡುವುದು.

ನಿಶ್ಯಕ್ತಿಯಿಂದ ಆರೋಗ್ಯದ ಮೇಲೆ ಆಗುವ ಪರಿಣಾಮಗಳ ಬಗ್ಗೆ ಮಾಹಿತಿ; ಪೌಷ್ಟಿಕ ಆಹಾರದ ತರಬೇತಿಯನ್ನು ಏರ್ಪಡಿಸಬಹುದು. ಎಲ್ಲಾ ಮಹಿಳೆಯರು ಚರ್ಚೆ ಮಾಡಿ, ಆರೋಗ್ಯ ತಪಾಸಣೆ ಶಿಬಿರವನ್ನು ಏರ್ಪಡಿಸಬಹುದು. ಅವರೇ ಅದರಲ್ಲಿ ನಾಯಕತ್ವ ವಹಿಸಿ ಅದರಲ್ಲಿ ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸಬಹುದು

ಹಿಂಸೆಯಿಂದ, ಮಾನಸಿಕವಾಗಿ ಬಳಲುವವರಿಗೆ ಮಹಿಳಾ ಸಂಘವು ಸಾಂತ್ವನ, ನೈತಿಕ ಸಹಾಯ ಮತ್ತು ನ್ಯಾಯ ಒದಗಿಸಲು ಸಹಾಯ ಮಾಡಬಹುದು. ತಮಗೆ ಯಾವ ವಿಷಯದ ಬಗ್ಗೆ / ಯಾವ ರೋಗದ ಬಗ್ಗೆ ಮಾಹಿತಿ ಬೇಕು ಎಂದು ಅವರೆ ತೀರ್ಮಾನ ತೆಗೆದುಕೊಂಡು, ಬೇಕಾದ ಸಹಾಯವನ್ನು ನರ್ಸ್ ಅಥವಾ ಡಾಕ್ಟರಿಂದ ಪಡೆದುಕೊಳ್ಳಬಹುದು.

ಇದರಲ್ಲಿ ನಿಮಗೆ *"ಸಮುದಾಯ ಆರೋಗ್ಯದ ಪರಿಕಲ್ಪನೆಯ"* ಯಾವ್ಯಾವ ಅಂಶಗಳು / ತತ್ವಗಳು ಕಂಡು ಬರುತ್ತವೆ – ಚರ್ಚೆ ಮಾಡಿ.

Annexure 4.3.2 **ORIENTATION TO CH:**

Group Discussion Exercise:

ಈ ಕೆಳಗಿನವು ಆರೋಗ್ಯ ಎಂದಾದರೆ ✓ ಇಲ್ಲ ಅಂದರೆ X ಎಂದು ಸೂಚಿಸಿ

1.	ಪೌಷ್ಟಿಕ ಆಹಾರ / ಊಟ.........	
2.	ಉಡಲು ಬಟ್ಟೆ---	
3.	ಶಿಕ್ಷಣ__.	
4.	ಚಿಕ್ಕದಾದರೂ ಚೊಕ್ಕ ಮನೆ	
5.	ಶೌಚಾಲಯ..	
6.	ಸ್ವಚ್ಛ ನೀರು	
7.	ಸರಿಯಾದ ಕೂಲಿ	
8.	ಕೆಲಸ / ಉದ್ಯೋಗ	
9.	ಬೇಕಾದ ವಿಶ್ರಾಂತಿ / ವಿರಾಮ	
10.	ಚಿಂತೆ ಇಲ್ಲದೆ ಬಾಳುವುದು	
11.	ಊರಿನಲ್ಲಿ ಜಗಳ ಇಲ್ಲದೇ ಇರೋದು	
12.	ಹೆಣ್ಣುಮಕ್ಕಳನ್ನು ಚುಡಾಯಿಸುವುದು	
13.	ಹೆಂಡತಿಯನ್ನು ಹಿಂಸಿಸುವುದು	
14.	ಸಣ್ಣ ವಯಸ್ಸಿನಲ್ಲಿ ಮದುವೆ ಮಾಡುವುದು	
15.	ಮೇಲ್ಜಾತಿಯವರು ಕೆಳಜಾತಿಯವರ ಮೇಲೆ ಹಲ್ಲೆ ಮಾಡುವುದು	
16.	ಒಂದು ಸಮುದಾಯವನ್ನು ಅಸ್ಪೃಶ್ಯರು ಎಂದು ಹೊರಗಡೆ ಇಡುವುದು	
17.	ಮನೆಯಲ್ಲಿ ಗಂಡುಮಕ್ಕಳನ್ನು ಮತ್ತು ಹೆಣ್ಣುಮಕ್ಕಳನ್ನು ಸಮಾನವಾಗಿ ಬೆಳೆಸುವುದು	
18.	ನ್ಯಾಯಬೆಲೆ ಅಂಗಡಿಯಲ್ಲಿ ಅಕ್ಕಿ ಮತ್ತು ಇತರೆ ದಿನಸಿಗಳನ್ನು ಸರಿಯಾಗಿ ವಿತರಿಸುವಂತೆ ಕೇಳುವುದು	
19.	ಆರೋಗ್ಯ ಕೇಂದ್ರದಲ್ಲಿ ವೈದ್ಯರು ಇಲ್ಲದಿದ್ದರೆ 'ಡಾಕ್ಟರ್' ಬೇಕು ಎಂದು ಸರಕಾರವನ್ನು ಕೇಳುವುದು.	
20.	ಪರಿಸರವನ್ನು ಚೊಕ್ಕವಗಿಟ್ಟು ಸೊಳ್ಳೆ ಸಂತತಿ ಬೆಳೆಯದಂತೆ ಮಾಡುವುದು (ಮಲೇರಿಯಾ ರೋಗವನ್ನು ತಡೆಗಟ್ಟುವುದು)	
21.	ಧರ್ಮ, ದೇವರ ಹೆಸರಲ್ಲಿ ಹಿಂಸೆ ಮಾಡುವುದು	
22.	ವರದಕ್ಷಿಣೆ ಸಲುವಾಗಿ ಹಿಂಸಿಸುವುದು ಮತ್ತು ಮಹಿಳೆಯರನ್ನು ಸುಡುವುದು	

Annexure 4.3.3 ORIENTATION TO CH:

Principles of the Alternative Paradigm of Community Health

ಪರ್ಯಾಯ/ಸಮುದಾಯ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆಯ ಸೂತ್ರ/ತತ್ವಗಳು

ಪ್ರಸ್ತುತ ಮುಖ್ಯವಾಹಿನಿ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆ	*ಪರ್ಯಾಯ / ತಳಸಮುದಾಯದ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆ*
ಮೇಲಿಂದ ಕೆಳಗಡೆ (ಖಿಔ-ಣಔ-ಃಡಿಂಣಡು)	ತಳದಿಂದ ಮೇಲಕ್ಕೆ (ಃಡಿಂಣಡು - ಣಔ)
ಕೆಂಪು ಪಟ್ಟಿಯ ವ್ಯವಸ್ಥೆ (ಬ್ಯೂರೊಕ್ರೆಟಿಕ್)	ಸರಳ
ಜನರ ಸಹಭಾಗಿತ್ವ ಇಲ್ಲ	ಜನರ ಸಹಭಾಗಿತ್ವ ಪ್ರಾಮುಖ್ಯ
ಜನರಿಗೆ ಉತ್ತರ/ಅಧಿಕಾರ ಕೊಡುವುದಿಲ್ಲ (ಜನರಿಗೆ ವಿಚಾರಿಸುವ ಹಕ್ಕು ಇಲ್ಲ)	ಜನರದೇ ವಿಚಾರ / ಜನರದೇ ಅಧಿಕಾರ
ಬಹಳ ರಹಸ್ಯಮಯ/ ಗುಪ್ತ ವ್ಯವಸ್ಥೆ 'ಗುಟ್ಟಾದ ವ್ಯವಸ್ಥೆ'	ತೆರೆದ, ರಹಸ್ಯವಿಲ್ಲದ 'ರಟ್ಟಾದ' ವ್ಯವಸ್ಥೆ
"ಸೇವೆ *ಕೊಡುವುದು*" ಮುಖ್ಯ ಕೆಲಸ	ಸೇವೆ ಅಲ್ಲ - *ಪಡೆದುಕೊಳ್ಳುವುದು* ಜನರ ಹಕ್ಕು
ಒಂದೇ ವಿಷಯಕ್ಕೆ / ರೋಗಕ್ಕೆ ಆದ್ಯತೆ ಕೊಡುವ "ಲಂಬಾಕಾರದ" ಕಾರ್ಯಕ್ರಮ (ಗಿಜಡಿಣಖಿಚಿಟ)	ಜನರ ಜೀವನಕ್ಕೆ ಸಂಬಂಧ ಪಡುವ ಹಲವಾರು ವಿಷಯಗಳನ್ನು ಜೊತೆಯಲ್ಲಿ ವೀಕ್ಷಿಸುವ "ಅಡ್ಡಾಕಾರದ" ಕಾರ್ಯಕ್ರಮಗಳು (ಊಔಡಿಥಿಚಿಣಔಟ)
ಜನರಿಗೆ ಸೌಲಭ್ಯ "ದೊರಕುವುದು" ಕಡಿಮೆ	ಜನರಿಗೆ ಸರಳವಾಗಿ ದೊರಕುತ್ತದೆ
ಸಿಬ್ಬಂದಿಯ ಮೇಲೆ ಅತ್ಯಧಿಕ ಖರ್ಚು	ಆರೋಗ್ಯ ತರಬೇತಿಯಂತಹ ಬೇರೆ ವಿಷಯಗಳಿಗೂ ಹಣ ಖರ್ಚು ಆಗುತ್ತದೆ.

ಸಾರ್ವತ್ರಿಕ ಆರೋಗ್ಯ ಸೇವೆಯ ವಿಸ್ತರಣೆ – ಬಹಳ ಕಡಿಮೆ	ಸಾರ್ವತ್ರಿಕ ಆರೋಗ್ಯ ಸೇವೆ – ಜಾಸ್ತಿ ಜನರಿಗೆ ಸಿಗುತ್ತದೆ
ಖರ್ಚು : ಪ್ರಯೋಜನದ ಪ್ರಮಾಣ ಕಡಿಮೆ	ಖರ್ಚು : ಪ್ರಯೋಜನದ ಪ್ರಮಾಣ ಹೆಚ್ಚು
ಒಂದೇ ಸ್ಥಾನದಲ್ಲಿರುವ – ಆರೋಗ್ಯ ಕೇಂದ್ರ ಮತ್ತು ಡಾಕ್ಟರ್‌ಗಳಿಗೆ ಆದ್ಯತೆ	ಸಂಚಾರಿ ಮತ್ತು ಹಳ್ಳಿಗೆ ತಲುಪುವಂತಹ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆಗೆ ಆದ್ಯತೆ
ಕೇಂದ್ರೀಕೃತ ವ್ಯವಸ್ಥೆ	ವಿಕೇಂದ್ರಿತ ವ್ಯವಸ್ಥೆ
'ಇಷ್ಟೇ ಎಂಬ ಗುರಿ' ಸಾಧನೆ ಮಾಡುವ ಕಾರ್ಯಕ್ರಮ	ಸಮಸ್ಯಾಧಾರಿತ, ರೋಗಗಳನ್ನು ತಡೆಗಟ್ಟುವ ಮತ್ತು ಒಳ್ಳೆಯ ಆರೋಗ್ಯಕ್ಕೆ ಪುಷ್ಟಿ ಕೊಡುವ ವ್ಯವಸ್ಥೆ

Annexure 4. 4.1:

RIGHT TO FOOD SECURITY:

1. Food Security: Indian Scenario

ಆಹಾರ ಭದ್ರತೆ/ ಅಭದ್ರತೆ : ಭಾರತದ ಪದ್ದತಿ

ಭಾರತದಲ್ಲಿ ಎಲ್ಲರಿಗೂ ಸಿಗುವಷ್ಟು ಆಹಾರ ಧಾನ್ಯ ಇದೆಯಾ? ಹೌದು

1950 – 51 ರಲ್ಲಿ 50 ಮಿಲಿಯ ಟನ್ ಆಹಾರ ಕಾಳು ಉತ್ಪಾದನೆ

2001 – 02 ರಲ್ಲಿ 211 ಮಿಲಿಯ ಟನ್ ಆಹಾರ ಕಾಳು ಉತ್ಪಾದನೆ.

2000 – 01 ರಲ್ಲಿ

- 47.7% ಮಕ್ಕಳು ಅಪೌಷ್ಟಿಕತೆಯಿಂದ ನರಳುತ್ತಿದ್ದರು
- 36% ಮಹಿಳೆಯರು ಅಪೌಷ್ಟಿಕತೆಯಿಂದ ನರಳುತ್ತಿದ್ದರು

ದಲಿತರಲ್ಲಿ :

- 36.25% (ಗ್ರಾಮೀಣ), 38.47% (ನಗರ ಪ್ರದೇಶ) ಸರಿಯಾದ ಆಹಾರ ಇಲ್ಲದೇನೇ ಇದ್ದಾರೆ

ಬುಡಕಟ್ಟು ಜನರಲ್ಲಿ / ಆದಿವಾಸಿಗಳಲ್ಲಿ :

45.86 % (ಗ್ರಾಮೀಣ) 34.75 % (ನಗರ ಪ್ರದೇಶ)

ಅಪೌಷ್ಟಿಕತೆಯಿಂದ / ಆಹಾರ ಇಲ್ಲದೆ ಬಳಲುವವರು ಯಾರು?

ಅಸಂಘಟಿತರು

ಬಾಲ ಕಾರ್ಮಿಕರು/ ಜೀತ ಮಾಡುವವರು

ಮಹಿಳೆಯರು

ಕೃಷಿ – ಕೂಲಿ ಕಾರ್ಮಿಕರು

ಇತರ ಕೂಲಿಗಾರರು

ಆದಿವಾಸಿ / ದಲಿತರು

ನ್ಯಾಯಬೆಲೆ ಅಂಗಡಿಗಳು – ಭಾರತದಲ್ಲಿ ಬಹಳ ವರ್ಷಗಳಿಂದ ಇವೆ

4,50,000 ನ್ಯಾಯಬೆಲೆ ಅಂಗಡಿಗಳಿವೆ

218 ಮಿಲಿಯ (21.8 ಕೋಟಿ) ಪಡಿತರ ಚೀಟಿಗಳು

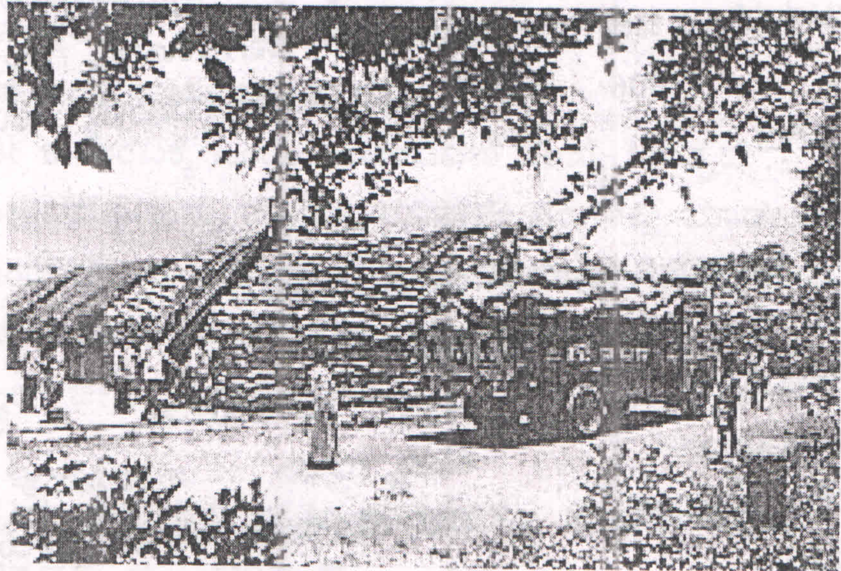
* 6.7 ಕೋಟಿ ಬಡತನ ರೇಖೆಗಿಂತ ಕೆಳಗೆ ಇರುವವರಿಗೆ (ಃಜು)
* 1.0 ಕೋಟಿ ಅಂತ್ಯೋದಯ ಅನ್ನ ಯೋಜನೆ (ಕಡುಬಡವರಿಗೆ)

1997 ರಿಂದ ಸರಕಾರ ಪಡಿತರ ಚೀಟಿ/ ರೇಶನ್ ಕಾರ್ಡ್‌ಗಳ ಸಂಖ್ಯೆ ಕಡಿಮೆ ಮಾಡುತ್ತಾ ಬಂದಿದೆ (ಖಿಜುಖ) - ಹಳ್ಳಿ ಹಳ್ಳಿಯಲ್ಲಿ ಕಾರ್ಡ್‌ಗಳನ್ನು ಹಿಂತೆಗೆದು ಕೊಂಡಿದ್ದಾರೆ

ಪಡಿತರ ವಿತರಣೆಯಲ್ಲಿ ಭ್ರಷ್ಟಾಚಾರ

ಆಹಾರ ಗೋದಾಮುಗಳಲ್ಲಿ ಆಹಾರ ಕೊಳೆಯುತ್ತಿದೆ – 20% ಅಂದರೆ ಎಲ್ಲಾ ಬಡವರಿಗೆ ಒಂದು ವರ್ಷಕ್ಕೆ ಸಾಕಾಗುವಷ್ಟು ಆಹಾರ ಇಲಿ / ಹೆಗ್ಗಣ ತಿಂದು, ಕೊಳೆತು ನಾಶವಾಗುತ್ತದೆ.

ಬರಗಾಲ / ನೆರೆಯಿಂದ ಜನರು ಪ್ರಭಾವಿತರಾಗಿದ್ದು, ಹಳ್ಳಿಗಳಿಂದ ನಗರ ಪ್ರದೇಶಗಳಿಗೆ, ಕೆಲಸ ಹುಡುಕಿ ಹೋಗುತ್ತಾರೆ.



Annexure 4.4.2 RIGHT TO FOOD SECURITY:

2. National Rural Employment Guarantee Act

ರಾಷ್ಟ್ರೀ0ಯ ಗ್ರಾಮೀಣ ಉದ್ಯೋಗ ಭದ್ರತಾ ಕಾಯಿದೆ 2005

ಸೆಪ್ಟೆಂಬರ್ 2005 ರಲ್ಲಿ – ರಾಷ್ಟ್ರೀ0ಯ ಗ್ರಾಮೀಣ ಉದ್ಯೋಗ ಭದ್ರತಾ ಕಾಯಿದೆ 2005 – ಓಂಖಖಔಓಂಖ ಖಗಖಂಖ ಇಒಹಔಜಒಇಓಖ ಉಗಂಖಂಓಖಇಇ ಂಅಖ 0ಯನ್ನು ಮಂಜೂರು ಮಾಡಿದೆ

ಉದ್ದೇಶ : ಗ್ರಾಮಿಣ ಜನರಿಗೆ ಉಪಜೀವನ ಭದ್ರತೆ0ಯನ್ನು ಹೆಚ್ಚಿಸಲು ಮಾಡಿದ ಕಾಯಿದೆ

- ಕನಿಷ್ಟ 100 ದಿನಗಳ ಕೂಲಿ ಕೆಲಸ
- ಪ್ರತೀ ಕುಟುಂಬದಲ್ಲಿ 18 ವರ್ಷಕ್ಕಿಂತ ಮೇಲಿನವರಿಗೆ ಕೆಲಸ ಮಾಡಲು ಅಧಿಕಾರ
- ಪರಿಶ್ರಮದ ದಿನಗೂಲಿ ಕೆಲಸ ಮಾಡಲು ಇಚ್ಚಿಸುವವರಿಗೆ
- ಕೆಲಸವನ್ನು ಕೇಳಿದ್ದಲ್ಲಿ ಕೊಡಲೇಬೇಕು.

ಪ್ರಾರಂಭದಲ್ಲಿ 100 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಇದನ್ನು ಅನುಷ್ಟಾನಗೊಳಿಸಲಾಗುವುದು. (ಕರ್ನಾಟಕದಲ್ಲಿ 5 ಜಿಲ್ಲೆಗಳು: ರಾ0ಯಚೂರು, ಬಾಗಲಕೋಟೆ, ಗುಲ್ಬರ್ಗ, ಫೆಬ್ರವರಿ 2, 2006 ರಂದು ಈ ಕಾ0ರ್ಯಕ್ರಮವನ್ನು ಉದ್ಘಾಟನೆ ಮಾಡಲಾಗಿದೆ.

ಅನುಷ್ಟಾನ ಜವಾಬ್ದಾರಿ : (ಖಟಊಟಜಚಚಟಿಣಚಿಣಚಟಿ)

ಹಳ್ಳಿ ಮಟ್ಟದಲ್ಲಿ	:	ಗ್ರಾಮ ಸಭೆ
ಪಂಚಾ0ಯತ್ ಪಂಚಾ0ಯತ್	:	ಜಿಲ್ಲಾ ಪಂಚಾ0ಯತ್, ತಾಲುಕು ಮತ್ತು ಗ್ರಾಮ ಪಂಚಾ0ಯತ್
ಜಿಲ್ಲಾ ಹಂತದಲ್ಲಿ	:	ಜಿಲ್ಲಾ0ಯೋಜನಾ ಸಂ0ಯೋಜಕರು
ತಾಲುಕು	:	0ಯೋಜನಾಧಿಕಾರಿ

ಹಳ್ಳಿ ಹಂತದಲ್ಲಿ : ಪಂಚಾಯತ್,ಸ್ವಯಂ-ಸೇವಾ ಸಂಸ್ಥೆಗಳು, ಸ್ವ - ಸಹಾಯ ಸಂಘಗಳು, ಸರಕಾರಿ ಅಧಿಕಾರಿಗಳು

ನೋಂದಾವಣೆ ಮತ್ತು ಉದ್ಯೋಗ

ಅರ್ಹತೆ : (ಇಟಙಥುಟಾಥಿ)

- ಎಲ್ಲಾ ಗ್ರಾಮೀಣ ಕುಟುಂಬಗಳಿಗೆ ಅನ್ವಯವಾಗುತ್ತದೆ
- ಒಂದು ಕುಟುಂಬದಲ್ಲಿ ಒಂದಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ವಯಸ್ಕರು ನೋಂದಾಯಿಸಬಹುದು
- ಎಲ್ಲಾ ವಯಸ್ಕರು ಕೆಲಸಕ್ಕೆ ಅರ್ಜಿ ಹಾಕಬಹುದು
  - ಸ್ಥಳೀಯರಾಗಿರಬೇಕು : ವಲಸೆ ಹೋದವರೂ ಸೇರಿರುತ್ತಾರೆ
  - ಕೆಲಸ ಮಾಡಲು ಇಚ್ಚಿಸುವವರು
  - ಒಂದೇ 'ಕುಟುಂಬ' ದ ಹೆಸರಲ್ಲಿ ಅರ್ಜಿ ಹಾಕಬೇಕು

ಅರ್ಜಿ : **(Registration)**

ಒಂದು ಮನೆಯವರು, ಕೆಲಸ ಮಾಡಲಿಚ್ಚಿಸುವವರು, ಎಲ್ಲರ ಹೆಸರುಗಳನ್ನು ಬರೆದು ಗ್ರಾಮ ಪಂಚಾಯತಿಗೆ ಅರ್ಜಿ ಸಲ್ಲಿಸಬೇಕು

ಮನೆ - ಮನೆಯ ಸಮೀಕ್ಷೆಯನ್ನು ಗ್ರಾಮ ಪಂಚಾಯತಿಯು ಮಾಡಿದ ನಂತರ ಪರಿಶೀಲನೆ ಮಾಡಿದ ಮೇಲೆ ಹೆಸರು ನೋಂದಾಯಿಸಿಕ್ಕೊಳ್ಳುತ್ತಾರೆ.

ಪ್ರತೀ ಕುಟುಂಬಕ್ಕೆ ಒಂದು ನೋಂದವಣಿ ಸಂಖ್ಯೆ ಸಿಗುತ್ತದೆ

ನೋಂದವಣಿಯನ್ನು ವರ್ಷದ ಯಾವುದೇ ತಿಂಗಳಲ್ಲಿ ಮಾಡಬಹುದು

ನೊಂದಾಯಿಸಿದ ಅರ್ಜಿದಾರರ ಗ್ರಾಮಸಭೆಯನ್ನು ನಡೆಸಲಾಗುತ್ತಾದೆ

ಸುಳ್ಳು ಅರ್ಜಿಗಳನ್ನು ತಿರಸ್ಕರಿಸಲಾಗುವುದು

ಉದ್ಯೋಗ ಚೀಟಿ : (ಎ�threw ಅಚಿಡಿಜ)

ಉದ್ಯೋಗ ಚೀಟಿಯನ್ನು ಪ್ರತೀ ಕುಟುಂಬಕ್ಕೂ ಕೊಡಲಾಗುವುದು. ಇದರಲ್ಲಿ ಭಾವಚಿತ್ರವನ್ನು ಅಂಟಿಸಿರುತ್ತಾರೆ

ಮುಂದಿನ 5 ವರ್ಷಕ್ಕೆ ಈ ಉದ್ಯೋಗ ಚೀಟಿಯನ್ನು ಉಪಯೋಗಿಸಬಹುದು

ಕೆಲಸಕ್ಕೆ ಅರ್ಜಿ ಹಾಕುವುದು: (೦ರಿರಿಟಟಿಭಿಬಿಣಚುಟಿ ಜಿಡಿಡಿ ಎಥ)

- ನೊಂದಾಯಿಸಲ್ಪಟ್ಟ ವ0ಯಸ್ಕ ಸದಸ್ಯನು / ಳು ಗ್ರಾಮ ಪಂಚಾ0ಯತಿ ಅಥವಾ 0ಯೋಜನಾಧಿಕಾರಿಗೆ ಕೆಲಸಕ್ಕಾಗಿ ಅರ್ಜಿ ಸಲ್ಲಿಸಬಹುದು.
- ಜನರ ಒತ್ತಾ0ಯದ ಮೇರೆಗೆ ಗ್ರಾಮ ಪಂಚಾ0ಯತಿ ಕೆಲಸವನ್ನು ಒದಗಿಸಬೇಕು
- ಮಹಿಳೆ0ಯರಿಗೆ / ಹೆಚ್ಚು ವ0ಯಸ್ಸಾದವರಿಗೆ ಹತ್ತಿರದ ಕೆಲಸ ಮಾಡಲು ಆದ್ಯತೆ ಇರುವುದು

ಕಾಲಾವಧಿ :

- ಅರ್ಜಿ ತಲುಪಿಸಿದ 15 ದಿನದ ಒಳಗಾಗಿ ಗ್ರಾಮ ಪಂಚಾ0ಯತಿ ಕೆಲಸವನ್ನು ಕೊಡಬೇಕು
- ಗ್ರಾಮ ಪಂಚಾ0ಯತಿ ಈ ಕೆಲಸ ಮಾಡಲು ತಪ್ಪಿದರೆ 0ಯೋಜನಾಧಿಕಾರಿ0ಯು ಕೆಲಸವನ್ನು ಕೊಡತಕ್ಕದ್ದು
- 15 ದಿನದ ಒಳಗೆ ಕೆಲಸ ಸಿಗದೇ ಇದ್ದರೆ, 25% ನಗದು ಹಣವನ್ನು ಅರ್ಜಿದಾರರಿಗೆ ಕೊಡಲಾಗುವುದು

ಕೆಲಸ ಮತ್ತು ಅನುಷ್ಟಾನ :

ಈ ಕೆಳಗಿನ ಕೆಲಸಗಳನ್ನು ಮಾಡಬಹುದು

- ನೀರು ಶೇಖರಣೆ
- ಬರಗಾಲ ತಡೆ (ಸಸಿಗಳನ್ನು ಹಚ್ಚುವುದು, ಗಿಡನೆಡುವುದು)
- ನೀರಿನ ಕಾಲುವೆಗಳನ್ನು ಮಾಡುವುದು
- ಬಾವಿಗಳನ್ನು ದುರಸ್ತಿ ಮಾಡುವುದು / ಕೆರೆ0ಯ ಹೂಳುತೆಗೆ0ಯುವುದು
- ರಸ್ತೆ ಕಾಮಗಾರಿ
- ಭೂಮಿ0ಯ ಸುದಾರಣೆ ಇತ್ಯಾದಿ

ವೈಧ್ಯಕೀ0ಯ ಸಹಾ0ಯ, ಕುಡಿ0ಯುವ ನೀರು, ನೆರಳು, ಶಿಶುಪಾಲನಾ ಸೌಲಭ್ಯ (6 ವರ್ಷಕ್ಕಿಂತ ಕಡಿಮೆ ವ0ಯಸ್ಸಿನ ಮಕ್ಕಳಿದ್ದರೆ) ಕೊಡತಕ್ಕದ್ದು

ಕನಿಷ್ಟ ವೇತನ ಕಾಯಿದೆಯ ಪ್ರಕಾರ ಕೂಲಿ ಕೊಡಲಾಗುವುದು (ಕರ್ನಾಟಕದಲ್ಲಿ ಈಗ ಒಂದು ದಿನಕ್ಕೆ ರುಪಾಯಿ 62.00)

ಮಹಿಳೆಯರಿಗೆ ಪುರುಷರಿಗೆ ಸಮಾನ ವೇತನ

ವಾರಕ್ಕೊಂದು ಸಲ ಅಥವ ಎರಡು ವಾರದ ಒಳಗೆ

ವೇತನದ ಕೆಲವು ಭಾಗವನ್ನು ದಿನಲೆಕ್ಕದಲ್ಲಿ ಕೊಡಬಹುದು

ತಪಾಸಣೆಯ ಕಡತಗಳು :

- ನೋಂದಾವಣಾ ಅರ್ಜಿಯ ಕಡತ
- ಉದ್ಯೊಗ ಚೀಟಿ ಕಡತ
- ಒದಗಿಸಿದ ಉದ್ಯೋಗದ ಕಡತ (ಗ್ರಾಮ ಪಂಚಾಯತಿ ಮಟ್ಟದಲ್ಲಿ)
- ಯೋಜನಾಧಿಕಾರಿ ಹಂತದಲ್ಲಿ ಉದ್ಯೋಗದ ಕಡತ
- ಮಸ್ಟರ್ ರೋಲ್ (ಕೆಲಸದ ಹಾಜರಾತಿ)
- ದೂರು ಸಲ್ಲಿಸುವಿಕೆಯ ಕಡತ

Annexure 4.4.3 RIGHT TO FOOD SECURITY:

3. Concept Of Food Security

Certain facts:

- The poorest 20% of the world's people saw their share of global income decline from 2.3% to 1.4% in the past 30 years. During the same period, the share of the richest 20% rose from 70% to 85%.
- The assets of the worlds 358 billionaires exceeded the combined annual income of countries with 45% of the world's people

The most serious manifestation of poverty is under-nutrition and malnutrition.

- Food production has improved: but hunger and malnutrition has increased drastically
- One of five persons in the developing countries is chronically undernourished
- 192 million children suffer from protein-energy malnutrition
- Over 2000 million (200 crore) experience micro-nutrient deficiency; there are many political and many other underlying factors for micro-nutrient deficiencies;
- Proportion of chronically undernourished people has increased.
- The poor starve or are malnourished as they lack access to resources, natural or economic
- The annual income of the poorest 2 billion = expenditure of the developed countries on military (UN Statistics: refer. Women, Food security and PR, by Ambika Menon in P. Chaturvedi, p.95)
- Women own 1 per cent of the land despite being about 50% of humanity and 66% of work
- Half of the world's food is produced by the poorest of the poor who have nothing to eat (Ambika Menon, ibid.)

Understanding of Food Security:

Food Security: = that every individual has the physical, economic, social and environmental access to a balanced diet that includes the necessary macro- and micro-nutrients, safe drinking water, sanitation, environmental hygiene, primary health care and education so as to lead a healthy and productive life.

(M.S. Swaminathan in Food Security and panchayati Raj, Pradeep Chaturvedi (ed.), New Delhi: Concept Publishing company, New Delhi, 1997)
Food security is defined as a situation where everyone on the globe has access, at all times, to the food needed for an active and healthy life.
At the household level food security implies having physical and economic access to food that is adequate in terms of quantity, quality and safety.

Important issues concerning food security are:

Availability: Enough food for all can be attained through efficient domestic production. India is already producing surplus food

Stability: Supplies, storage, anticipation of natural disasters, food supplies, efficient systems, PDS, etc. Sustainable asset base for the poor is a must to ensure food security.

Access: (Purchasing power) to obtain adequate and safe food by all is possible. The problem:

Cannot produce food

Cannot afford to buy enough food

They have inadequate access to natural resources, jobs, incomes or social support.

Among those who do not have access to food are women, dalits and tribals, unorganised sector, etc.

Question of Equity

Global and macro reasons for food insecurity:

- The policy of global north to protect its access to and control over the natural resources of the south
- Done through the proliferation of wars and ethnic conflicts, unfair trade rules, policy changes etc.
- Natural resources: access is denied to the people, the powerful have established control
- Investment in Agriculture: the small and marginal farmers, women do not have access to these.
- Water and food production: Food security is linked to water. Water availability is less, polluted rivers, the exploitation of water sources by the capitalists (sand mining, privatization of rivers, dams etc.)
- Food marketing, processing and distribution
- Agro based industries, agro technology (e.g. organic farming, producing organic fertilizer etc.) is not reached to people. It is highly chemicalised.
- Public Distribution System (PDS) in shambles
- Green revolution destroyed bio-diversity, helped monocropping, interfered with the self-sufficiency in seeds food sufficiency was achieved, self-sufficiency in food was destroyed.
- Green Revolution: debts, displacement of small farmers, chemicalized agriculture, traditional knowledge destroyed,
- Socio-political and economic environment: anti-poor, anti-rural, anti-women, anti-agriculture (Neo-liberal policies)
- Land reforms have not adequately taken place; land is more and more corporatised.
- Development programmes (food for work etc.) are not planned with the people. The top-down approach still continues strongly.
- Wage labour: minimum wages are not paid.
- Food insecurity is affecting the women the most and the worst.
- Food trade, MNCs in seeds, pesticides, fertilizers, food processing and sales;

- Genetically Modified Food (GM)
- WTO and global pricing system

The Spectre of Mass Hunger

- Per day intake of nutritious food is 460 grams (~half k.g.) – Min. standard
- Per day intake of calories : 2400 cal.: Min. standard
- Body Mass index is another indicator
- NSSO: 1983: the cal intake was 2211, declined to 2149 in 1999-2000 (declined in 17 states of India)
- Body Mass Index (BMI): Weight to the ratio of of Height square.= 18.5 (min): using this Shetty and James found 46% chronically deficient in 1991-92 and severe under-nourishment was observed among 9%. = half of the country's population is malnourished. 53% of children are undernourished and 21% severely undernourished.
- Calculation of Poverty: USA: if one spends more than 1/3 of ones expenditure on food then considered poor. By that standard 95% of rural households would be poor. China if the share of food is more than 60% then one is poor. Then more than 80% households will be poor.
  - In India the top 20% can be excluded from the food security.
- According to MS Swaminathan, 50% adults are undernourished and 70% households are deficient in food consumption.
- Structural adjustment:
  - Food subsidy was cut
  - Agricultural subsidy was cut: However, one finds that in the so called developed nations like USA, Canada etc the farm and food subsidy is the highest.
  - State conspiracy to dismantle PDS: Raising the price of food grains , reducing the supply of food grains, reducing the PDS cards (e.g. Maharashtra 60 lakh household were entitled to hold PDS cards, but only 43 lakh cards are issued). Dharavi (Mumbai) is the largest slum in Asia (nearly 5 lakh population) but the BPL are only 365 families (1997) then fell to 151 in 1999. Now new categories are made: very poor, moderately poor.
- Near collapse of PDS system everywhere
- corruption and maladministration: food grains being lifted, bogus ration cards, poor quality grains: only 17.5 per cent of the wheat lifted from the FCI by the State governments reached the final consumer in Bihar.
- Suicides by small and marginal farmers

Example of Kerala:

In UP and Bihar, in 1987, 98% of the rural population did not purchase any grain from PDS. In Kerala, 87% of the population purchased grain from PDS. Kerala establishment of the strong PDS system is the outcome of strong people's movement for food. The coverage is almost universal. In 1995 almost 95% were covered. The functioning of the delivery system is far better than other states.

Ruthlessness of the Indian State:

- Excess food stocks were exported, did not use for food for work schemes (2000-02: export of 20 mil. Tonnes of food for a lesser price than BPL price)
- Proposed slashing of BPL list (millions were removed under the name TPDS)
- India exported genetically modified grain, for higher price from the transnationals and circulated in the market

What is being done? What is the way ahead?

Right to food campaign in which JSA is an active participant took part in several components of this campaign such Hunger Watch; universalisation of ICDS; Midday meals in schools; disseminating the information on Supreme Court rulings; prevention of hazardous/toxic material/waste.

Annexure 5.1

JAN SWASTHYA ABHIYAN
(People's Health Movement – India): An Introduction

What is Jan Swasthya Abhiyan (JSA)?

The Jan Swasthya Abhiyan is the **Indian circle of the People's Health Movement**, a worldwide movement to establish health and equitable development as top priorities through comprehensive Primary Health Care and action on the social determinants of health. It is a growing coalition of people's organisations, civil society organisations, NGOs, social activists, health professionals, academics and researchers that are working consistently towards the goal of 'Health for All'.

How did JSA emerge?

From 4th to 8th December 2000, representatives from 93 countries came together for the People's Health Assembly (PHA) at Savar near Dhaka, Bangladesh. The objective of this assembly held in the end of the year 2000 was to give a call to renew the pledge of 'Health for All'. Though the goal committed on at Alma Ata was "Health for all by the year 2000", this goal had been subsequently marginalized in health policy discussions, and as the year 2000 approached was quietly being forgotten by Governments around the world. The assembly also aimed to build global solidarity, and to bring together people's movements and organisations working to advance the people's health in the context of globalisation policies. A total of 1350 delegates participated in PHA, of which about 180 were from India, sponsored by the National Coordination Committee of the Indian campaign.

A National Health Assembly at Kolkata preceded this global event on November 30th and December 1st 2000, where as the culmination of a very extensive mobilization across 19 states, a massive number of over 2000 delegates congregated. This National assembly declared the major goals of the Indian People's Health Movement, and demarcated the specific issues on which the people's health movement in India would concentrate. It adopted a 20-point charter known as the Indian **People's Health Charter,** outlining a critical analysis of the Indian health scenario in the context of globalisation. This charter provides a statement of the shared understanding and goals that unite all the organisations working as part of this network.

The national networks and organisations that had come together to organize the National Health Assembly decided to continue and develop this movement in the form of the **Jan Swasthya Abhiyan** (JSA – People's Health Movement).

Why is Jan Swasthya Abhiyan necessary today?

Despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people worldwide. Enduring poverty with all its facets and in addition, resurgence of communicable

diseases including the HIV/AIDS epidemic, and weakening of public health systems is leading to reversal of previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under threat.

These trends are to a large extent the result of the inequitable structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, unfair world trade arrangements and uncontrolled financial speculation – all part of the rapid movement towards inequitable globalisation. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Within the health sector, failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis, leading to the following deficiencies:

- A retreat from the goal of comprehensive national health and drug polices as part of overall social policy;
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society;
- A failure to promote participation and genuine involvement of communities in their own health development;
- Reduced state responsibility at all levels as a consequence of widespread and usually inequitable policies of privatisation of health services;
- A narrow, top-down, technology-oriented view of health and increasingly viewing health care as a commodity rather than as a Human right.

What does the JSA aim to achieve?

In view of the above analysis, the organizations constituting the Jan Swasthya Abhiyan have come together to launch a campaign, emerging from the Peoples Health Assembly process. The objectives that this coalition set for itself (which are set out in detail in the Peoples Health Charter) can be briefly listed as below:

1. The Jan Swasthya Abhiyan aims to draw public attention to the adverse impact of the policies of iniquitous globalization on the health of Indian people, especially on the health of the poor.
2. The Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 A.D.' pledge. This historic commitment needs to be renewed and taken forward, in the form of the campaign to establish the Right to health and health care as basic human rights. Health and equitable development need to be reestablished as priorities in local, national, international policy-making, with Primary Health Care as a major strategy for achieving these priorities.
3. In India, globalization's thrust for privatization and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialize medical care. Irrational, unethical and exploitative medical practices are flourishing and growing. The Jan Swasthya Abhiyan expresses the need to confront such commercialization, while establishing minimum standards and rational treatment guidelines for health care.
4. In the Indian context, top down, bureaucratic, fragmented techno-centric approaches to health care have created considerable wastage of scarce

resources and have failed to deliver significant health improvements. The Jan Swasthya Abhiyan seeks to emphasize the urgent need to promote decentralization of health care and build up integrated, comprehensive and participatory approaches to health care that places "Peoples Health in Peoples Hands".

0. The Jan Swasthya Abhiyan seeks to network with all those interested in promoting peoples' health. It seeks to unleash a wide variety of people's initiatives that would help the poor and the marginalized to organize and access better health care, while contributing to building long-term and sustainable solutions to health problems.

How is JSA organised?

The Jan Swasthya Abhiyan at the national level is the **coalition of all the 21 networks of voluntary organizations and peoples movements** involved in healthcare delivery and health policy in the country, who made themselves a part of the Peoples Health Assembly campaign in the year 2000, and have continued to participate in this process. Many of these national networks have numerous constituent organisations, which implies that a few hundred organizations are involved directly in the national process. Outside of these networks, several hundred other organizations have been involved at state, district and block level activities across the country.

The networks that constitute the **National Coordination Committee** of Jan Swasthya Abhiyan are:

3. All India Peoples Science Network
3. All India Democratic Women's Association
3. All India Drug Action Network
3. Bharat Gyan Vigyan Samiti
3. Catholic Health Association of India (CHAI)
3. Christian Medical Association of India (CMAI)
3. Federation of Medical Representatives and Sales Associations of India (FMRAI)
3. Forum for Creche and Child Care Services (FORCES)
3. Joint Women's Programme (JWP)
3. Medico Friends Circle (MFC)
3. National Alliance of Peoples Movements (NAPM)
3. National Alliance of Women (NAWO)
3. National Federation of Indian Women (NFIW)
3. Ramakrishna Mission
3. Society for Community Health, Awareness and Research Action (SOCHARA)
3. Voluntary Health Association of India (VHAI)
3. Association for Indian Development, India (AID-India)
3. Breast Feeding Promotion Network of India (BFPNI)

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3. Association for Indian Development, India (AID-India)
3. Breast Feeding Promotion Network of India (BFPNI)

National Resource Groups:

1. SATHI-CEHAT, Pune.
2. Centre for Social Medicine and Community Health, Jawaharlal Nehru University, Delhi.
3. Community Health Cell (CHC), Bangalore.

Jan Swasthya Abhiyan presently has state units or contacts in the following states:

Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh, West Bengal.

This **National Coordination Committee** is the national decision making body of the JSA. Dr. N.H. Antia is the **Chairperson** and Dr. D. Banerji is the **Vice-Chairperson** of JSA. Executive functions are handled by the National organisers of JSA who are as follows:
National Convenor: B. Ekbal
Joint National Convenors:

Abhay Shukla
Amit Sen Gupta
Amitava Guha
Thelma Narayan
T. Sundararaman

SATHI-CEHAT is hosting the **JSA National Secretariat** at present, though it is a collective responsibility shared with other National Secretariat members. These National Secretariat members presently consist of N.B. Sarojini from SAMA, a resource group working on Women's Health, and Vandana Prasad, a senior volunteer physician, both of whom are based in Delhi.

The JSA National Secretariat is currently being hosted by SATHI-CEHAT, Pune. The collective responsibility of the Secretariat however, is shared by N.B. Sarojini of SAMA team and Vandana Prasad, a senior volunteer physician, based in Delhi. SAMA is a resource group working on Women's Health, and the SAMA team handles the Delhi-based work of the National Secretariat.

What are the key themes of the JSA?

JSA aims to not only achieve a broad based involvement of voluntary organizations and peoples movements, but also to achieve considerable synergy and sharing of ideas, technical, financial and human resources. The goal is to reach a critical mass level, needed to influence health policy in favour of the poor and organise those most affected by the trends of current policies. One major effort in such sharing was the manner in which the five JSA health booklets were produced as a joint venture – both editorially and as a publication.

The over-arching concern of the Jan Swasthya Abhiyan is to secure an adequate quality of health and health care for every Indian. The Jan Swasthya Abhiyan has

within its wide range of members a large number of resource persons and activities in a number of thematic areas, for example:

- Policy level interventions for Right to Health and Health Care
- Primary Health Care and health systems that can provide access to health care services for the poor and marginalised
- Community Health Worker Programmes and Community Based Monitoring of Health services
- Women's Health issues and Reproductive health rights
- Child health and Malnutrition
- Right to Food and investigation of hunger related deaths
- Violence & Women's Health
- Sex determination and sex selective abortions
- WTO, Intellectual property rights, patents and Drug policy
- Medical Professional Reform and Regulation of medical practice
- Privatisation of health services and the commercialisation of health care
- Health care in conflict situations
- Indigenous Medicine and Folk healing traditions
- Rational Drugs and Diagnostics
- Drinking Water, Sanitation, Environment & Health
- Health among Displaced people, Adivasis and other marginalized sections
- Population control programme and issues of Contraceptive choice
- Trends in Medical and Vaccine Research
- Control of Communicable Diseases
- Mental Health issues
- Human Resource Development for Health Care
- Tobacco Control for better health

This set of themes and activities continues to grow.

What strategies/techniques does JSA adopt in its campaign?

To be effective in policy interventions the Jan Swasthya Abhiyan member-organisations deploy different strategies depending on their own strengths and preferences. These include:

- Public information and education on health issues largely through publications, meetings and other events, press conferences and media information.
- Social mobilisation and protest actions by means of health enquiries, public hearings, health dialogues, seminars and cultural events
- Representation to decision makers on policy concerns, grievances and gaps in health services, while seeking increased representation for communities in local health related decision making .
- Health surveys and studies to understand and highlight health issues concerning the people

- Organisation of people through community health programmes, to help the poor cope with the burden of disease, gain better access to public health services and monitor health services

JSA seeks to promote synergy of its constituents not only at national and state levels but also at district and local levels.

What are the activities the JSA has undertaken so far?

Below is outlined a brief overview of the major nationally coordinated initiatives by Jan Swasthya Abhiyan since its inception after the National Health Assembly 2000. ***In addition to the activities mentioned here, state JSA networks have organized a large number of activities and programmes.***

- The JSA developed a **critique of National Health Policy 2002,** which was widely circulated and served to educate all the JSA member organisations on this development, and has been published in booklet form. A series of seminars and press releases explained this position to the general public. This detailed critique with alternative proposals was submitted to Health Ministry. The **National Policy on Pharmaceuticals** too was discussed when it was in the draft stage and a JSA critique was evolved which was widely shared.

- **Campaign against the practice of sex selective abortions.** In the context of the Public Interest Litigation regarding PNDT (Prenatal Diagnostics Techniques, prevention of misuse Act, 1994) and Sex selective abortions filed in Supreme Court, JSA organised a National Policy dialogue on this issue in April 2001. Some states subsequently took up actions related to constitution of appropriate authorities, registration of Ultrasound centres, ban on advertisements, displaying posters in clinics and the issue of son preference.

- **World Health Day on April 7th 2002 was observed as 'Health Rights Day', with various JSA constituents in different states, by raising the issue of health rights and emphasizing the recognition** of health rights as human rights.

- **JSA associated organisations had a major involvement in the Right to Food campaign in several states.** In the context of a Public Interest Litigation filed by PUCL Rajasthan in the Supreme Court and an emerging campaign, the Bharat Gyan Vigyan Samiti (BGVS) initiated action on Mid-day meal schemes in February 2002. Subsequently, in several states, surveys were conducted by JSA constituents on the status of mid-day meal and other schemes. **In some states, a convention on 'Right to food – Right to health' was organised on April 7th 2002.**
  - During the Asian Social Forum at Hyderabad in January 2003, Jan Swasthya Abhiyan constituent organisations conducted **several workshops / seminars on key health issues**, with facilitation by JSA.
  - A **JSA 'Hunger Watch' group** consisting of public health and nutrition experts was formed in 2003, which has prepared a draft protocol to investigate cases of Hunger-related or starvation deaths. This group conducted a national workshop for activists on the method

of investigating and addressing hunger related deaths, in August 2003 at Bhopal.

- In January 2004, an **International Health Forum (IHF)** was organised by the global People's Health Movement and locally hosted by Jan Swasthya Abhiyan in Mumbai. Over 600 health experts and activists from nearly 50 countries attended this two-day forum, organised in continuity with the **World Social Forum**, which was also in Mumbai in January 2004. JSA participated in the World Social Forum as a coalition.

- On 12th March 2004 the JSA **organized a public dialogue on Health issues with representatives of various political parties**. Around 300 people attended the public dialogue including members from different political parties and the media, both print and electronic. JSA representatives initially presented a specially prepared policy brief, which outlined the current health scenario and called for specific political initiatives in health care - most important of which was making health a fundamental right and increasing the budgetary allocation for public health. The politicians then shared their perceptions related to health care with a panel of social, legal, economic and health care experts.

➢ **A Peoples tribunal on population policies** was held at Delhi, organized by Human Rights Law Network, Health Watch –UP, Bihar, Jan Swasthya Abhiyan and Sama – Resource Group for Women & Health. Nearly 70 women from 15 states such as Uttar Pradesh, Rajasthan, Himachal Pradesh, Madhya Pradesh, Haryana, Tamil Nadu, Gujarat and Bihar assembled in Delhi to depose before a Public Tribunal comprising leading personalities and activists. On the pretext of promoting small family, as many as 4,000 men and women from the states of Rajasthan, Madhya Pradesh, Chhattisgarh and Haryana have been disqualified from various Panchayat positions on the grounds of infringement of the two-child norm. Nearly 120 men and women affected by the coercive policies from 14 states deposed before the panel and expressed the anger, severe pain and humiliation that they experienced in the process.

➢ **Drug policy seminar:** JSA with the help of its constituent network organizations focusing on the pharmaceutical policy (Federation of Medical Representatives' Association of India - FMRAI, All India Drug Action Network - AIDAN) and the National Campaign Committee for Drug Policy-NCCDP together organised a National Seminar on 16th – 17th April 2005 in Kolkata on 'Pharmaceutical Policy in India and Access to Essential Drugs.' Over one hundred delegates from different parts of the country participated in this seminar in which renowned experts presented papers on major issues in pharmaceutical policy. A four-page resolution (Kolkata Declaration) outlining various policy measures for a Rational Drug Policy in the context of globalization was adopted. A signature campaign in support if this resolution is being planned.

The Right to health care campaign

- JSA organized a National workshop and National public consultation on the 'Right to health care' on the 5th and 6th of September 2003 (25th anniversary of the Alma Ata 'Health for All' declaration) in Mumbai. This two-day programme has constituted the **launching point of JSA's 'Right to Health Care' campaign**. The public consultation, which was in the nature of a public hearing, was conducted in the presence of **Justice Anand, Chairperson of the National Human Rights Commission (NHRC)**. It was attended by over 250 delegates from 16 Indian states, representing 85 different organisations dedicated to health and rights based movements including rights for women, children, people affected by HIV, displaced people, people living in areas of conflict, as well as a number of academicians, health policy analysts, social and health activists and other interested citizens.

As a part of the process of establishing Health rights, a series of **Regional public hearings on Right to Health Care were organised by National Human Rights Commission (NHRC)** in collaboration with JSA in various parts of country. The Regional public hearing on health rights for the Western region of country was organised at Bhopal in July 2004, followed by the Southern region public hearing at Chennai in August 2004, the Northern region public hearing at Lucknow in September 2004, the Eastern region public hearing at Ranchi in October 2004 and the North-eastern region hearing in Guwahati in November 2004. These major regional hearings, each attended by hundreds of delegates and with presentation of dozens of cases of denial of health care, were followed by a culminating event, the **National public hearing on Right to Health Care organised by JSA and NHRC on 16-17 December 2004 at New Delhi.** Subsequently a National action plan was released by the NHRC with inputs from JSA, towards operationalising the right to health care within the Indian context.

People's Rural Health Watch

The National Rural Health Mission of the Government of India has been launched on 12th April 2005. Based on the available documents concerning the Mission, there are a large number of concerns regarding the conceptualisation, design and implementation of this Mission. In this context, JSA has started an ongoing activity to monitor and influence the Mission in a pro-people direction, in the form of a **'People's Rural Health Watch'**. A National level consultation was organised by JSA in May 2005, to plan the broad outline of this Watch. Besides monitoring the actual implementation at state level, available documents regarding NRHM including task group recommendations, funding sources and financial allocations etc. will be analysed, and an NRHM Action Alert is being compiled. This would put forth JSA's position on the NRHM, and guide local groups and organisations on how they could possibly engage with and monitor the implementation of the NRHM.

What are some of the interventions planned for the future?

1. The Public Hearings on Right to Health Care have opened up new dimensions of work for JSA. The state units of JSA have demanded implementation of the

NHRC 'National Action Plan' on Right to Health care on the occasion of World Health Day 2005, and will continue to follow up this issue. At the national level it would be important to plan a campaign that puts pressure on the Government to implement the NHRC Action Plan, including putting in place a comprehensive legislation that guarantees the "Right to Health Care". JSA would participate in Review meetings to be organised by the NHRC, where dialogue would be held with State health departments, regarding concrete steps to be taken for implementation of the National Action Plan.

1. The JSA is also planning a major national level health event in 2006, on the lines of National Health Assembly that was organised in Kolkata in 2000. This national event would see the participation of a few thousand delegates from across the country and would focus on publicizing the key issues that the JSA has raised in recent years, while putting public health and health rights on the national agenda. This would also include a national level dialogue with political decision makers and parliamentarians, to push for adoption of policy and legal measures which would promote the Right to health care as a fundamental right.

1. The 'People's Rural Health Watch' team of JSA linked organisations based in Delhi will co-ordinate the activities of the Watch in collaboration with relevant JSA state units. JSA constituents would also involve themselves in initiatives for community monitoring of health services.

How can your organisation contribute to JSA?

Following are a few suggestions on how you can get involved with the Jan Swasthya Abhiyan and the issues it supports:-

- Join hands with your local JSA network to build pressure on the government for implementation of the National Action Plan of the NHRC as well as the state action plans.
- Get involved with the Right to Health Care Campaign by documenting cases of denial of health care. These can be utilised to reiterate the need for implementation of the Action plan, if required.
- Try to access documents related to the Rural Health Mission of the Government of India and see what role you can play locally in the proposed 'People's Rural Health Watch' of the JSA.
- Right to food campaign – Get involved in the campaign activities in your area.
- Organise a small exhibition on the action points of the People's Charter for Health as well as the NHRC National Action Plan.
- Write articles in the newspaper or in magazines, journals or your local newsletter on the need for a strengthened Public health system in light of actual cases of denial of health care, the NHRC National Action Plan and on other JSA themes.
- Participate in JSA activities towards a rational drug policy, opposing coercive population policy and other emerging issues.
- Volunteer your services to translate all the relevant documents regarding the health rights campaign in your local language and distribute them to organisations, and individuals.
- Do keep us informed about any efforts you take locally, as these can be incorporated in the consolidated JSA campaigns and may also be replicated elsewhere.

The following publications of the JSA may help you start :-

1. Indian Peoples Health Charter.
2. International People's Charter for Health
3. The Mumbai Declaration by the International Health Forum.
4. Health For All Now: The Peoples Health Resource Book.
5. Report of National workshop and National public consultation on the 'Right to health care'
6. Handbook on documentation for Denial of Right to Health Care.
7. Policy Brief published prior to the Lok Sabha Elections in 2004.
8. Reports of the Regional and National Public Hearings.
9. NHRC National and State Action Plan.

How to contact JSA?

Please contact the joint convenor of the JSA network in your region, the National secretariat currently being hosted at SATHI-CEHAT or the national convenor. These addresses are given at the end of the brochure. To contact the state member organisations of the JSA or the state JSA coordinator in your state, you may contact one of the JSA joint convenors from your region, as per the list mentioned at the end of the brochure.

B. Ekbal *National Convenor* Kuzhuvalil House, Arpookari (East) Kottayam - 686008 Phone:0481-2598305 e-mail: ekbal@vsnl.com	**Abhay Shukla** ***Convenor, National Secretariat*** SATHI-CEHAT **Flat No. 3 & 4, Plot No. 140** Aman Terrace-E, Dahanukar Colony, Kothrud, Pune - 411029 Phone:020-25451413, 25452325 e-mail: cehatpun@vsnl.com	**Amit Sen Gupta** *Jt. National Convenor, JSA* Delhi Science Forum;D-158, Lower Ground Floor, J Block, Saket, New Delhi-110017 Phone:011-26524324, 26862716 e-mail: ctddsf@vsnl.com
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To know more about the international peoples health movement log on to www.phmovement.org

Yet another way of getting in touch with the JSA network is to visit its website – which has a compendium of information about JSA, a regular update of activities, a notification of future events and the contact addresses: The website ID is www.phm-india.org

Annexure 5.2

The Rights Based Framework – Which Way To Go?

Anant Phadke

As a preparation for the discussion on 'right to health care' in the forthcoming MFC meet, in this note I would attempt three things –

II. To put the rights based framework in a larger, historical context so that there is more clarity on the meaning of the issue of rights and human rights

II. To argue that limiting ourselves purely in the rights based framework, without analysing the political economy of health and health-care would not take us forward.

II. To locate the need and importance of a detailed discussion on right to health care in the health-care movement in India.

Needs and rights

Let us begin with a simple, elementary question: why do we talk in terms of rights and not in terms of needs? Food, water, health-care, education etc. are human needs in the modern world. There are enough resources in the world to meet these basic needs of everyone. But this does not happen because there are -

- huge wastages on preparations for wars, nuclear or otherwise;
- massive inefficiency in use of resources (for example use of individualised transport instead of mass transport);
- mind-boggling creation of false needs like unnecessary medical interventions;

All this is basically a product of profit mongering and power mongering capitalist system. Add to this, the greatest ever inequality in human history fuelled by the shameless greed of a few in the new phase of globalization and complete sway of speculative finance capital. All this together makes it impossible to fulfill even the basic needs of the vast-majority of the people inhabiting this unique globe. ***Therefore, unless human needs are couched in the form of rights, these cannot be fulfilled in our today's society and there is a necessity to talk in terms of basic human rights, the fulfillment of which has to be ensured by the state. This conversion of basic human needs into rights is not exactly a very desirable thing. Our ultimate goal should be to build a society wherein basic human needs are fulfilled without involving the language of rights.***

Unlike animals, human needs change and expand. There is nothing like human rights, which are valid for all times. The content of human needs and of human rights would develop as society develops. For example, the content of 'Right to education' would change as society develops.

Professional Rights and Human Rights

Today's society is divided into various social groups whose interests are opposed to each other- employers versus employees; landlords' versus servants; people being benefited by developmental project versus those displaced by it or suffering from it; men versus women, one caste – group versus other etc. etc. Each

of these social groups is competing with the other to gain more wealth and prestige. Since resources are limited and especially in view of huge wastages, inefficiencies, false needs mentioned above, they cannot suffice to meet all these competing needs, the specific interests and needs of each of these groups have to be protected from others by converting these needs into rights. In situations where interests of different groups are not opposed to each other, there is no need to involve the discourse on rights. Thus generally we do not talk about rights of mothers versus those of their infants. While rights of members of one foot ball teams are guarded against those of the rival team members by the match referee, there is no question of any rights of any team member within the team being pitted against those of others. The point being made here is that ***the discourse of rights in today's society is premised on opposed social groups and their interests.***

Human rights belong to a different category of rights. Out interest, needs as human beings, and not as members of a particular class with particular interests also need to be protected from violations from the society in general. If I am old man, my interests, needs arise not out of belonging to any professional group but arise out of my being an old person. Similar is the case of not only groups like infants, pregnant mothers who have special needs but is also of many of our needs as human beings and not as part of a professional class. However, ***in today's society human interests take the form of interests of a professional class or are intrinsically bound by it.*** For example, my interest as tenant-farmer lies in reducing the rent. I have to pay my landlord and the fulfillment of my human interests as an old man partly depends on the protection of my interests as tenant farmer. If the latter are violated, the former gets threatened. But nevertheless theses two have different trajectories of development. My interests as tenant farmer are bound up with the existence of tenant-land lord relationship. With the dissolution of this relationship my interests as tenant – farmer will also disappear whereas, my human interests as an old man would continue in any society.

Our long-term aim should be to build a society not based on antagonistic or opposed professional interests but based on harmonious co-operative interests. In such a society, particular ***class interests*** and rights will gradually wither away. There will not be a need for a powerful class state to ensure that the rules of competition between opposed professional classes are observed. However, there will be some contradiction between human interests of individuals and those of the society as a whole. This is because ***the earlier Marxian vision of withering away of scarcity with the unfettered development of productive forces no more seems to be realistic; energy and other natural resources no longer seem to be limitless.*** Hence some amount of limited scarcity would continue, so also the need to ration resources. Even though complete plenty and hence a good bye to the rationing of resources will never be achieved, if exploitation, inequality, ecological-socially destructive use of resources is overcome, modern productive powers can reach a stage when there is less and less need to encroach on somebody else's needs in order to fulfil my needs.

To decide how much resources individuals would be entitled to from the common societal pool would require the presence of a state power to ration the resources. ***The rights framework and the state will be required to ensure the fulfilment of human needs of all.*** This state would not guard the interests of any

particular class or social layer. It would not be a state in the classical sense of the word but will balance the human rights of individuals with those of the society as a whole. The point is - the rights framework would be needed even after the withering away of class interests.

II. Political economy and human rights

Protection of ***civil and political rights*** is in a sense one of the fundamental principles of the capitalist society. If the market is to function properly, each buyer or seller in the market has to be political independent and free. This political equality is no obstacle to the inequality generated by the logic of the market i.e. the logic of the purchase and sale of different commodities, including the sale of human labor power. Hence political equality has been guaranteed by constitution in all capitalist countries. A fair degree of observance of civil and political rights in advance countries has been quite compatible with great socio-economic inequalities in these countries. However, people's organizations/human rights organizations have to be vigilant and fight for consistent observance of civil and political equality. This is because, though the rulers as a whole have agreed to recognize political rights, some times individual money bags, blinded by short-term interests and profits, tend to violate these rights. The altitude of the rulers towards political rights is thus inconsistent, whereas that of the people's organizations, civil rights groups is of consistently upholding of these rights. The US government raises the issue of violation of political rights when it suits its interests, whereas for us, its a matter of basic principle.

As regards the ***socio-economic rights,*** the position of the rulers is much more inconsistent. Here, it is more of paying lip service to these rights. The rulers are wedded to the interests of propertied people and not to the interests of the vast majority of the laboring population. Hence they cannot afford to guarantee the socio-economic rights of the people - right to livelihood, water, health-care, etc. But there are different sections within the rulers. If health-care becomes very costly and thereby leads to the demand for higher wages, many employers would like health-care to become a right to be fulfilled through public funds so that the their wage-bill would not rise an account of spiraling health care costs. They may thus support the demand for health-care as a right. But overall, taken together, the rulers are not in favor of granting socio-economic rights, whatever may be the international declarations. ***Unlike the civil-political rights, granting the socio-economic rights is not compatible with the existing social order, at least in the developing countries.*** When we talk of fulfilment of socio-economic rights, we have to keep this is mind.

Since some leading United Nation's organizations talk about economic, social rights also, we can use these declarations to put pressure on our governments, and we can make some progress in harnessing some of these rights. But we have to be clear that demand for complete fulfilment of all the socio-economic rights is actually a revolutionary demand. Just appealing the rulers or merely demanding from them the socio-economic rights is not going to make any substantial progress in achieving these rights. Neither is it adequate to keep merely monitoring the violations of these rights. We have to find out concretely, who would be opposed to our concrete demands like right to food, right to essential drugs and to health-

care, etc. We will have to strategise how to overcome this opposition; to what extent the existing state can ensure fulfilment of which demand and why. ***If we keep away from the political economy of socio-economic rights, we would be merely indulging into a sterile repetition of nicely worded international declarations or making a list of various rights or would be kept busy with mere monitoring of their violations.*** We also need to go into the ***political economy*** of the concerned issue and reveal the forces, which would be in favor of or would be opposed to this demand, put forward an ***alternative policy*** of how things can be done differently if balance of power is changed. For example, in health care, we have to point out what are the socio-political obstacles in achieving the right to health care and how to struggle against these forces. This point brings us to the third, last issue of my note- the need and importance of a detailed discussion on the right to health care in the ongoing health movement in India.

III. What is our alternative?

The new challenging situation

I would argue that today we are in a challenging, somewhat fluid socio-political situation and we have to make efforts to shape the changes in health-care policies. The rulers are restructuring the world. The post-war strategy of state capitalism or welfarism in which the state played a leading role in the economy, in which the provision of basic social services was considered the responsibility of the state, is now being abandoned. In India, the Nehruvian path of development is being left behind. Thanks to the Nehruvian model of state capitalism in India, there was a relatively very rapid development after independence. But this development has unleashed new problems, which cannot be solved by merely continuing the Nehruvian policies. The economy needs restructuring.

The rulers are trying to restructure the economy with their trinity formula of Globalisation, Liberalisation, Privatisation (GLP), which suits the rulers but spells disaster for the ordinary people. We need to formulate and press for an alternative strategy of restructuring in opposition to the GLP strategy. In the field of health–care it is not adequate to oppose the various elements of 'GLP in health care' in a piecemeal manner. Nor can we demand going back to the Nehruvian era. ***Our opposition should be based on an alternative plan for restructuring*** of the health care system in India. 'Right to health care' can be the rallying slogan, theme of this alternative framework. Thus the direct, indirect privatisation of public health services should be opposed on the basis of an alternative framework of Universal Health Insurance of which a very much reformed, efficient, accountable, expanded public health services would be a part. Our alternative policy could be 'reform the public sector and regulate the private sector.' (Instead of giving a call of 'Save the Public sector' it will be more appropriate to give a call – "reform and expand the public sector; regulate the private sector".) In our plan for reforming the public health services, by way of example, on the issue of accessibility of Primary Health Care we can argue for -

- a much more important role for Community Health Workers and their much better integration into the public health services;
- much more accountability of the health services to the community and to the patients;
- a more rational use of the PHC staff by introducing multi-tasking wherever possible.

The point is, the current system is obsolete, the rulers are restructuring it with their GLP strategy and our opposition to it has to be based on an alternative policy, which goes beyond the Nehruvian model of development. Whether one is part of the system or want to reform it or revolutionise it, today, one needs to go into the debates about strategic, policy issues. MFC offers a broad platform for such debates.

The MFC debates

In the earlier MFC – annual meets, we have discussed in some detail various policy-issues ranging from medical education to drug policy to women's health. The People's Health Charter of the Jan Swasthya Abhiyan, of which MFC is a part, summarises our alternative on 20 crucial aspects of a comprehensive alternative policy. Amongst us there can be differences of opinion about some of these measures in this 'twenty point programme'. But this Charter is an indication that the Right to Health Care movement in India has not confined to a conventional 'rights based approach' but has also involved itself in formulating alternative policies and has time and again pointed out specific changes in the current policies. We have thus not confined ourselves to merely making a list of various health-rights of the people, but have argued for concrete policy-measures needed to make health-care accessible to all. Now what needs to be done is to show concretely that India has the resources to implement the various policy measures we have been arguing for. This is necessary because officials, politicians say that they agree with the measures we have been suggesting but say that "However, the state does not have the resources." We need to work out at least to a certain extant, how much funds would be required to institute the measures we are suggesting and how the state can raise the resources to meet these funding requirements. This is ***necessary to delegitimise the existing system and to move from a purely oppositional to a hegemonistic politics.*** People will come forward to fight for these rights and there will be broader support to such struggles if we are able to show that Indian economy has the resources, but the existing rulers are not ready to harness these resources as this would involve harming the interests of those sections to which they are wedded.

I hope that the MFC meet would recognize the need to overcome the "there is no alternative" (TINA) syndrome. Let us realise that policy-measures that we discussed in earlier meets have acquired new significance as we have entered the era of restructuring of the economy and society. In this new context let us revisit various policy measures we had debated. Let us decide, how as part of the JSA, in this new situation we can contribute to pushing forward measures which we had formulated earlier. MFC provides an open space for detailed discussions on the content of various policy measures. Let us use this space more productively in the new situation. The election results during the last few months have shown that people are expecting an improvement in their daily lines. Emotional issues have been pushed back. The rulers are under pressure to show results. In this fluid situation, policy – level interventions are likely to be much more productive than hitherto. Now is the more opportune time to put pressure on the system, to expose it. But we need to raise the quality and quantity of our efforts in this direction. Can MFC do this?

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ANNEXURE 5.3

ANNEXURE 5.3

JSA CAMPAIGN MATERIAL FOR NHA II

FEB.25-26, 2006

'DEFENDING' PEOPLE'S HEALTH IN THE ERA OF GLOBALISATION

Threats and assaults to people's health

Corporate-led Globalisation is injurious to health- Amit, Mohan

- **What do we mean by globalisation?**
- **Imperialist / hegemonic globalisation**
- **IMF, W Bank, WTO (wrt health)**
- **Multinational corporations (wrt health)**
- **Neo liberal Macro economic policies (CMH critique)**
- **World Bank projects and prescriptions**
- **International donor agencies and institutions; impact of vertical programmes, consultancy organisations**
- **Privatisation and PPPs (PHM critique)**
- **WTO, Patents, GATS**
- **Medical tourism**
- **Changing role of UN agencies**
- **Migration of H professionals, brain drain**
- **Impact of LPG on key health determinants incl. food security, water, livelihood**

Defend the Right to health for various sections of the people

- **A) Women's Health – separate booklet (incl. population, women workers,) – Sarojini, Mira, Veena**
- **B) Children's Health – separate booklet - Vandana**
- Workers Health (agri, non-agri,…)
- Health for persons with mental health problems - **Naidu**
- Health in context of HIV-AIDS – **Sunil**
- Health for Dalit communities - **Premdas**
- Health for Adivasi communities –
- Health for displaced communities – **Sr. Prabha**
- Health for urban poor - **Chander**
- People with disabilities - **Naidu**
- Elderly people **- Mira**
- Sexuality minorities – **Sama**

Promote the determinants of the RTH!
Amit

- **Food security and nutrition (PDS, rural impoverishment & agriculture, droughts, commercial farming)**

(Veena + Vandana; consult Madhura, Sainath, Mohan)

- **Environment and technology (DSF, CHC/CHESS)**
- **Water and other public utilities (roads, power, education) (DSF)**
- **Livelihood, employment conditions and displacement**
- **Social exclusion (Sarojini, Premdas)**
- **Conflict and militarisation** (Jaya Velankar, Renu)
- Culture of consumerism; tobacco, alcohol etc. (Ekbal)

Reflecting on JSA campaigns

Preparation of the history of JSA in the last 5 years, the key campaigns and the issues that were addressed – by CHC

In the end....

is the

the new beginning!