CONSTITUTION OF INDIA

Preamble

WE THE PEOPLE OF INDIA, having
solemnly resolved to constitute India into a
Sovereign Socialist Secular Democratic Republic
and to secure to all its citizens
JUSTICE
Social, economic and political:
LIBERTY
of thought, expression, brief, faith and worship
EQUALITY
of status and of opportunity; and to
promote among them all
FRATERNITY
assuring the dignity of the individual and
the unit and integrity of the Nation

IN OUR CONSTITUENT ASSEMBLY
this twenty-sixth day of November, 1949, do
HEREBY ADOPT, ENACT AND GIVE TO
OURSelves THUS CONSTITUTIO
Some Readings on CAA/NRC and health

1. India’s medical community rallies to help protestors injured in police violence
   Anoo Bhuyan
   BMJ 2020;368:m203 doi: 10.1136/bmj.m203 (Published 17 January 2020)

2. Indian health care caught up in violence
   https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930097-0

3. Protests in India: doctors condemn police violence and restrictions on hospital access
   https://www.bmj.com/content/368/bmj.m13

4. Statement, 23 December 2019 Re: CAA Protests, Medical Ethics And The Right To Medical Assistance

5. STATEMENT By Health Networks, Health Activists, Health Professionals, Women’s Rights Activists and Concerned Individuals against Indiscriminate Use of Force At Jamia Milia Islamia University and Aligarh Muslim University (AMU)

6. UNAFRAID The Day Young Women Took the Battle to the Streets- Women’s Testimonies from Ground Zero at Jamia Millia Islamia University
   https://counterviewfiles.files.wordpress.com/2019/12/unafraid_thedayyoungwomentookbattletostreets.pdf

7. How the police prevented medical volunteers from working at the CAA protests
   https://caravanmagazine.in/politics/how-the-police-prevented-medical-volunteers-from-working-at-the-CAA-protests

8. Delay of Medical Care to the Injured by Police Is Unconstitutional
   https://thewire.in/rights/protesters-medical-care-police

9. Report on NHRC Mission to Assam’s Detention Centres from 22 to 24 January, 2018

10. Health professionals must call out the detrimental impact on health of India’s new citizenship laws
    January 14, 2020

11. Reports of students visiting Delhi (from MFC e-group)

General Readings on CAA and NRC

1. The NRC is a bureaucratic paper-monster that will devour and divide India
   https://scroll.in/article/948969/the-nrc-is-a-bureaucratic-paper-monster-that-will-devour-and-divide-india

2. NPR, NRC: 2 sides of the same coin

3. Dr BR Ambedkar, Not Nehru, Gave Us the Preamble to Constitution
   https://www.thequint.com/lifestyle/books/bhim-rao-ambedkar-nehu-constitution-preamble

4. Why the National Population Register is more dangerous than the Assam NRC
   https://scroll.in/article/949097/why-the-national-population-register-is-more-dangerous-than-the-assam-nrc

5. CAA & NRC III: Who are ‘doubtful’ citizens NPR seeks to identify?

6. Risks of digitalisation with NPR

7. State Of Affairs In UP Shows Complete Collapse Of Rule Of Law: People’s Tribunal
   https://www.livelaw.in/news-updates/peoples-tribunal-on-state-action-in-up-was-conducted-in-delhi-151784

Issues for discussion

1. The doctor’s oath to treat all equally as a fundamental professional commitment to an important Constitutional dimension of equality and non-discrimination, i.e., the dimension of the right to health.

2. The importance of the Preamble in posing the issue of justice, equality, liberty and dignity as fundamental. How all these are the markers of well being and primary psychic health -- leading directly to physical health.

3. How is citizenship linked to health and well-being? Does statelessness lead to ill-health, psychological distress and lack of access to health and healthcare?

4. The experience of NRC and of the detention centers in Assam and its health impacts?

5. What are the potential impacts of NPR/NRC along with CAA on health?

6. What is MFC position?
   • CAA, NPR and NRC
   • Rights of person who has been subjected to police violence to access health care
   • The issue of providing medical care of protestors.
Dilemmas of Young Health Professionals

- Shrinidhi, Mohammed Khader Meeran, Savithri

Why?

The last few years of MFC Meet have witnessed a rising trend of attendance of younger members. We saw a lot of inquisitive faces and minds eager to know people who have devoted their lives to working for those in need. Some of the youth were already working to create an impact while many others were still completing their college life. We also were a part of it, and from what we could see, we were welcomed by the MFC members. So much so that, we never felt we were ever away from it! It was a pleasure to see a group, members of which are doing incredible work but still grounded to their roots. It will not be wrong to say that somewhere this very background has culminated in the selection of the current theme of MFC. In the Annual meet that took place last year at Sewagram, young members spent considerable time talking with the senior members, asking them questions about their own lives and also seeking answers to their personal and professional questions. It was then that the AGM came up with the idea that these dilemmas per se be a topic for the next Annual Meet.

Dilemmas of Young Health Professionals

The situation that the youth are currently in is not promising. ‘Healthcare’ has become a market-driven commodity over the years. The impact of the healthcare industrial complex could be made out by a statement made by Dr Devi Shetty (founder of Narayana Health) that the global healthcare and wellness industry is going to drive the world’s economy of the 21st century and India’s healthcare industry will grow phenomenally. [1] This statement itself is an indicator of how healthcare is viewed as a medium of growth of an ‘industry’ by even doctors! If we are to look at medical education alone, by design or by accident or by plan, private medical colleges in India are mushrooming. The number of private medical colleges in the country has exceeded the total number of government medical colleges last year [2] (245 government medical colleges and 254 private medical colleges). More than 100 private medical colleges were started within the last decade. Among 313 dental colleges, only a meagre 49 colleges are run by the government. This means, every year more than half of the medical professionals are coming to the field of practice from the profit-driven private medical education sector.

In healthcare delivery, the private sector provides 80% of outpatient services and 60% of inpatient services. [3] Over the years, the relationship between a doctor and patient has transformed into a ‘consumer-good approach’ where s/he sees the patient as a subject through which s/he can make profits. As a result, private healthcare is expanding over the years. A market strategy is devised by the corporates in which medical practitioners are made to feel insecure about their employment and quality of life. By making them prescribe unnecessary medications and procedures, they make the young doctor earn a little bit more and in turn help make a greater profit for the corporation. Regarding updates and recent advancements in medical practice, practitioners get information only through CMEs. CMEs are yet another profit-making operation organised by private pharma companies to train the doctors to write their products by labelling them as superior to existing medicines. Every health professional – not just doctors – face similar dilemmas.

The State’s Encouragement of the Private Sector

If one believes that health is a fundamental right and the state is accountable to provide its citizens with equitable, affordable and quality healthcare, the recent proposals by NITI Aayog are alarming. Based on models operational in Karnataka and Gujarat and so-called international best practices, a ‘concession agreement’ has been made to link private medical colleges and district hospitals by PPP. This is supposed to address the problems of both medical education as well shortage of doctors simultaneously! It raises the doubt as to whether NITI Aayog is still an independent body or is it hijacking the work of the Department of Disinvestment and Public Asset Management! On the one hand, the increasing drive towards privatisation poses multiple dilemmas in front of doctors about the public healthcare sector.

On the other hand, the changing political environment along with arbitrary undemocratic decisions such as withdrawal of special status to Jammu and Kashmir and the effects on the health status of the population of Kashmir has made it impossible for the medical fraternity to remain silent. Numerous reports have emerged regarding the difficulties in access to healthcare facilities, availability of medications, mental health conditions of people under chronic stress, injuries during incited violence during protests and related health issues.

Another distressing trend that has come up is polarisation within the medical community and this is becoming the basis for which doctor treats who! This is particularly evident in the treatment of protestors as reported by a few young MFC members who visited the protestors in Delhi.

It is noteworthy that even amidst such evident crises due to the changing political scenario, voluntary
medical associations, bar a few, have remained largely silent on these issues.

Organizational Context within which Young Professionals find themselves

In this setting, it is but obvious that a health professional who wants to do what his/her profession was originally meant to do, that is work for the health of the people, faces multiple dilemmas. Over the years, values among health professionals have changed as a reflection of changing societal values. Gone are the days, when a doctor with altruistic tendencies was the norm. Today, patient-centric behaviour, as we now call them, are seen as desirable but not mandatory. Among other factors, students often experience a dearth of role models who can inspire them to go beyond one’s immediate circumstances and work for the larger good. In this context, MFC can play a major role in filling this felt gap. Hence, many senior MFC members agreed that dilemmas in front of such a rare group of students must be discussed, if MFC has to act as a support group for them.

Planning the Annual Meet

When we sat together to reflect on how the theme must be presented in the Mid-Annual Meet, we decided that the experiential sharing of individual dilemmas can a good approach. Even though dilemmas were largely personal, still with some effort we could club different dilemmas under subheads and discuss them thereafter. The mid-annual meet (MAM) paper was again an example that collective knowledge can be used to generate something more complete.

Discussions during the MAM indicated that these dilemmas have their origins in the current socio-politico-economic scenario and there is a need to understand these dilemmas in this context.

The MAM began with a presentation of the background note. The questions raised by the different contributors of the paper along with the ones compiled after discussions in small groups were combined.

The questions put forth were pooled into 6 major categories:
1. Lack of social orientation in education
2. Financial issues
3. Personal dilemmas regarding partner and family
4. Medical education
5. Dilemmas about working in existing NGOs
6. Ethical issues

It was also agreed upon to look at each of these categories at 3 different levels: first, an understanding of the problem and its genesis in socio-political milieu; second, a sharing by the members about how they have tackled/dealt with the situation/problem. The experiences of the senior members can help us deal with the problem and find our solutions to it. And third, to explore ways how MFC as a group can contribute in some way to help and support the youth navigate the question.

The organising of the mid-annual meet was challenging in that we had to find a way to look at the diverse dilemmas of a personal nature presented by various health professionals without it becoming just an analytical discussion on human resources in health. The senior members of MFC helped us group these dilemmas and identify certain heads under which to discuss. Also, we wanted the members present at the MAM to share their dilemmas. For this, an informal discussion was also necessary. This ensured that more intense sharing happened and more points were shared. However discussions with the larger group were also important, and this led to some discussions being repeated and was overall time-consuming. But sharing in small groups improved the familiarity between members and this was along the lines of improving interaction among newer and older members of MFC. Also after the formal discussions, the informal interactions and sharing in the evening hours were enriching.

Drawing from the above experience, the OC (Organising Committee) discussed how the annual meet can be conducted effectively. Two important directions emerged from these discussions – one related to how the papers need to be written and two, how the discussions need to be taken forward in the annual meet.

Right at the beginning of these discussions, it had become apparent that a traditional approach of only writing papers and having objective discussions was not perhaps the best way to approach these dilemmas. Along with, experiential sharing of the members, informal discussions, understanding each other at a deeper level, also should be given more time to deal with the theme. Therefore the papers designed for the Annual Meet also tries to meet this objective of effectively discussing the topic and involving members in various fields of health. Also, it was apparent that the young people that had spilled out their dilemmas were hoping for a discussion regarding what could be done with regard to their dilemmas, even though it became clear that there were no ready-made solutions. The evening sessions of informal discussions seemed to further clarify our dilemmas and it became apparent that such informal discussions need to be given more time and importance, at least in the context of this particular topic.

Keeping this in mind, the current Annual Meet has been designed to give more time for informal interaction between the young members and the more experienced members in the MFC. The papers designed for the Annual Meet also are a reflection of
the needs of youth today. There has been an attempt to carry forward the discussion in MAM in the papers of the Annual Meet.

Individual Papers/Sessions

There is a paper on developments in the AYUSH sector where we attempt to present to the youth practicing AYUSH examples of low-cost, effective and ethical AYUSH practices in different areas of the country. This we believe can be a morale booster for the students who seem to appear lost in the vicious cycle of poor quality of education in AYUSH colleges, lack of role models and opportunities in the social sector. Also, it can be a good idea to discuss examples where integrated care is given to promote health holistically.

Another paper is on what are the support systems available to today’s young generation who are looking to work for the people in need but do not get proper orientation in the current educational system. A very popular youth initiative NIRMAN in Maharashtra is discussed. The NIRMAN initiative has been instrumental in motivating a huge number of young persons to work in the social sector in various capacities. Also discussed are the initiatives like the Rural Sensitization Program (RSP) held in Sittilingi. Support systems play an important role especially when it involves meeting role models in the field, and more importantly, its a place to meet several of like-minded young persons who like us are also in search of a place where they are listened to by seniors and others.

It was a collective view of the members that the problems and challenges being posed were from a small proportion of health professionals in the NGO sector. It was pointed out that there were a large number of young professionals working in the public and private sector that ideally MFC should be talking about and supporting. Keeping this in mind we have a paper on account of Tamil Nadu Medical Officers’ Association (TNMOA) which has acted as a support group for Government doctors in the state. Also, an account of Alliance for Doctors In Ethical Healthcare (ADEH) is taken as an example which is acting as a group of private practitioners who intend to practice rationally and ethically.

A very interesting paper is on people working in conflict zones such as Naxal areas, civil wars, terrorist infiltrated areas, etc. It could be a good study to see how these people have managed to sustain in these difficult zones.

The medical fraternity was rocked by the suicide of junior resident, Dr. Payal Tadvi, in Mumbai last year. Caste, class issues and ragging were all alleged to have traumatised the victim. This attracted the attention of activists across India. MFC along with other groups conducted a fact-finding study into the whole incident. The report is also to be discussed in the Annual Meet as it appears that we need to understand caste, class and ragging issues in colleges and that it can be a serious barrier to learning for the students.

MFC has never shied away from responding to the current problems that the country has faced. If we are to consider health as political, socio-economic and political changes in the environment always have a bearing on the health of the people. Two events have rocked the country and have shaken our understanding of what it is to be a citizen and health professional:

1. The health situation in Kashmir
2. Citizens Amendment Act, NPR, and NRC and related protests

It was felt that the discussions on the above events need a prominent feature in the Annual Meet of MFC. Also included in the Annual Meet is a compilation of life journeys of senior members of MFC who have been in the field of public health in different capacities and have been a source of inspiration. We as OC believe in learning and understanding their journeys and their dilemmas and paths, they choose to take that can help us to understand and find solutions to our dilemmas as well. Also, this exercise will give the much-needed informal and open atmosphere for such a discussion. We would like to extend a heartfelt thanks to all those members who have sent their journeys in the form of a writeup.

Medico Friend Circle (MFC) has been in existence since 1975 as a forum for discussion, debate, and friendships beyond ideologies. The discussions are based on various experiences encountered by individuals working at the ground level. The members try to understand the issue to the core and its implications on the larger level. However, being a friends’ group, friendships have always blossomed in the Meets, largely evident from numerous personal sharing between the members. The members have had incredible journeys in the field of public health as well as other aspects of improving human existence in spite of existing social injustices and inequalities. In this regard, MFC as a collective can be seen as a trove of wisdom and experience and a learning centre for young restless individuals who want to start their own story of contributing to the welfare of society. Therefore, it wouldn’t be all that unseemly to urge MFC to collectively take on a mentorship role for the younger crowd that is increasingly taking an interest. There is a paper outlining some suggestions in this direction and we hope a healthy discussion followed by concrete steps result.

We believe the discussions this year MFC will be richer and more refreshing: bringing out the dilemmas and discussing what can be done. We are all happy that the problems of the youth are receiving so much footage in a forum like MFC and hope that it leads to positive outcomes.

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Background

(Dhadak Mohim is a volunteering activity organized by the NGO Maitri based in Pune. Maitri has been working in the interior of Melghat region of Amravati in Maharashtra. Melghat is difficult to access and is mostly a tribal region. Maitri works mainly on MCH and malnutrition. It invites volunteers to the region for minimum one week and for work in designated village. That activity is known as Dhadak Mohim - Dhadak Mohim literally means ‘to hit’. In this context, to hit the problem of malnutrition in Melghat head on.)

In 1997, there were several news items in the media about the presence of malnutrition in the Melghat region of Maharashtra. A few volunteers from Pune organised themselves and went to see the exact situation. They came back and formed a network among them and started visiting Melghat each year during monsoon to decrease child mortality and malnutrition.

History

Since 1997, the volunteers from all over the country come and stay for a duration of 10 days each in Melghat and work in the field of health, education, and hygiene in the remote villages of the area. For 3 months of the monsoon, the volunteers come in batches for 10 days and handover the work to the next batch. So, since 1997, it is being conducted every monsoon to give the youth first-hand exposure of directly working with the people in the field.

Philosophy - Let no child die of malnutrition or by any other cause this monsoon.

Aims

Decrease child malnutrition and child deaths by giving health education, timely treatment, proper referral and general awareness about health.

Objectives

• Decrease child death.
• Decrease child Malnutrition.
• Health Education of the community.
• Reducing superstitious beliefs.
• Helping the community workers in disseminating health-related information.
• Ensuring proper health services to villagers.
• Providing necessary information about their rights.
• Provide a platform for volunteers for learning by doing various skills.
• Impact of initiative
• Reduced malnutrition at the time of camps for 3 months.
• Reduced child deaths during the time of 3 months.
• Health awareness among locals.
• Importance of hygiene
• Prompt referral to serious cases.
• Training of many volunteers in health, health education, social changes, behaviour changes and observing the other part of India.
• Exposure of local population and student to outsiders.
• Information to school children about health education and overall education.
• Help the local health system.
• Limitations
• No proper planning in terms of measurement of objectives, changes, and impact.
• The same villages are taken for years with no seen/measured impact.
• No participation of people in the undertaking of these camps. (Not felt need of people)
• No proper follow-up of students after the camps.
• Volunteer-based (students have to pay for their stay and also work)
• Few mentors or facilitators in the camp.
• Lacking focus on sensitisation among the students.

References:

1Email: priyadarshthure@gmail.com, pankaj23008@gmail.com, shobiashok@gmail.com
The medical curriculum has always been a topic of interest to debate. The environment of a medical college educates students in mainstream medical knowledge and practice in large tertiary care hospitals. However, there are widening disparities in health and poor access to health care particularly in the rural parts of our country. There is a mismatch between the settings where education takes place and where health work is much needed. The advent of corporate hospitals and an increase in the number of tertiary medical college hospitals has pulled the students far from the perspectives and realities of rural or primary and secondary levels of care. It is indeed disheartening to see young doctors being pushed into the rat race of post-graduation without being exposed to the real health scenario of India.

There have been many experiments across the country in the NGO sector providing health delivery systems that engage actively with the local context and are thus linked with efforts in related fields such as school education, food security, livelihood, housing, etc. Such an experiment is the work of Tribal Health Initiative (THI), Sittilingi, Dharmapuri District, Tamil Nadu.

The Inception

Tribal Health Initiative (THI) is an organisation, founded by Regi George and Lalitha Regi, that works for and with the Malayaali and Lambardi tribals in Sittilingi, Dharmapuri district of Tamil Nadu for more than 26 years. Though it started as a community maternal and child health program, THI has stepped into organic farming and craft initiatives to work on the determinants of health itself - food, migration, and livelihood.

The Rural Sensitization Program was conceived to expose the medical students to the real scenario of the community at the village level through an institution like Tribal Health Initiative. One of the camps happened in ASHWINI, Gudalur as well - which is a similar organization placed in the Nilgiris of South India working on social justice for tribals along with health and education.

Objectives

1. Introduction to rural health care and unique health care systems in rural areas.
2. To discuss the rural health issues and their possible holistic solutions through working models of primary care and community programs.
3. To understand the social realities of disease and treatment.
4. To introspect and reflect on the question, “What is my role and responsibility in the bigger picture of health and health care?”
5. To create a platform for friendships and generating contacts amongst like-minded, socially aware health professionals, for catalysing a larger movement in the future.

Day 1

Introduction - Understanding expectations.
Work of the institution (THI and ASHWINI) - Health, education, farming, and social justice. Visit to the hospital.

Day 2

Community - Village visits.
Student presentations of the community visits - Farmer, Artisan, Health worker, and Patients.
Discussions about the social, economic, political and cultural determinants of health.

Day 3

Health care status in the country.
To summarise the village the hospital visits - to emphasise on community oriented primary and secondary care in a rural context.
Exploring “My role” in the bigger picture of health.

Other Activities

Discussion about the dilemmas of students and their expectations from medical education. Interaction with young doctors working in rural primary or...
secondary care.

Relooking at the idea of education itself and visit to the alternate schools rooted in the community (Thulir and Vidyodaya).

A platform to establish connections to attain solidarity within the students from different medical colleges.

Inculcating the idea of mentorship and role models in a socially aware professional life.

Feedback

A few students/doctors who attended RSP gave a mix of responses of what RSP did to them after they left.

One of the most significant responses was, “RSP helped me reignite my passion for medicine itself”. Other positive responses includes - Trying to understand the social fabric behind every patient, the reassurance that many people are interested in socially aware work, joining local NGOs or strengthening students groups, the constant trigger within to think about the poor and marginalised. Few students even told they would strongly consider working in a rural area in the future.

Traveller Fellowship

The Travel Fellowship is an initiative by an informal collective of organizations committed to rural health care to help these young doctors explore the path less traveled. It evolved out of RSP discussions, when concerns were raised that it is too short to explore deeply at the personal and grassroot level about rural health care. The organizations involved address the different dimensions of ‘Health’ through Development, Education, Awareness, Hospital, etc. A total of 5 travelers (Doctors) will be chosen after an interview. The duration of the fellowship is 12 months during which time the traveler can choose to go to 3 different organizations of his/her choice, under the guidance of local and distant mentors throughout the journey. They will be given incentives every month.

There will be inter-posting meetings with the other travelers during the fellowship. The focus is on experiential learning by self and also through the rich experiences of the other travelers. It is indeed a very flexible fellowship, where the fellows are not expected to do clinical work alone. Any community work that the organisation is involved in is open to be explored by the traveler. The pilot fellowship starts in May 2020. In the future, probably this will not be limited to these 8 organisations alone and there will be more choices to explore! We hope this will be an enriching journey for both the organisers and the fellows.

RSP - Limitations and Future

RSP is still in its infant stages and as organisers, we are also involved in constant discussions about possible changes. So far six camps have been conducted over the last two years, and more than 170 members have participated. We do have our own limitations like,

True Rural work is never about health alone and true health work is never about doctors alone. RSP started with an interaction between senior medical college teachers and grassroot NGOs. We have considered RSP so far, as an extended, exposure-based-classroom for medical students and to give them a space to open up, interact, to understand the determinants of health and to show how impactful work can be done. Maybe, it’s time for us to understand how we can go forward with RSP itself.

We are now looking back and trying to figure out how impact evaluation can be done. This is constant feedback, both from organisers and participants that we don’t have any sort of follow up sessions and they still go back to their complex system after these three days. It is also not very simple to do impact evaluations since there are many changes possible at the personal level.

The need for a longer program is addressed by Traveller fellowship, but again we might need something in between as well. Perhaps a shorter program for people to come back, raise concerns and have more discussions.

We also need to work on a proper network of the participants of various camps together and also to link with other platforms like MFC, NIRMAN, etc.

To put together, RSP is indeed a great learning experience for all of us.

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Sevankur was started in 2006 by Dr Avinash Saoji for youth. The camps occur mostly in Maharashtra. Each camp has 50 to 150 students. The camp is organised in some organisations’ location so that the youth can know about the organisation and also understand its work.

The camps are mostly for youth who are exploring options for living a fruitful life.

**Philosophy:** To sow the seed of selfless work among the minds and hearts of youth for working for self and society.

Structure: The camps are for 3 days. The camps have different themes each time. But mostly, the camp consists of 3 important things:

- Important discussion and issues pertaining to youth.
- Listening and meeting socially active role models.
- Planning post-camp individual and group activities.
- Each day the camp has a discussion session. The students form into groups with facilitators in each group. They are given selected topics to discuss among the groups. These are followed by the presentation by each group and further discussion on the concept.

This is alternated with a session by role models about their life journey. The role model shares their experience of work and also about their personal life journey. The life-changing situation and advice/events are discussed. It is done along with interaction about failures and challenges while doing the work. The role models honestly share their mistakes and the learning they had from it. The question answers session following the interview-cum-interaction helps the participants to raise their concerns and ask questions related to the person’s life and any specific philosophies they are attached to.

The post-camp individual and group activities help the participants plan some activities feasible for them when they return from the camp. This also helps the camp friends to meet again and start doing some activities in their native place.

**Impact**

It has helped many youth in Maharashtra to come together and think about themselves and society.

It made many like-minded people know each other.

It helped people try to find out their answers through life stories of role models.

The networking by Dr Avinash Saoji helped many youth to explore their interest in work.

The friendships built in camps is a deep source of bonding to date.

The students who continued their interest in work and philosophy of Sevankur are still networked with each other.

**Limitations**

3-day camps don’t allow much attachment among students nor a depth of discussion achieved.

One time 3-day camps help motivate the students but there is no follow-up mechanism.

The camp structure is not rigorous, with a lot of time to slip off and enjoy rather than being serious.

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What is NIRMAN?

The parent organization of NIRMAN is SEARCH (Society For Education, Action and Research in Community Health), which was started by Dr Abhay and Dr Rani Bang for rural healthcare and research in Shodhgram, Gadchiroli. NIRMAN is a youth initiative started by Dr. Abhay and Dr. Rani Bang to identify, nurture and organize the young changemakers to solve various societal challenges. It is an educational process to train the youth to take up crucial issues and problems in society. NIRMAN provides guidance, expertise, and the environment to inculcate self-learning and encourages youth for social action. As it says, Youth for a purposeful life. As it was felt that there was a lack of emerging youth leaders to take on various developmental challenges in the state of Maharashtra, NIRMAN was started as a program under SEARCH in the year 2006. In the year 2008, SEARCH collaborated with MKCL (Maharashtra Knowledge Corporation Limited) and since then, NIRMAN has spread to various corners of Maharashtra.

Vision

NIRMAN aims to create a large group of young professionals having the desire and the capability to understand and solve the burning social problems. It plans to achieve this by developing an educational process that will facilitate a deeper search of these youth for leading a purposeful life. NIRMAN believes that such a pursuit of social problem solving will bring out the best in those individuals. Society has problems like poverty, malnutrition, unemployment, lack of quality education, food, and water scarcity, global warming, etc. which are waiting to be solved.

On the other hand, there are many youths who are in pursuit of a more meaningful life, something beyond just earning money. NIRMAN attempts to create a bridge between these two things to fulfill both the needs.

NIRMAN believes that the self-actualization of its participants cannot take place in isolation or in the narrow confinements of a secured lifestyle. It, therefore, attempts to bring the youth face to face with the reality of life, enabling them to identify, analyse and solve the societal problems. NIRMAN is a continuously evolving process of problem based experiential learning and identification of self through it. It focuses on enabling the participants to understand the world outside to find peace within.

Educational Philosophy

NIRMAN educational philosophy finds its roots in the Nayee Talim principle proposed by Mahatma Gandhi and Vinoba Bhave. As against the conventional education system which compartmentalizes formal education and real life, NIRMAN aims to bridge this gap and achieve education through real problem-solving. Education for life, Education through life and Education throughout life is the motto of this process.

The various educational interventions and techniques used in the NIRMAN workshops include:

- Personal Exercises and Introspective Questionnaires
- Case Studies, Group Discussions, and Sharing
- Interactive Sessions with the Experts and Resource Persons
- Field Visits and Exercises, Group Presentations
- Community and Peer Learning Spaces and Freeform Question/Answers
- Books and Journal Club
- Reading and Discussion of different Articles
- Songs, Role plays and Games
- Movies and Documentaries
- Shram-Daan
- Self-learning Activities and Reflections Sharing
- Personal one-on-one Discussions with NIRMAN Team Members
- Preparing Action-Learning Plans for the intervening six months before the next workshop.

Along with the workshops, study visits, educative sessions, reading assignments, internships, fellowships, individual mentoring, individual volunteering and group actions are carried out. They help sensitize the youth towards societal challenges through exposure and experience. In
this intermediate period between the workshops, the participants keep in touch with each other and build further understanding of social issues through self-initiation and self-learning activities.

**Impact**

Around 350 NIRMAN youth are working full time on specific social challenges in different parts of Maharashtra, Chhattisgarh, Madhya Pradesh, Gujarat, Assam, Odisha, Uttar Pradesh, Karnataka, Delhi, Bihar, Jharkhand, Rajasthan. Their work domains can be broadly classified as: Health, Education, Environment and Energy, Development and Governance, Other.

Together these NIRMAN youth have contributed over 860 person-years of social action so far, by working with around 82 different social organizations across the country. The various problems they have chosen to work on include topics like providing health services in remote rural and tribal areas, rural electrification, watershed development, waste management, improving the implementation of national rural employment guarantee scheme, activism through RTI for improving transparency, spreading books and reading culture in the rural and tribal areas, research on chronic diseases and malaria, research on cattle breeds to improve farmers’ productivity, appropriate technology for improving well-being of laborers and porters, brain based education, organic farming, environmental impact assessment, providing management support to different NGOs, village-based livelihood programs, etc.

**Possibilities of Future Expansion**

MoU with MUHS: As a fantastic validation of its work with the youth so far, NIRMAN was invited by the Maharashtra University of Health Sciences (MUHS, Nashik) to enter into a formal partnership for conducting educational programs for the social sensitization of medical students spread across various medical colleges throughout Maharashtra. Representatives of NIRMAN and MUHS exchanged the MoU in this regard in a function in Mumbai in the presence of Hon. Medical Education Minister of Maharashtra.

NIRMAN – IITB: IIT Bombay approached NIRMAN with the request of conducting such process exclusively for their students. Accordingly, two workshops with total 50 students (B.Tech. & M.Tech.) of IIT Bombay took place in Gadchiroli in December 2014 and 2015. The process was conducted in Hindi/English and the experience has been very encouraging.

Other States: NIRMAN is already reaching wide to various corners of Maharashtra with participation from all the 36 districts in the state and also from 16 other states apart from Maharashtra. There have been requests from NGOs in Karnataka, Gujarat and Jharkhand about replicating NIRMAN in their states.

**Experience of Nirmanees**

“Nirman was suggested to me by a friend who has been part of the process earlier. When I filled the application form, it forced me to think about what I meant by ‘service’. I remember there was a question on my understanding of a social issue of my choice. I chose to write about the agrarian crisis. For answering this question, I read papers and newspaper articles on the agrarian crisis and listened to interviews on YouTube to understand the issue. It was the first time I had put in efforts to read and understand a social problem with the same seriousness that I would give to an academic subject. In the interview and a subsequent pre-Nirman visit to SEARCH that I undertook, conversations with several individuals there deepened my thought process and those were my first lessons in reflecting upon an experience and learning from it. I learnt several things at Nirman, but most striking of all was the importance of forming objectives. It is at NIRMAN that I learnt to transcend above the ‘feel-good’ factor of working for others and bring a professional seriousness into it. Along with this, NIRMAN has provided me with a group of highly inspiring mentors and a reliable group of friends that have a similar thought process.”

“NIRMAN for me came at a time when I found myself alone in my interests of working for the society. It gave me a whole new environment and culture of individuals who thought differently and share a common dream of becoming a social change maker. That networking of friends transcending beyond age groups, educational qualifications, I think, has been my biggest gain from the NIRMAN process. Also it has given me that much needed boost that social service should be done professionally with devotion and a penchant for perfection. Otherwise it cannot bring a desired change in the society that one attempts to bring.”

(Source: www.nirman.mkcl.org)

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Sunday Meets

Background
In many medical and other professional colleges, there is often no availability of a platform for youth to talk and share. To dream and listen. To get a proper support group to talk about self, about society and the problems present there. Such sensitive youth often feel excluded from the rest of the crowd with no one to share and work with. There are fewer and fewer youth who think differently in terms of social sensitivity and who want to discuss and learn among themselves, to express themselves and also form a good bond of friendship with like-minded individuals. Some youth also want to form a good discussion and study group where they will share and listen to varied topics and gain a deeper understanding of them.

Starting Point: Started in MGIMS, Sewagram. In Dec 2016. People used to come to meet each other and discuss some topic each Sunday.

Philosophy: To meet each other and “rest all things will be automatically taken care of.”

Aims: To build a platform for socially sensitive youth to share, discuss various topics and develop a deep bond of friendship among themselves.

Objectives:
- Develop a platform for sharing among socially sensitive youth
- Form a deep bond of friendship among them
- Periodic meeting to keep everyone engaged
- Brainstorming and activity-based learning by doing

Impact of initiative
- Last 3 years, around 10-15 people are closely attached to it
- 2 youth camps organised by the members for others
- Around 20-30 topics discussed in last 2-3 years
- Planned Kerala flood relief
- Organised fundraising for 2 MFC annual meets
- Actively participated in shramdaan activity of Paani Foundation
- Reduced intellectual and emotional isolation of socially sensitive youth
- Friendships for lifetime formed
- Lots of information sharing and growth together

Limitations
- Each batch in college will not have the same enthusiasm for the cause
- To have something for Youth who are Doers and/ or Thinkers
- To get recognition by college authority as part of college.
- To get enough depth as well as to be appealing to youths who are on sidelines.
- To get good mentors, in teachers and near-by role models, for binding together.
- Lack of understanding of group dynamics among students from different batches.

*Email: Source: The Hindu
Tamil Nadu Medical Officers Association (TNMOA)

TNMOA is a Government doctors’ association for medical officers working under the Public Health Department initially, now encompassing all three directorates.

It is an organization founded on the ideals of providing equal and quality care to the public while upholding the rights of doctors as primary healthcare providers.

On 17th Feb 2015, in the remote village of Alangudi in Tiruvarur district, during a routine block-level review meeting conducted at the Block PHC, the doctor who was reviewing the field activities of a poor performing field worker was assaulted and threatened by the field worker. It is noteworthy to know the doctor concerned was the best performing doctor in the district, acknowledged by the district-level Best Performer award. After this unfortunate event, it was hurting to find the district level administration siding with the fieldworker as the concerned person was the state president of a corrupt, yet powerful association.

We raised the question with the district administration and subsequently the state administration, as to how the system could allow a field worker to be negligent of their duties, due to their position in an association. We demanded that action be taken on the fieldworker for the negligent work due to which several people in the service area were unable to access various welfare schemes of the Government. To our anguish, the Health Department not only stood silent on the issue, rather the doctor was transferred to the neighboring district for discharging the duties assigned to him. To fight against this injustice, the representation was given to an existing doctors’ association, which was the only prominent Government doctor’s forum for doctor’s grievances. But it was found to be rather voiceless for the doctors. Hence, to empower doctors working in the public health department in the primary healthcare system of Tamil Nadu, we formed the Tamil Nadu Medical Officers Association on 5th April 2015.

After mounting protests at both state as well as multiple district levels and after a month-long struggle of negotiations with the Government, we were able to reinstate the doctor to the original deserving post and the field worker at fault was transferred to a nearby district, posted in an institution as opposed to fieldwork.

Objectives of TNMOA

- Addressing personal grievance of doctors working in the Government health system
- Addressing the issues of the public concerning the public health system, such as unavailability of common essential drugs, ensuring dignified care of the public in hospitals and other similar policies.
- Addressing post-graduation related issues to ensure adequate specialist availability at public sector
- Addressing Pay and Promotion related issues to ensure career progression of the doctors working in the Government health system.

Struggles

- 19 days continuous protest demanding restoration of 50% reservation for Government doctors in the postgraduate seats in the state
- Siege protest at District collectorate against the prosecution of Health officials for incompetence in dengue prevention activities that were taken up by the revenue department.
- Siege protest at the state directorate for 10-point agenda including unavailability of common essential medicines for the public
- Massive protest to get adequate pay to doctors on par with other states in the country
- Various demonstrations at district level against the existing hierarchy

Achievements

- The regularization process of doctors in the Government sector reduced from 8 years to 3 years
- Monthly salary being credited to women doctors in maternity leave, denied previously due to laborious office procedures.
- Corruption free district and state-level Grievance redressal for doctors
- Due to our continuous negotiations, field protests, and legal battles, we ensured a stable intake of Government doctors for postgraduation for the past 3 years.

Upcoming activities

- Currently, TNMOA fighting to restore 50% reservation in postgraduate seats for Government doctors in the State quota. The case is pending at the constitution bench of the Honorable Supreme Court of India.
- TNMOA registering our constant opposition of UG-NEET, NEXT examinations.
- TNMOA opposed NMC Act, demanding more representation of states and doctors in the decision-making process.
- Pay protest for doctors (one work, one country, one pay)

Future

- TNMOA aspires to be an organization active against corruption at all levels in the system.
- Co-ordinating with fellow healthcare worker associations in the public sector, we are planning to protest against the privatization of health care in the state.

*Email: tnmoa.state@gmail.com
**Alliance of Doctors for Ethical Healthcare (ADEH)**

**Beginnings and Objectives**

The Alliance of Doctors for Ethical Healthcare (ADEH) was formed in 2017 as an independent ethical voice from within the medical community, distinct from other professional associations, to counter the growing menace of corporatisation and commercialisation of medical practice.

ADEH called for doctors trying to do rational, ethical practice to align themselves with the interests of patients and rally on a common platform against profit oriented corrupt practices in healthcare, especially corporatization. This is for the larger aim of working towards Universal Healthcare in India and strengthening of the public health sector.

ADEH stands for:

- Checking the corporatisation of healthcare
- Regulation of fee structure in private medical colleges
- Regulation of the Pharmaceutical, Medical Equipment and Consumables industry
- Solving practical concerns of rational doctors like the high-handed implementation of PCPNDT Act
- Speedy resolution of medico-legal cases, with capping in compensation.
- Honouring Patients’ Rights and Transparency in pricing.
- Following Standard Treatment Guidelines, prepared by relevant organizations.
- Implementation of the Clinical Establishment Act, that protects ethical medical practitioners and does not create unnecessary red tape
- Constitution of the National Medical Council on democratic lines.

The formation of ADEH was facilitated by the NGO SATHI, whose members Dr Arun Gadre and Dr Abhay Shukla had co-authored a book titled “Dissenting Diagnosis”, which was published by Penguin in 2017. A national bestseller based on the “whistleblower” testimony of 78 private practitioners across the country, the book effectively documents the degeneration of ethics in the medical profession and the challenges faced by doctors who wish to practice rational evidence-based medicine, free from commercial influences. The release of the book provoked heated debate and discussion on the state of the private healthcare sector in India in the media and in the medical community.

It was during the discussions and interactions held with doctors from different parts of India that we realised that there are several voices of conscience within a sea of commercialization, but they are scattered and lack a platform to raise their concerns.

Moreover, many doctors are engaged in rational ethical practice and are deeply disturbed about the increasing malpractice, corruption and increasing privatisation, especially corporatization in the medical sector. They wish to make a difference, but do not know how. Some of them have faced their struggles for survival, despite being qualified and competent, some have borne the direct brunt of “resisting” prevalent corruption.

The ADEH network emerged out of the crucial need to unite all such medical professionals, who are opposed to the deteriorating standards of this noble profession, and to create an advocacy group of medical professionals that can lobby the government to implement much needed reforms in health policies.

Along with the ADEH, SATHI also facilitated the formation of Citizen Doctor Forums such as the Poona Citizen Doctor Forum (www.mypcdf.org), which aimed to address the negativity surrounding the doctor-patient relationship, which is currently at its lowest, through the joint efforts of like-minded citizens and doctors working on a common platform. PCDF has requested citizens to recommend names of patient friendly doctors, based on their interaction on its website. Based on this feedback, PCDF offers details of such doctors on its website. To enhance the interaction between such doctors and patients, PCDF has organised a number of public programmes in Pune.
Challenges faced by Medical Practitioners

ADEH focuses on the issues faced by private medical practitioners when they try to practice ethical rational medicine.

The challenges are manifold and affect every strata and level of specialisation. Doctors, especially specialists, starting out in their medical careers face immense pressure to conform to industry and employer expectations.

The entry point for such specialist doctors, who lack an established set up, is to seek employment in the many corporate or multi-specialty hospitals that are springing up in metros and tier 1 and 2 cities. Doctors are set admission and other targets in such hospitals. Their very survival depends on their “performance” which is the revenue that they can generate for the hospital through admissions, investigations and surgical procedures. Many doctors report feeling stressed due to the pressure to achieve monthly targets and to prescribe inappropriate or unnecessary treatment. Most junior consultants cannot take a stand against corporate management tactics for fear of repercussions on their fledgling careers.

If practising as independent private practitioners, they are dependent on referrals from other doctors and are forced to comply with commission-based market practice of referrals. Doctors practicing in diagnostic branches of medicine such as radiology and pathology also have to agree to commission based referrals and be complicit in a corrupt system. Doctors who have taken a stand against corruption and unethical medical practices have faced censure, isolation from the medical community and professional failure.

Small family run hospitals, which are the backbone of the private healthcare sector have to compete with the unlimited financial and political clout of corporate hospitals which pursue aggressive market tactics to buy them out or use them as referral centres. Many young medical professionals report feeling increasing anxiety about their ability to survive and thrive in such a cut throat environment.

Challenges faced by ADEH during Inception

At the onset, many doctors felt the very name and mission of the “ADEH” was an implicit acknowledgement that a majority of doctors were unethical or profiteering. They felt that the ADEH was a platform for a subsection of medical professionals who had a “Holier than Thou” mindset and was meant for doctors who were not affected by the market realities of the medical profession as they were senior and established.

The ADEH had to clarify that it stood FOR Ethical healthcare and it was cognizant of the realities of the private healthcare sector “market” and the constraints it placed on doctors. Time and again, ADEH core team members draw attention to the fact that doctors are also victims in the increasing commercialisation of the private healthcare sector. Starting from commercialised, privatised medical education, problems are compounded by corporatisation of hospitals, the insidious influence of the pharmaceutical industry, poor and ineffective regulations and lack of accountability.

Another challenge faced by ADEH was the reluctance of the younger generation of medical professionals to join the Alliance, due to conflicting career interests. “Ethics are a luxury that only the very senior and established doctors can afford because they are powerful and immune to criticism. We have to make compromises and stay in the system if we have to progress” was an oft recurring observation from mid-career professionals.

Another expectation from the ADEH was that it should represent the reality of private medical practice in India such as the red tapism, hidden costs, the increasing need for investment and lack of protection. It should actually put forth solutions for problems faced by doctors today and not just label the entire community as flawed and profit seeking. Time and again, we have had to clarify these misconceptions by asserting that the ADEH agenda is to advocate for systemic changes through comprehensive policy reform for an accountable, affordable and accessible healthcare sector, which will ultimately benefit both patients AND doctors.

Pressures from other Establishments

The ADEH has had to face covert criticism from professional medical associations who feel that books/articles written by ADEH core team members such as “Dissenting Diagnosis” and “Healers or Predators – Healthcare Corruption in India”, the public stance taken by many ADEH members tend to vilify the medical profession in toto and intensify the feelings of hostility and suspicion against hospitals and doctors in the public.
The ADEH has tried to counter this perception with open dialogues and debates. This has been done through various fora and through a concrete solution-centred approach which aims to restore the trust in doctor patient relationships and the dignity of the profession. Our advocacy for a model of healthcare based on principles of Universal Health Care. It will enable doctors to thrive professionally, to practice ethical compassionate and rational medicine, without commercial or corporate influences.

The ADEH also has created a separate chapter for young medical professionals called as Young Doctors for Ethical Healthcare (YDEH), which works with medical students and young doctors and engages them in dialogue on health sector reform. We hope it will build their understanding about the current issues afflicting medical practice, the possible solutions and enlist their support right at the beginning of their medical careers.

While the ADEH works on creating awareness and support for its cause in the medical community, PCDF aims to do the same amongst the public through its programs and foster understanding and demand for policy driven reform of the healthcare sector.

**ADEH Activities**

ADEH has been involved in the following activities:

- Creating awareness amongst the medical fraternity including medical students. This is being done through organizing regional meetings and workshops with medical professionals across India, regarding challenges of ethical healthcare and solutions, current issues in healthcare such as violence against doctors, impact of corporatization and privatisation of healthcare, accountability in healthcare, UHC, etc.
- Advocacy with the government regarding health policy reforms
- Media advocacy for ethical healthcare through contributing analytical articles in newspapers, journals and television and participation in conferences and symposia.

**ADEH’s Achievements till date**

ADEH has contributed to Health Policy Dialogue in India through varied approaches:

- Invited by the Joint Parliamentary Committee for submission of demands related to National Health Commission

- Participated in a workshop organized by the Competition Commission of India (CCI) with NITI Aayog to discuss business models in private healthcare
- Statement on opposing the irrational ban on Oxytocin, support in capping prices of cardiac stents.
- Statements on current issues in healthcare.
- Launch of Ethical Doctors Manifesto, prior to National Elections in December 2018.
- Through participation in and organization of conferences and workshops
- Organized the First national Conference on Ethical Healthcare at AIIMS, New Delhi in April 2018
- Participated in the 14th World Congress of Bioethics & IJME’s 7th National Bioethics Conference, held in Bangalore in December 2018
- Organized a national workshop on ethical healthcare for medical students and professionals in Pune in August 2019.
- Through creating awareness about ethical healthcare and the value of a regulated healthcare system for medical professionals
- Holding lectures and talks on Universal Health Care and its advantages for doctors, violence against doctors, ethical healthcare in medical colleges in Maharashtra and Kerala
- Organizing regional meetings with doctors across India in Maharashtra on current health policy issues. We have held talks with doctors in Kerala, Madhya Pradesh, Goa, Punjab so far.

**Limitations of the ADEH**

The ADEH is an informal coalition of medical professionals who identify with the ADEH mission and purpose. It is not registered as an entity. As such, it is loosely organized and depends completely on
the voluntary input of its members, all of whom are extremely busy medical professionals. Therefore, it lacks dedicated resources in terms of funds and manpower to increase its outreach, membership and activities. For example, many of the action points decided in the National Conference in April 2018 remain on paper, as ADEH members are mostly senior clinicians who are very busy in their routine work and majority are not able to make time for proposed ADEH activities.

The core team of the ADEH is composed of senior medical professionals and lacks representation of young medical doctors, who feel that the alliance does not adequately represent their concerns and limitations. However, we have tried to address this issue by creating the YDEH which reaches out to medical students in colleges, to young medical professionals and incorporate their concerns in our talks.

The ADEH also lacks gender equity, as we do not have equal representation of women in our core group and are therefore now focusing on identifying more female medical professionals for inclusion in the ADEH core group.

The Alliance needs funds for increasing its outreach and one or a few persons on board, who can focus on systematically harnessing the limited energies of ADEH members.

Role of young doctors

As private medical practitioners, young doctors are subject to a lot of pressure to be successful and establish themselves in a very competitive environment.

With the advent of corporatization of hospitals, doctors will also have to contend with loss of their professional autonomy to a certain extent.

The loss of trust and faith in the doctor patient relationship due to lack of accountability and transparency in the system and the consequent abuse and rise in violence against doctors and medical institution are issues which this generation of medical professionals will have to tackle on a war footing.

These issues can be best addressed if young medical professionals can come together and collectively voice their demands for a better and safe working environment through bringing a system of Universal Health Care which will “de-commercialise” the health care sector and ensure professional success for medical professionals.

Younger doctors can chip in by

- driving the national dialogue on reform of the private healthcare sector through systemic reforms that will bring accountability, transparency in the private healthcare sector, through platforms like the YDEH and Citizen Doctor Forums.
- promoting and adopting a patient centred approach in healthcare, which respects patients’ rights, acknowledges their concerns and focuses on restoring the trust in the doctor patient relationship.

Possible role of MFC to support and mentor Private Practitioners in India

- To support and mentor private practitioners in the country, the MFC could work on identifying their concerns and work on offering solutions to empower them to be a part of the policy making process.
- For doctors who are not usually informed about healthcare systems, the MFC could first of all build on awareness about different models of healthcare, one that is a win-win for both doctors and patients – such as the NHS in the UK which is based on Universal Health Care.
- Instead of the current approach adopted by medical associations, who are defensive and denialist, the MFC could spearhead an agenda for introspection and the need for change within the medical profession, by highlighting the link between violence against medical professionals and the lack of accountability in the sector.
- The MFC could create awareness about ethical patient centred healthcare for medical students by engaging with them through different creative approaches using popular social media channels and interactive communication methods.
- It could conduct a series on role models for ethical healthcare, showcasing young medical professionals who are thriving despite consciously rejecting corporate pressure, commission and incentive linked practice.

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AYUSH Health Providers – Some Case Studies
-Compiled by Shrinidhi, Savithri

- Dilemmas of Young AYUSH Health Service Providers
- BNYS – Possibilities and Challenges
- Dhawale Trust – a Center Practicing Low Cost Homeopathy Care
- University of Trans-Disciplinary Health Sciences and Technology
- Model of Ayurveda used in Low Resource Settings: Experiences of a Young Ayurveda Practitioner
- An Account of SAMBHAVNA Trust, Bhopal

Dilemmas of Young AYUSH Health Service Providers
-Ritu Priya

The Problem

The crisis in health care that is currently confronting countries and peoples is about the design of health service systems that lead to huge inequities in access to health care, the governance of health care that is state and institution-centred rather than people-centered. The content of health care that is iatrogenic [1] and disempowering is another problem. Therefore, there are continuing unresolved health problems and their determinants along with emergent new ones, which the system is unable to deal with adequately. Underlying all these is the hegemony (meaning: dominance) of a medical-industrial complex that underlies how the world has moved to an increasingly medicalised understanding of health and a mindset dependent on bio-medical interventions, largely technological and some behavioural, as the pathway to health.

Amid all these challenges, health care providers of AYUSH who are socially conscious and want to provide people-centred services face many issues that are similar to their counterparts of conventional bio-medicine. These problems include the financial viability of their practice and sustenance of their own families; of social and organizational structures that are more aligned with the medical-industrial complex and commercialization of health care. The state policies and programs also do not facilitate competent and ethical professional practice but rather discourage it by their very design.


In addition, the AYUSH practitioners also face other challenges, especially those related to the delegitimisation of their knowledge system, i.e., considering the understanding of health and disease, of health-related prevention, promotion, and therapies that they are educated in as invalid, unless verified by modern biomedical science. This does not allow for any different view of, e.g., of physiology or pathophysiology, or of ways of treating diseases, to be considered as ‘legitimate’. With this as the dominant perception over the 20th century, there has been less support for the services of AYUSH by the institutional systems (GoI, 1946), and subsequently by the community. Conventional modern medicine (or Allopathy) has become dominant in India over the past century. Yet other codified systems of health knowledge [4] are in practice, surviving despite the withdrawal of state support by the colonial and post-Independence governments. They did get some support in the post-Independence period, being administratively put together as the Indian Systems of Medicine and Homeopathy (ISM&H), and currently known as AYUSH—seven knowledge systems that have official recognition by the Indian government—Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa Riga (Tibetan Medicine) and Homeopathy. However, they have, together, received only 3% of the health budget, reflecting the fact that they suffer from an ‘undemocratic pluralism’ (Priya, 2012). AYUSH practitioners who are officially recognized are the ones with a five-year degree, similar to the MBBS of conventional medicine. But, given the official ‘undemocratic pluralism’, the AYUSH practitioners in the public system have been treated as second class citizens, with lower salary structure and designations, even when they are expected to fulfill the same job responsibilities, such as when

1Email: ritu_priya_jnu@yahoo.com
they are the solo doctors in PHCs. This has led to the following 2 scenarios-

1. Given the pervasive social and official perception, the AYUSH practitioners have themselves tended to be very diffident about their knowledge system and often resorted to combining their practice with that of ‘Allopathy’. They have easily adopted the commercial medical-industrial complex’s mechanisms and becoming part of it.

2. Others have turned to Public Health, Health Education, Health Management and other such specialized disciplines as an alternate channel for their professional careers.

What kind of dilemmas does this pose, when you obtain the degree of one knowledge system but practice another?

On the other hand, these codified AYUSH systems have had their support systems in the resilience of their widely appreciated texts, lineages and organizations of practitioners, institutions of teaching and research along modern lines, and their pharmaceutical industries that have expanded their reach through mass production and marketization, and thus kept them alive (Banerjee, 2012). At the same time, there is a vastly declining, but still alive and struggling, set of practitioners who believe in the purity of their knowledge system and practice it in that way. Their experience of challenges and achievements, dilemmas encountered and ways of dealing with them would probably be very different.

Among the AYUSH systems themselves, there is a hierarchy of status. Ayurveda dominates the scene, with Yoga now getting high priority too. Ayurveda, Unani, Siddha, and Sowa Riga are the most comprehensive knowledge systems in terms of well-established theoretical bases, depth of knowledge and practice, with methods of diagnosis, therapy, prevention, promotion, and palliation. However, Ayurveda dominates the scene, while Unani, Siddha, and Sowa Riga too have all of these features and yet they are relegated to lower positions within AYUSH. This is reflected in the funding as well as the number of colleges, hospitals, and dispensaries as well as degree-holding doctors. This is partially due to the geographical and demographic extent of the presence of these systems across India, but it results in much less support to the latter three, whether in research, service provisioning, education, and training, or production of their medicines and equipment.

Even more pronounced is the hierarchy between these codified systems and ‘folk medicine’. There has been no official recognition to the practitioners of folk medicine until the 2000s, except for the traditional birth attendants. The TBAs or Dais were ‘trained’ and allowed to practice because of the compulsion that there were inadequate facilities and personnel for providing services during all pregnancies and childbirths. As the public services have expanded and a range of primary level workers made available, even these TBAs have been considered redundant. Mostly folk healers have been prized as sources of knowledge about herbal medicine and medicinal plants for leads to new pharmaceutical products (Priya and Kurian, 2018). With their practice and knowledge delegitimized as obsolete and backward, they have been given no space in health service design, and so the younger generations of family lineages of practitioners of folk medicine have largely decided to opt-out and join other professions. Documented are, however, instances of young members of such families who either combine the practice of the family expertise with other sources of livelihood or who return to it after having established themselves in other fields (Sujatha, 2011). Since AYUSH practitioners who are officially recognized are the ones with a five-year degree, similar to the MBBS of conventional medicine, some of them have taken a degree but come back to practice with the seniors of their lineage.

One remarkable development to be noted is the entry of women in large proportions in what were traditionally bastions of the men (Abraham, 2019). Vaidas, Hakims, and Siddhars were all males, even though the women of the household participated in substantial ways in the preparation of medicines and service delivery. Over recent decades, given the low status and remuneration expected by providers of their services, the male members of lineage families have tended to opt for becoming Allopathic doctors or get degrees in the system closest to their lineage’s system of practice. In such cases, the women of the
family, daughters, and daughters-in-law, have been passed on the family tradition, or gone to college to obtain degrees and then practice the system. They may have a different set of travails to tell.

The Challenges

Socially conscious and people-centered health care providers have seen the value in providing AYUSH services, with both medicinal and non-medicinal inputs. The challenges posed by the politics of knowledge in doing so are evident in the narratives of the four initiatives that have been put together for initiating discussions on the dilemmas of AYUSH providers.

For instance, even when benefits have been documented, official support for yoga is denied for the victims of the Bhopal gas tragedy. The body of evidence generated by the Foundation for Revitalization of Local Health Traditions/Transdisciplinary University of Health Sciences and Technology (FRLHT/TDU) has not been put to use at scales to make public health impact. Low-cost services of Homeopathy or Ayurveda take a long time to build trust in the community and get even the poor to use their services.

(Ritu Priya, Centre of Social Medicine and Community Health, JNU & Health Swaraaj Samvaad)

References


Endnotes

[1] ‘Iatrogenic’ is defined by the McGraw-Hill Concise Dictionary of Modern Medicine (2002) as “a physical or mental condition caused by a physician or health care provider—e.g., iatrogenic disease, due to exposure to pathogens, toxins or injurious treatment or procedures.”. ‘Iatrogenesis’ refers to ill-health that is caused by side effects of medical treatment, medical errors and the over-medicalisation of health (Illich, 1976).

[2] Politics of Knowledge refers to the power equations that exist between different ways of ‘knowing’ and understanding a phenomenon, and questions the basis of these power equations. Here they refer to the higher status given to modern conventional bio-medicine over other systems of health knowledge as well as between the various knowledge systems included under the acronym of AYUSH. (Gaitonde et al, 2019)

[3] Medical ‘pluralism’ refers to the simultaneous presence of more than one system of medical knowledge, and the Indian government has accepted this with its recognition of Modern conventional medicine and 7 other knowledge systems. ‘Undemocratic Pluralism’ denotes the fact that in India we have officially accepted ‘pluralism’ of health knowledge systems, but not treated them on an equal footing. The hierarchy that prevails between modern conventional bio-medicine and AYUSH, as well as between the 7 systems within AYUSH, without fair consideration of the strengths and limitations of each knowledge system, makes the pluralism ‘undemocratic’ (Priya, 2012)

[4] Health knowledge systems that have theories, concepts, structured classifications of diseases, therapies etc. put down in widely accepted texts are referred to as the ‘codified systems’. These include modern medical science and the AYUSH systems. In contrast, we must recognize the existence of local health traditions that do not have such texts but are passed on from one generation the next by oral communication and hands-on practice as ‘folk medicine’.

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Bachelor of Naturopathy and Yogic Sciences (BNYS) - Possibilities and Challenges

– Ganesh Vasudevan1

What is BNYS?

Bachelor of Naturopathy and Yogic Sciences (BNYS) course work is composed of various streams of drugless therapies along with basic medical science subjects. As per the revised syllabus, in a duration of five and half years, a BNYS student learn subjects like Anatomy, Physiology, Biochemistry, Pathology, Microbiology, Community Medicine, Forensic Medicine, Basic Pharmacology, Modern Diagnosis, Nutrition & Dietetics, Psychology, Obstetrics & Gynaecology, Research Methodology, Emergency Medicine & First Aid which makes them well aware about the human body and also about the diseases to the existing standard of Medical Science. Along with these subjects they are also getting trained in other subjects like Yoga, Hydrotherapy, Fasting Therapy, Manipulative Therapies and Acupuncture which are complementary or alternative Medical Systems. Theoretical as well as practical exposure received by a graduate in the whole coursework enables him/her to excel in the preventive, promotive and rehabilitative health care. Being a country with a huge increase in the burden of non-communicable diseases (NCDs), the relevance and importance of such a health system in India is obvious. Probably this will be the only curriculum that has such a diversified set of subjects and which also has a daily practice of physical exercises as part of evaluation which keeps even the graduate healthier in the whole course of time. World Health Organization (WHO) recommends a vigorous high-intensity level of physical activities for 1 hour every day for the prevention of NCDs. Perhaps BNYS is the only professional medical course that follows this recommendation for its students in the form of yoga daily for the whole period of the course.

NCDs are responsible for almost 70% of death across the globe and among this 75% are occurring in Lower and Middle-Income Countries (LMIC). It is now well known that alcohol, tobacco, improper dietary habits and lack of physical activities are the major risk factors for NCDs. Nutrition and physical exercise are the core areas where Naturopathy and Yoga as a health system can effectively intervene. Disease-specific or individual-specific prescriptions for diet and physical exercise are the major ways of treatments in this system. Yoga and Naturopathy is an excellent system that helps an individual to set up a lifestyle away from diseases with adequate physical activities, good quality & a healthy diet and also helps to keep themselves away from addictions.

Influence of Philosophies

Initially, the system is developed upon a strong foundation of a set of principles and philosophies, where many of them cannot be validated with science easily. But after two decades, the system could overcome this to a great extent. It is unfortunate to say that even with the scientifically sound syllabus, due to various biases and misguidance, some of the graduates follow the philosophies over the science for their clinical practices. Out of around 40 institutions of Naturopathy and Yoga, only very few are under the government. The establishment of the majority of private institutions is based on some of the other ideological backgrounds and religious philosophies. It was MK Gandhi and his philosophies which became the face of Indian Naturopathy, which itself has many drawbacks when we assess scientifically. But when it was developed into a medical course like BNYS the philosophies had to get less importance. Initially, half of the syllabus of BNYS, was composed of philosophical subjects. Since the pressure for scientific validation has come from all the sides, many of the therapies and practices were studied and found to be scientifically sound for many ailments. But since the majority of the Institutions were private and also since many of them are religious or spiritually motivated trusts, they could never achieve the liberty from its philosophical values. Lack of motivation, lack of funds, lack of proper cooperation from other established Medical Research bodies are the major obstacles for this. And this has conflicts within the system and has created two different schools; Traditional and Modern practice of Naturopathy and Yoga.

Often the misinterpretation or misconceptions of philosophically motivated individuals being at the key positions of the system is also one among the major pitfalls for Yoga & Naturopathy by hindering

*Email ganesh.vnvn@gmail.com
scientific research in the field. These factors often lead to the false claim about the system as an alternative independent stream of curative medicines; which is unacceptable for a progressive society. It is in such cases the practitioners often make emotional and misleading arguments on modern medicine and preach pseudoscientific claim which is the greatest threat to the system of Naturopathy and Yoga from within.

On Research Studies

After the change in the political scenario of 2014 in India, there was unprecedented attention towards Yoga which has given an entirely new face for the BNYS. International Yoga Days were celebrated across the country to such a level that even Yoga itself been claimed as an independent curative medical system for all kinds of diseases which is absurd.

Though there are various studies conducted and published on the effectiveness of Yoga, hydrotherapy, acupuncture, etc. for several ill-health conditions, none of them could establish them as independent systems of medicine for all kinds of ailments or curative medicine. Considering an example, the practice of various specific yoga postures for a long-term gives significant relief from lower back pain and reduces the chance of vulnerability to back and neck pains but in acutely painful conditions the system has its limitations, though some treatments like acupuncture and hydrotherapy can alleviate the pain to certain extent.

There are 2 central government institutions established for the development of Yoga and Naturopathy in India; Central Council for Research in Yoga and Naturopathy (CCRYN) & National Institute of Naturopathy (NIN). The purpose was to aid the emerging researches in naturopathy and yoga and also to promote the system by conducting camps and CME’s. SVYASA, a private establishment in Bengaluru is a deemed university that has both BNYS, BAMS, and several other yoga courses have an immense role in the field of research in Yoga. Many papers have been published by these institutions as well as other institutions of yoga and naturopathy, mainly on their clinical effects.(RESEARCH OUTCOME 13.08.2018_0.pdf, n.d.)

Competency of papers published as well as the studies conducted are often being questioned by conventional medicine. But this is largely due to lack of motivation towards the research field and also the practical and ethical challenges to conducting studies like RCTs with the treatments of this system.

A study has been conducted and published on the Effects of Naturopathy and Yoga intervention on CD4 count of individuals receiving ART, conducted by NIN in patients of HIV sanatorium under Yoga and Naturopathy, Pune. This study has shown a significant increase in the CD4 count of patients proportional to the duration of the stay with Yoga and Naturopathy lifestyle treatments at Bel-Air HIV sanatorium, Pune. Perhaps larger controlled studies are warranted for conclusive results for establishing the reduction of viral load due to the treatments. Bel-Air HIV sanatorium is the only HIV sanatorium under Yoga and Naturopathy in the country. The centre is a good example to show the integration of medicine with Yoga-Naturopathy and modern medicine. (Effects of naturopathy and yoga intervention on CD4 count of the individuals receiving antiretroviral therapy-report from a human immunodeficiency virus sanatorium, Pune Joseph B, Nair PM, Nanda A - Int J Yoga, n.d.)

School-based interventions for treating anaemia by providing a nutritive diet in the form of low-cost nutritional kits to the school students are being studied in Bhopal Naturopathy College and found to be very effective. The study is being conducted by Sant Hirdaram Medical College for Naturopathy and Yoga and monitored by NIN, Pune. Such studies will be helpful to prove that naturopathy based interventions can be cost-effective and sustainable for the community-based approach as well. The nutritional kits mainly consist of sprouts, which are produced and supplied daily with an affordable rate for students, i.e., Rs 2 per kit. In the long term, this can also result in preventing NCDs by avoiding junk food culture and by nurturing a healthy diet at a younger age.

State-wide Interventions

State-wide projects are being implemented in Kerala, under the department of Indian System of Medicine (ISM) which includes conducting daily yoga practice sessions, diet and exercise consultations, pain management treatments to the public with totally free of cost. The number of patient inflow is quite promising and that itself shows the acceptance of the system by the Public. Such a system will be a
good and sustainable solution for the societal and individual burden of unnecessary medical expansion due to overdiagnosis and medicalization. In the long run, the daily practice of Yoga and awareness about a good lifestyle with a healthy diet helps to bring down the burden of NCDs in the state. But the project consists of only a single contractual Medical Officer post per district which has a lot of limitations.

Muhammad, a gram panchayat of Alappuzha district in Kerala has been announced as the first ‘Yoga Gramam’ (Yoga village) in the country which was a concept defined as part of National AYUSH Mission (NAM). Regular yoga sessions are being conducted at two different centres of all the wards in the Panchayat for the public. At least one person from all the families of the panchayat is trained with Yoga through these 32 yoga centres. The instructors were selected from the interested people from the panchayat and are trained and frequently monitored by BNYS graduates who are posted under contract with NAM. Due to the lack of funds and proper guidance, the opportunity to conduct a study was missed here. (Reporter, 2018)

Karnataka government has established an outpatient centre in each taluka across the state which provides affordable Yoga and Naturopathy treatments and consultations for the general public. The centres are public-private partnership setups in collaboration with SDM Trust of Daharmasthala, who also established the first college for BNYS in Ujire, D.K., Karnataka. Public utilization of these centres is yet to be studied. Government Yoga & Nature cure Hospital, Varkala, Kerala is an excellent example of a Yoga-Naturopathy IP in the government sector. It has 60 in-patient capacity with 3 medical officers and is situated in a soothing ambience of Varkala cliff, which itself heals the ailments. The centre offers treatments at a cheap and affordable rate for the general public and is the only hospital in Kerala under the public sector.

**Lack of Awareness**

Though Yoga and Naturopathy are much known among the common public, they lack proper awareness about the system. The authenticity of the system is often questioned mainly due to the presence of a huge number of unqualified practitioners or quacks. It is often them who make unscientific claims and most of the practitioners lack even basic education. BNYS is the only qualification that allows a person to practice Yoga and Naturopathy legally in the country. Even though BNYS has registration in respective medical councils of each state, the public still is not much aware about this medical degree.

More studies have to emerge in this field and integration of the medical system has to be assured than promoting Yoga and Naturopathy as a single and opposing entity against conventional medicine. NEET is not yet mandatory for the admission of BNYS which significantly affects the quality of the system. Private institutions are often unchecked about the quality of teaching, which is an important issue for BNYS, as almost 90% of institutions are private. The syllabus is not yet standardised in all the institutions. Appointment of teaching faculties is also not centralised. Salary and duty timings are also not been standardised. Yoga and Naturopathy medical officers in private institutions are pressured to work round the clock. Even weekly offs are not included in the schedule. Though there are associations for BNYS graduates, such issues remain unaddressed.

As a newly emerged mainstream system of medicine, Naturopathy and Yoga have their limitations. Opportunity in the public sector is much limited even now. Central Research Institutes has been announced to be established in different states which are still on paper. The system can be well integrated with the conventional medical system to prevent the increasing burden of NCDs including mental health. Enhancing the opportunity for conducting the researches, escalating the funds and motivation for research-oriented programmes are the need of the hour.

**References**


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Dhawale Trust – A Centre Practising Low Cost Homeopathy Care

The following account is given by Sunil Chavan associated with Dr M L Dhawale Memorial Trust based in Mumbai.

Healthcare service and lack of its accessibility to the poor and marginalised is often talked about. While many NGOs and Individuals are working towards combating this problem, their efforts though laudable are indeed inadequate. AYUSH has a very good potential to penetrate far and wide in this effort of reaching healthcare to communities.

While I may not be knowledgeable to talk about all aspects of AYUSH, I will keep my comments restricted to Homeopathy practice.

I have been associated with Dr M L Dhawale Memorial Trust, based in Mumbai. The Trust has one charitable hospital in Mumbai (serving the slum communities) and two in Palghar district, with a focus on the poor patients, deprived peasants, manual workers, destitute women, and tribal population. With a high emphasis on Homeopathy, the Trust’s clinics and hospitals look after more than 2 lakh patients per year.

Dr M L Dhawale’s thinking was reaching healthcare to the poor. Consequently, the then young doctors, who were students of Dr M L Dhawale decided to start work in Palghar knowing that it was a backward and ignored area. A lot of poverty, inaccessible area, lack of infrastructure, etc. was evident. Hence, they started visiting the region and providing service and slowly realising the immense unfulfilled need, we chose to further penetrate and work in the area.

The basic value with which the Trust was set up and continues to run is that no one should be denied access to health care simply because s/he cannot afford it. Keeping in line with that, we do not send anyone back from our doorstep whether she needs medicine for cough and cold or needs a Joint Replacement Surgery (some of the services do need allopathic management and we do administer that through suitably qualified medical practitioners). The staff is constantly encouraged to uphold the values of the Trust i.e., Spirit of Service, Integrity, Transparency, Commitment, Discipline, and hard work, Passion for Excellence, Endurance and resilience, Teamwork, Innovation. Continuous learning is not just encouraged but conscious efforts are done to make it happen.

One of the main advantages of Homoeopathic services is that the cost of medicines is minuscule. However, the cost of medical practitioners is comparable (to any other pathy) because the skills required are the same and the time that the practitioner is required to spend with the patients is very high. The biggest disadvantage is the myth around the pathy that it takes a long time to cure. Consequently, one of the challenges we had to overcome was to convince people that the pathy works and for non-chronic ailments also the cure is reasonably quick. Our team took a lot of effort to create awareness about the pathy, explain its mechanism in the words that they (mostly illiterate) would understand. As it always happens, the proof of the pudding is in the eating. The community started to witness results, both for chronic and normal ailments. Their faith in the pathy grew and we are able to slowly see improvements in the community’s health.

Given the poor state of healthcare services and abject poverty, the worst to suffer are women and geriatrics. Thus, our hospital decided to focus on women and more specifically on Mother & Child care. Encouraging women to follow ANC and institutional delivery has helped in reducing MMR & IMR substantially. For Geriatric care, we opened a fully equipped ward to serve senior

1Email sunil3924@gmail.com
citizens with mental or physical disorders through Homoeopathic management and rehabilitation through physiotherapy, occupational therapy, counseling, etc. We are probably the only Homoeopathic hospital with a special ward for Psychiatry and an ICU in Paediatric department. In all poor, rural, backward parts of the country, tobacco and alcohol addiction is rampant. We have a special team working to tackle this problem too.

One of the challenges we face is compromised knowledge of allied subjects and (lack of) efficiency in clinical skills due to limited exposure to patients given the lesser number of patients willing to get treated under Homeopathy. In emergency and life-threatening conditions, where Homeopathy practitioners, though well aware and trained in procedures cannot perform them only because the regulations do not permit them to do so. As a result, the patient does not get appropriate treatment and can result in morbidity or mortality.

Hospitals in Malad and Palghar city generate revenue that is adequate to run the operations. For capital expenditure or expansion, these hospitals depend on fundraising. Hospital in Bhopoli, a tribal belt in Vikramgad, Dist. Palghar, generates virtually zero revenue (barely 3-4% of the annual expenses). This hospital runs entirely on donations.

The Government per se does not take any effort to promote Homeopathy. It could be because the lobby promoting allopathy is very powerful. Secondly, none of the allopathy practitioners refer patients to our hospital. Pharma companies, which is another powerful cog in this wheel, also look down upon us and create major impediments. It is impossible to fight these mighty giants (Private Sector, Allopathy practitioners, Pharma companies). Hence our emphasis is on winning the trust of the community so that they will demand more of these services. Unfortunately, in a critical situation, they obviously buckle down and accept the advice of their physician, albeit reluctantly.

While the Trust also runs a Post-Graduate institute (connected with the Palghar Hospital). In all 36 students complete their three-tier curriculum and graduate with an M.D. degree every year. Unfortunately, none of these youngsters are willing to stay and practice with the Trust. Worse yet, most of them do not practice homeopathy.

We do wish that more and more youth would join AYUSH and help (manpower starved) institutions further their work in the community. Undoubtedly such an association will give the youth very enriching community welfare and clinical experience. However, the non-glamorous rural setting and low remuneration shun most of the youth from this much-needed service. Working with the Government or an NGO will teach how to deliver a much-needed service in a resource-constraint setup. A doctor in such scenarios is not just a medical practitioner but has an opportunity to work towards holistic nation-building by contributing in various dimensions such as education, agriculture, livelihood, hygiene, sanitation, water, et al.

Continuous awareness and actual proof of the treatment are two main factors for strengthening the belief in Homeopathy. When people see a stroke patient improving and becoming reasonably independent instils their faith in the pathy. Recently there was an outbreak of high fever in an ashram school and in two days it spread to 100+ students. Our team worked on it for 48 hours continuously to identify the cause of the fever and the remedy. In the next three days, the epidemic was under control entirely through Homeopathy. Research indeed is a pressing need, but unfortunately, very limited funds are available for it. A Trust like us at least through the PG institute we have can afford to do some research with limited funds available (and we do). But there are no other eminent institutes doing research. Even large commercial houses like Dr. Batra’s and others are not engaged in any kind of research.

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University of Trans-Disciplinary Health Sciences and Technology

– Hariramamurthy Govindaswamy

University of Trans-Disciplinary Health Sciences and Technology (TDU) is a state legislated private university that evolved from the Foundation for Revitalization of Local Health Traditions. It supports and participates a wide range of projects such as:

• Maintaining the country’s only national herbarium and raw drug repository of medicinal plants of India.

• Working with the Forest departments to establish a large network of 108 Medicinal Plant Conservation Areas.

• Designing and developing a large computer database on medicinal botanicals of the country along with their traditional pharmacopeia and their geographical distribution.

• Supporting a grassroots network of village-based traditional healers and working for their training and certification.

• Developing an ‘Ayurveda Biology Research Centre’

• Running a 100-bed Integrative Healthcare hospital

TDU was founded by the joint efforts of Darshan Shankar and Sam Pitroda.

The story of what is now TDU extends back around a hundred years ago, when all form of Indian medicine was denied institutional support by the then British Government, including what is now Ayurveda. India is home to several Lok Swasthya Paramparas (local health traditions). There were grandmothers’ cures that she created from her kitchen garden in the backyard. There was the local ‘Vaidu’ who was also a village priest. There was the barber community with their knowledge of herbs with hair and skincare potential. There were nomadic cattle rearing community that knew a lot about the wild herbs with the potential to treat poisonous animal bites. Therefore, the traditional healers of India consisted of a wide range of practitioners with no recognized formal training or institutions, except for certain families, such as Vaidyamadham in Kerala, that were considered authorities in their medicine and ran ‘gurukulas’ for transferring the knowledge. The knowledge of these health systems was mostly transmitted verbally from teachers to disciple until, after many generations, manuscripts and stone engravings were created to write them down. Among these, some knowledge was processed and written down in a structured way to fit in a theoretical framework and consisted of concepts like the ‘tridosha’ and ‘pancha mahabhoota’. These became the ‘shastriyapaaramparas’ with authentic texts that dictate their practice, such as Ayurveda. By independence, even though Ayurveda was revived by institutionalization and eventually Ayurveda, Siddha practitioners have been conferred the title of ‘Dr.’ like allopathic practitioners, the rest of the traditional medicines have not gotten institutional support. To work for these local health traditions, the Lok Swasthya Parampara Samvardhan Samiti was formed in the early 1980s. A group of enthusiastic individuals worked on an almost voluntary basis from its office in Arya Vaidya Pharmacy’s building in Ramanathapuram in Coimbatore district of Tamil Nadu. Over time, as their work expanded the organization became the Foundation for Revitalization of Local Health Traditions with a wider support base and larger funding in 1993.

We spoke to Prof. G Hariramamurthy, working with the Centre for Local Health Traditions and Policy of TDU and in a delightful conversation that was almost story like to listen to, he discussed with us the working of TDU, their various challenges, and achievements.

One of TDU’s significant works is the identification and maintenance of Medicinal Plant conservation areas. The combined knowledge of the systematized traditional medicine practices recognizes around 1700 plants with medicinal values. Whereas the non-institutionalized traditional health practices recognize around 6500 medicinal plants. These undocumented plants now face a higher threat of extinction than the documented plants and thus the traditional health practices stand the danger of turning useless just because their resources have become extinct. TDU, therefore began educating the forest department about the rich medicinal flora that grows in the wild and started measures for its conservation along with them.

Once these plants have been identified and measures are taken to conserve them, TDU also has laboratories that research into their medicinal properties as...
mentioned in the texts of Ayurveda, Siddha, Unani, Sowa-Rigpa (Tibetan medicine). This is important if the advocates of traditional health practices are to have a dialogue with the propounders of biomedicine. While such research helps explain the traditional health practices in the language of biomedicine, which it epistemologically differs from, the noteworthy thing about TDU’s research is that it is done in a way to understand the practice as prescribed in the texts rather than isolating the active principle of an herb. For example, studies into the diurnal variation of medicinal property of certain herbs and correlating it to the timing of harvest of the herb prescribed in the texts.

When TDU successfully procured an international grant for research into medicinal plants, its biggest question was where to start! Because the knowledge they were looking to understand was not available in books, libraries or universities, dialogue with people and reaping into the traditional knowledge of communities was the answer. They started organizing Vaidya Sammelans to initiate this dialogue. TDU has been involved actively in the debate with the government to alter policies and recognize the rights of traditional healers to practice with their knowledge. In this aspect, the recent announcement of the Chhattisgarh government about the establishment Chhattisgarh Paramparik Vaidya Board is a grand achievement.

In this situation, an organization such as TDU which is a charitable trust faces difficulty finding funds to continue its R&D activities. For this, TDU partners with community-based organizations, including self-help groups so as to work with the community itself. By this method, they are harnessing the existing strengths of the community and creating groups that can pressure policymakers in the desired direction. Therefore, like most work in the AYUSH sector, the contribution of the government budget is too insignificant.

In addition to this, the traditional unwritten forms of medicine face the threat of extinction because of the lack of manpower to carry forward the knowledge. This knowledge is usually carried forward by subsequent generations of a family. They were legitimized not by the government authorities, but by the social respect within their community. With the advent of modern education and the breakdown of such social structures, the newer generations are not interested in carrying forward these practices. For this TDU conducts awareness programs for these communities and uses traditional art forms such as Yakshagana in Karnataka, and Villuppaattu in Tamil Nadu to popularize the need for maintaining these practices.

If we are to look at health as a fundamental right of every individual and the community as a unit that can be empowered to take care of its health, traditional health practices play a vital role in this process. When biomedicine is running out of answers for questions like drug-resistant microorganisms or toxic side effects of chemical drugs, we could look to traditional medicine to help us out. The discovery of Artemisinin from the Chinese medicinal practice of boiling the roots of the Artemesia plant in water and drinking it to treat malaria is an excellent example. Traditional medicine also does a better job of looking at health in a holistic manner and keeping the overall well-being of an individual above just the cure of a disease. Beyond this, the role of traditional medicine in helping a community take care of its health needs, both preventive and curative, in a sustainable and eco-friendly manner cannot be overlooked. In this context, the work of TDU is unique and an excellent opportunity for youngsters not only from the AYUSH sector but for anyone interested in a holistic approach to health.

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Anandlok Holistic Health Centre has been practicing Ayurveda in low resource settings for the last 10 years or so. We talked to Viraj, a passionate and enthusiastic young doctor who has been in this field for quite some time now.

There are 3 doctors in the group and recently 2 have joined as paid employees. The group mainly works in the Nagpur city of Maharashtra, slum areas near Butibori in Nagpur as well as Kurkheda taluka in Gadchiroli. Along with the clinical practice of treating patients, the doctors also have consciously included projects based on prevention and promotive aspects of health. “Ayurveda largely focuses on promotive and preventive aspects of health. Its principles involve to try and maintain a healthy mind, body, and soul. So curative aspects though important is not the primary focus”, he says.

“Our values are pretty clear. We go by the needs of the patient and his paying capacity. We avoid any unnecessary interventions which are costly and unlikely to have a significant impact on his health.” Anandlok provides services that are at costs way lower than the usual market rates. It does not indulge in market policies, competitive pricing and keeps away from commercialization. “One sitting of Basti in Nagpur city can cost you around Rs 300. But we do the same procedure at around 50 rupees. If the patient can pay well, we take around Rs 100, however if he cannot he can undergo the procedure at Rs 40 as well. At every point, the cost of the services provided is always considered. Similarly, Vaman and other procedures are done at unbelievably lower prices …. Also, we target to cure the patient of the disease and not just that he continues to take medicines for his life.”

How did they gather motivation for this kind of work? “Namrata (his batchmate first and later his wife) and I always used to discuss the need of demystifying Ayurveda amongst the lower rungs of the society. They need it but the commercial market seems to be out of reach for them. And we came across Dr Avinash Saoji who runs an initiative called Prayas. We went to their camps in Amravati and understood the need for working in the social sector. We also managed to understand Ayurveda on our own as our colleges seemed to do little to enrich and motivate us. To attend clinics outside from second year onwards boosted my confidence which usually is lacking in the Ayurveda graduates. They are not motivated for doing Ayurveda even by their teachers and they turn out to be average general practitioners and nothing more. Thankfully we took a different path and it helped.

Did they suffer any dilemmas and challenges? “Patient acceptance”, he outrightly admits. “People generally do not accept Ayurveda that easily. Sometimes there are already so many myths that it becomes very difficult to convince people to persist with the treatment. Some want just a quick remedy and not ready to change their lifestyle and behavior. How that is possible? Our pathy completely relies upon a positive lifestyle. We have to try and convince a lot to make people understand the importance of a positive lifestyle.” Also, there are other practical problems like difficulty in follow up. As daily wage earners have difficulty to comply with the doctor’s schedule. For such people, we have to make sure we still come up with the best possible alternatives. “There are also economic issues which can be resolved only as time passes by. Initial periods are difficult. Like even now we do not take a salary from the little profit the hospital makes. It is the patients that come and help us. From discounts on grocery items to now paying the hospital rent of Rs 25,000, the kind patients have helped us each time. Namrata and Prashant bhau (founder of Anandlok) also generate income as counselors of different private firms and companies because of their study in psychology. Such issues arise but only time, experience and goodwill can help us along.”
He believes Ayurveda practitioners do not document their positive results in the patients and that also is a hindrance to the positive spread of the knowledge. The reluctance of the doctors in this part leads to a decreased number of chances of spread of the pathy. It is necessary, he said, that local knowledge of communities regarding traditional medicines is preserved so that very important information about herbs and medically useful plants are preserved.

When he was asked whether he faced any restriction in work from commercial establishments he answered, “There may be criticism or ridicule, but we always stayed away from it. Our work speaks for itself, on the contrary, many ethical doctors have always extended valuable help to us.”

Explaining his work in brief he said: “We run 2 clinics in Nagpur city. Also, we run awareness activities as well as clinical care in nearby slum areas in Butibori. Our practice area also extends to Kurkheda taluka of Gadchiroli district. Here we have adopted 13 villages. We have identified some local persons and begin training them for imparting Ayurveda care and herbal medicines which are available locally. It is a fact that nature provides the local communities with the natural herbs which are relevant for diseases they face. We have designed a course for 3 years and our vision is that the local health worker (Vaidu) be able to take over the responsibility of imparting treatment of basic diseases by then. Also, we run a mobile ambulance service with a trained BAMS doctor imparting modern care as well in those villages. In these villages, we are documenting the preventive and promotive efficacies of local herbal medicines in illnesses like malaria. “

Anyone visiting their clinic will surely undergo psychological counseling as well. Where did the interest in Psychology come from? “Ayurveda teaches us to look into mind-body-soul as well. Also because of our interest in understanding the influence of patient psychology on disease and body’s response to treatment. We underwent training in REBT and it all helped in our treatment of patients a lot. Many diseases have a deeper psychological link”.

Ayurveda practice takes a lot of patience. After so many years of practice now we are getting a good flow of patients visiting us. We have managed to cure (stop medicines) of almost 40 patients of thyroid disorders, 80 patients of infertility and currently also started to work on hypertensive and diabetic patients. Also, we have worked on dengue patients in OPD, treated patients of cervical and lumbar spondylosis. The most important success according to me is people have started to take responsibility for their own health! To create awareness at that level is important. Our next targets are to keep sustaining our work and also concentrate on economic as well as administrative issues of our organization.

The time required to gain patient’s trust is a lot more and that is one of our limitations. Also because of economic concerns, we cannot take new projects at once; there are restrictions in taking up newer initiatives. However, patients becoming more aware and goodwill amongst previously treated patients are some positive signs.

What are his thoughts on the newer graduates of Ayurveda? “Lot more are taking up Ayurveda practice as compared to our times. However, still, post-graduation seems to be the new menace hitting our youth today. New BAMS graduates do not get that required clinical orientation during their PG years and thus appear to have lost after PG. Going into a teaching job in colleges remains their only alternative and such disoriented lecturers cannot impart effective teaching in college as well. Lack of role models in the social sector, no mentorship, lack of patient-based learning during UG and PG days lead to directionless future in Ayurveda graduates. We are helping out some of our students though who come to us for help and guidance. It has been an experience that years of clinical practice and hard work can lead to much better training than doing PG in some institute with dismal patient intake. It is necessary that students today do not run behind the market forces and take up seemingly easy alternatives over hard work and patience,” he sums it up.

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An Account of SAMBHAVNA Trust, Bhopal

-Satinath Sarangi

1. What are the values that you follow?

Some time back we had a discussion among all staff members and each member mentioned what she/he thought were the values of the organization. We had no previous discussion on the values of the organization and were curious to find what values were apparent in practice. The following is a list of 10 values of our organization in order of votes

1. Equality
2. Working together
3. To be of help
4. Struggle
5. Service
6. Truth
7. Awareness
8. Honesty
9. Focus on Quality
10. Transparency

2. What is the motivation behind you doing this work?

I landed in Bhopal in the immediate aftermath of the disaster and then became part of a survivors’ organization fighting for criminal punishment of the corporation and its executives, adequate compensation, medical care, economic and social rehabilitation. Though I was not trained in medicine I was most interested in the medical care of survivors. In June 1985, I was the manager of the peoples’ health centre (Jana Swasthya Kendra) that was administering sodium thiosulphate (NaTS) to survivors (10 ml IV for 7 days) and monitoring its effects. The effectiveness of NaTS administration demonstrated that Union Carbide’s poisons had indeed reached the bloodstream of exposed persons and potentially had caused multi-systemic damage. Union Carbide refused to acknowledge this and maintained that the gas had caused damage to only those organs it came directly in contact with – the eyes and the lungs. The government, ever helpful to Union Carbide, never made arrangements to administer NaTS to the survivors, despite positive findings of the ICMR’s study on the drug’s efficacy. The Jana Swasthya Kendra was raided in midnight by armed policemen after it had run for 20 days and administered NaTS to 1300 persons. I along with my colleague was taken to different police stations till morning and the next day we were sent to jail along with 30 others including volunteer doctors on trumped-up charges. When I came out of jail after 18 days, the Kendra had been razed to the ground and all information attesting to the efficacy of NaTS taken away. Two successive attempts to restart the NaTS administering clinic were unsuccessful due to pressure by police and intelligence agencies. Meanwhile, the government had begun responding to the demands of the survivors’ organizations for setting up a system of health care, especially for the gas affected people.

Over the next few years, 6 hospitals and a large number of dispensaries were set up exclusively for the survivors. The number of beds per thousand people in gas affected Bhopal became better than that in the USA and Europe. However, some of us who were visiting survivors in their homes almost on a daily basis were finding that the health care system was not providing sustained relief from exposure-related complaints to anyone. In 1993-94 we carried out a study with help from young medicos and others and found that between 40 and 45 % of the medicines prescribed at the government hospitals were either potentially harmful or unnecessary. We found that in particular four groups of medicines – antibiotics, painkillers, steroids, and psychotropic drugs - were being prescribed indiscriminately. We also found that the disaster caused by a chemical multinational had become a windfall for the pharma multinationals – a dozen pharma multinationals were selling the most drugs in Bhopal. Among them was Rhone-Poulenc, a pharma company that was also the owner of Union Carbide’s MIC plant in the USA at that time. We looked more and found that this was true for most chemical corporations, that they themselves produced pharmaceuticals for diseases caused by the harmful chemicals they produce, emit or otherwise trespass into people’s bodies. Certain corporations such as Astra Zeneca overdid this – it produced acetochlor, a herbicide that is known to cause breast cancer, and the company also produces tamoxifen which is the treatment for breast cancer and it also owns the month of October – Breast Cancer Awareness month – when it keeps out any and all mention of environmental pollution causing breast cancer.

All this led me to think of creating an example of a proper medical response to the Bhopal situation by integrating Ayurveda and Yoga with modern medicine. By then there were also several revelations about the ICMR terminating research projects well

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1Email sathyusarangi@gmail.com
before they were completed, so I thought any new initiative has to include medical research as well. The government healthcare system had no place for peoples’ collective initiatives towards health improvement, so I planned in community health. After I wrote up the project, I started looking for a possible source of funds. Through a friend in the USA, I came in touch with Indra Sinha who lived in England. Indra, a creative director in an advertising agency in London, had raised 500 thousand pounds for the Kurdish relief fund through advertising in newspapers. I went and met with Indra and he agreed to write advertisements for newspapers that could potentially raise funds through individual donations. After this, I went around the country meeting with individuals who had provided support to the ongoing struggle of the survivors through their actions in the aftermath of the disaster. Interestingly, all the persons I met and requested to become trustees of the trust that would run the clinic agreed to be so. Meanwhile, the double-page advertisement that Indra had created and published in the UK Guardian did very well in terms of raising donations. The SAMBHAVNA Trust was registered in June 1995 and the Clinic started functioning in September 1996. That is when we appointed 12 staff members including doctors of modern medicine and Ayurveda and panchakarma therapists.

3. Dilemmas/challenges/problems faced by you?

1. Shortage of funds:
   From the very beginning, we decided we will run the clinic solely through individual donations. Because we saw/see most corporations as committing crimes against people and the environment we decided we will not accept funds from corporations because we saw/see most governments to be complicit in corporate crimes. We decided that we will not accept funds from any government. We saw large funding organizations to be vulnerable to political pressure and counted them out too. My experience of the Jana Swasthya Kendra had made me realize how political the medical issues of Bhopal are and I thought individual donations would be the most dependable source in the long run. We don’t believe in taking funds from corporates who themselves contribute to large scale damage of the environment. All our staff is paid, those in lower grades are usually paid higher compared to other NGOs. For higher grades such as doctors, we pay as per prevalent market rates.

2. Lack of professionals qualified for the unique medical challenges

3. Official threats and actions (currently our FCRA registration is cancelled).

4. Spying by the Corporation

In 2012 we came to know that Dow Chemical, USA after it took over the global assets of Union Carbide appointed a private intelligence firm called Stratfor (Strategic Forecasting) to spy on Bhopal activists. A 27-year-old hacker named Jeremy Hammond exposed the spying that Stratfor had carried out from 2004 to 2011.

4. How have you have handled the administrative/legal issues that have come up with the formation and running of the organization?

1. Over several years the staff of the clinic has made a rule book for running of the clinic. Every rule in there has gone through discussions in the weekly meetings and has been arrived through consensus.

2. There are 9 committees running the clinic including a steering committee that is elected by all staff members.

3. We have got proper licenses from the state government for the production of herbal medicines and our medicine samples are tested by the government-run laboratory.

4. We remain careful that all our activities are directed towards fulfillment of the major objectives as presented in our trust deed.

5. What are the restrictions you feel (if any) that have been put on you from government/private/corporate sector?

So far, we have not felt any restrictions from the government or the corporate sector. Rather almost all referrals we send to government hospitals are honoured.

6. As a group working to give low cost services was there any pressure from private practitioners, pharma or other commercial establishments? How have you handled it?

We provide free services and have not faced pressure from commercial establishments.

7. About the work you do in brief

We provide free medical care through integration of modern medicine, Ayurveda and Yoga to those poisoned by Union Carbide (through acute gas
exposure or chronic exposure to contaminated groundwater) including diagnostic facilities and medicines. We grow and manufacture herbal medicines, carry out community health and community research work and run a documentation unit. Between 150 and 200 persons visit our clinic which is situated in the middle of the gas and contamination affected area. A population of 45,000 is benefited by our community health work and our research cohort has close to 100,000 individuals with different histories of toxic exposure. We do not accept funds from corporations, governments or large funding agencies.

8. What are your achievements/success to date?

1. Provided free medical care to over 60 thousand persons through Ayurveda, Modern medicine and Yoga.
2. Over 35,000 persons exposed to Union Carbide’s poisons (25, 217 gas exposed, 7,330 exposed to contaminated water and 1,522 with both kinds of exposures till 11/12/2019) registered for long term care.
3. Growing from a small outfit of 12 staff and 1200 sq. ft workspace to a clinic spread over two acres with a staff strength of 59.
4. Developed treatment protocols through the integration of modern medicine, Ayurveda and Yoga for safe, simple, inexpensive and effective treatment of problems caused by toxic exposure.
5. Successful treatment of chronic illnesses through Ayurvedic detoxification procedures of Panchakarma.
6. Provided effective drug-free therapy to over 9000 persons, majority of them Muslim women, through Yoga and Pranayama.
7. Providing facilities for Biochemical, Microscopic, Microbiological and other laboratory investigations.
8. Computerized Medical Information System customized to ascertain therapeutic efficacy and incorporation of treatment protocols in different systems of medical care.
9. Funds for running the Clinic have come through small contributions of over 30,000 ordinary individuals and without any donation from Corporations or funding agencies.
10. Eradication of malaria and dengue, reduction of TB, cervical cancer and anaemia in a population of over 40,000 through Community Health work with support of over 100 Community Health Volunteers.
11. Inspiring and training health volunteers to grow herbs in 6 community herbal gardens and promoting their use in addressing a majority of common ailments.
12. Developed and successfully used simple inexpensive technology for testing contamination in groundwater.
13. Growing 100 kinds of medicinal plants without using synthetic pesticides and fertilizers. Providing 60% of the raw material for in-house production of herbal medicines.
14. Manufactured 85 kinds of Ayurvedic medicines following standard texts and adhering to strict quality control.
15. Published research papers on health impact on children of parents exposed to toxic gas in prestigious international medical journals.
16. Carried out health survey to document the impact of exposure to toxic gas, contaminated groundwater or both, on close to 100,000 persons.
17. The most complete repository of information on medical, scientific, legal, corporate, survivors’ campaign and other aspects of the Union Carbide disaster and its aftermath.
18. Addressing global medical issues such as treatment of chemical injuries, antimicrobial resistance and safe disposal of medical waste.
19. Won several national and international awards including the “Mead 2001” for exemplifying the Anthropologist’s famous words: ‘Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it’s the only thing that ever has.”
21. All cleaning in the clinic is done with Soapnut (Areetha), mopping done with water in which
Neem leaves have been boiled, toilets are deodorized with effective microorganisms and herbal mosquito repellents are produced in house by sanitary workers. Solar disinfection is used for disposal of medical waste.

23. Participatory democracy in action in the running of the clinic where every staff has equal rights and rules is made (or unmade) and implemented through discussion debate and consensus.

9. What are your limitations?

First, regarding our inability to influence the dominant health care system, you may fault us to be ambitious but we thought that if we present enough positive examples of better medical care and highlight the terrible consequences of the prevalent medical response we could contribute to improving the prevalent system of health care through push and pull. In 2007 we added the political pressure of the survivors’ organizations. Among the demands pressed by several survivors’ organizations was a demand that hospitals meant for the medical care of survivors must provide Yoga therapy. The data in support of the demand was that generated by the clinic. After a 17-day fast by several survivors and supporters, the government accepted all the demands of the organizations including Yoga therapy. The data in support of the demand was that generated by the clinic. After a 17-day fast by several survivors and supporters, the government accepted all the demands of the organizations including Yoga therapy. To start with the state govt agreed to pay two Yoga instructors (trained by SAMBHAvNA’s Yoga therapist) to work in two government hospitals for survivors. After two years of their work and collection of data on successful treatment with Yoga of over 2000 survivors (and written testimonials from many), we wrote to the chief minister (presenting the data from two govt hospitals) to make Yoga therapy available in all hospitals meant for survivors of the disaster. On the basis of our letter the chief minister’s office wrote to the six hospital superintendents to respond to the SAMBHAvNA clinic’s claims that 1. Yoga helped avoid side effects of allopathic medicines and 2. Yoga offered the possibility of providing sustained relief from exposure-related ailments. The answers to all the superintendents were the same – 1. Allopathic meds had no side effects and 2. Yoga could do nothing for exposure-related ailments. On the basis of these responses from the six superintendents, the state government stopped providing Yoga therapy in the two hospitals.

Regarding our inability to take advantage of opportunities, I believe we could do a lot more than what we do in a place where herbs are grown, medicines are made and that has a well-equipped laboratory. Also, in a place where we have facilities for providing care through different systems and for storing and processing clinical data on a regular basis, we could do a lot more in assessing comparative efficacy and developing treatment protocols.

10. What role do you feel youngsters have to play in such organizations/ What are the opportunities for the younger people in your field?

I think young medicos can contribute a lot to Indian society but it is currently not happening. I hold our medical education system responsible for this. Over the last decades, I have witnessed medical education becoming much more expensive and exclusive and with the sole purpose of enabling students to make money after they pass out of the system. Whatever little I know about AYUSH does not inspire any confidence that it will/can address issues of public health effectively.

Compared to an earlier generation, I think young people today are much more alienated from immediate realities, much more conforming and more materialistic. It is good to find them less bothered about traditional mores and outmoded ways of thinking.

11. What has been the role of MFC in your work of SAMBHAvNA?

From what I remember, MFC as a group stopped doing anything on or even paying attention to the medical situation in Bhopal after 1991. Two of the original trustees of SAMBHAvNA were MFC old-timers, and one of them, Dr Padma Prakash, continues to be on the SAMBHAvNA Board. MFC as a group never interacted with the SAMBHAvNA Clinic in the last 23 years. I do not know the exact reason behind MFC’s non-response to the ongoing medical disaster in Bhopal or to SAMBHAvNA, but I think it is a question serious enough for the younger MFC people to probe. However, I doubt that honest answers will be provided by the old guards.

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Working in Difficult Areas: Experiences and Dilemmas of Young Doctors

— Sarinkumar, Nidhin Joseph, Sachin Barabde, Ayswarya Revadkar

This paper contains first-hand experiences and dilemmas of young doctors from across India who have been working in difficult, remote and conflict-ridden areas of the country. Their stories teach us not only about the challenges and conflicts that arise from working in these areas but also the strength, courage, and determination that they have had to draw upon in order to persevere.

1) It was 5 pm when I saw a family consisting of a 20-year-old man with his 19-year-old wife who was pregnant, along with his 2-year-old son and two of his sisters-in-law. They had come from a village on the other side of the big river named after a local word meaning ‘God River’. They were sitting on the parapet wall of our PHC. As the OPD time was over, the nurse asked them why they were so late in coming to the PHC. Grimacing with pain, the man said that the family had left their village at 10 am in the morning and as all of them were sick with fever and chills, they could not walk continuously and had to take rest while walking. In addition to this, they had to cross two big rivers which had swollen to their limits due to heavy rains in order to reach the hospital. A healthy person would only take 2.5–3 hours to reach the PHC from the village from which they came, however, it took 7 long and tiring hours for this family. As I inquired about his health, the man told me that he kept asking God while walking as to why he had given them such a terrible sickness. Out of the five members of this family, two tested positive for falciparum malaria. This malaria is the most dangerous of all - the kind that affects the brain.

On the evening of the same day, anti-malarial treatment was given to those who tested positive. Despite their sickness, the family refused to get admitted and went to stay for the night at their relative’s place in the village. The next morning we found out that the remaining three family members had suffered from fever and chills for the whole night and they subsequently tested positive for falciparum malaria.

This story illustrates just how common malaria is in this area of North Eastern India during the rainy season from June to September. In fact, malaria never disappears from this area at any time of the year. Every year the people here die from malaria-related complications, especially due to delayed diagnosis and initiation of treatment. In addition, as this area is one of the most remote in the hills, doctors never serve in the PHC for long. This leads to insufficient monitoring of ASHA and ANM activity as well as inadequate training of ASHAs on the latest malaria treatment guidelines. Even if they somehow receive training, government anti-malaria drug supplies are erratic and the ASHA’s do not receive enough medicines.

As mentioned, the village from which the family came is situated in one of the hill districts of a North-Eastern state in India. The village is only 37 km away from the town in which the PHC is located - however, it still takes 3 long and painful hours to reach! To provide some context, the villages in this area are rich in mineral resources, most commonly coal. The people have done coal mining for a very long time and the trucks are so overloaded with coal that they wear out and destroy the roads in the area. Big stones also block the way on the roads. In some areas, the paths along which people travel look like river beds that have gone dry. We have heard that roads have been in this condition since India’s Independence. The roads after having been fixed once, none of the authorities have bothered about this to this day.

This was the experience of Nidhin Joseph, who along with his wife Sejal, has worked in many difficult and remote areas of India. Their journey has been full of excitement, new experiences, and learning. They have lived and worked in many different geographical areas and along with people from different cultures. This includes a year of working in the extreme conditions of Antarctica as part of the India Antarctic program. It is important to understand that every time they have had to work in a different remote area, Nidhin and Sejal have had to prepare themselves mentally. This preparation included visiting NGOs working in the area, which not only gave them an understanding of the ground realities they might face when working there but the amazing work they encountered served as immense motivation for them to move forward. Nidhin and Sejal also took the effort to mentally prepare their own family members regarding their work. This involved open discussions, sharing experiences, and they even invited their family members to visit the places where they were working. Once their family members were able to witness the kind of work they were doing and understand their motivation in doing so, any resistance that came from their family would eventually fade away.
There were, of course, immense difficulties and major challenges that they had to face, however, the biggest strength that Nidhin and Sejal had was each other’s support. One plus one worked as three for them in a beautiful way.

2) Next, let us take a look at the experiences of Sachin Barbde who is a public health doctor and has worked in conflict areas in India.

During my undergraduate days as a medical student, I had the amazing opportunity of participating in the NIRMAM camps. NIRMAM is a youth initiative started by Dr Abhay and Dr Rani Bang to identify, nurture and organize young changemakers to solve various societal challenges. It is an educational process to train the youth to tackle crucial issues and problems in society. NIRMAM provides guidance, expertise, and the environment to inculcate self-learning and encourages social action. Participating in NIRMAM was a huge inspiration and motivation for the trajectory that my work has taken. As part of the camps, we would go to villages to serve the rural poor as well as actively discuss the need for improved healthcare in rural areas. As a result of this, even as an undergraduate, I wanted to continue on with the same work. Once I finished my internship in 2011, I decided to do the compulsory rural bond service. This was unusual back then as most of my colleagues did not choose to do this.

As part of the rural service, I worked for one year in a remote PHC in an underdeveloped heavily forested area of a central Indian state. The place was difficult to reach and had internal political conflicts. It was challenging for me – I had lived in a city until then and now I had to adjust to village life, in a remote and difficult part of the country, and with an ongoing conflict situation on top of that! I was not sure how I was going to handle it. However, I saw it as a test of my endurance and motivated myself to move ahead.

The area was very difficult to travel to due to geographical reasons. The public transportation services were not regular and there were frequent strikes (bandh/hartal) by rebel protesters that made daily life difficult. I had to stay alone in the PHC that had limited facilities. Irregular electricity and a poor telephone network made the stay tough. However, the real challenge for me was the fact that I was not familiar with the role of a PHC medical officer. I had no clue what the duties and responsibilities were or what was expected from me. I just knew that I wanted to serve the people.

However, the irony was that not many patients came to the PHC for OPD services. In addition, the majority of the patients were reserve police personnel deployed there to control the conflict. Initially, this demotivated me as I had come to a remote place to serve the neediest people, however, the people were not coming to avail of my services. I was disappointed, but I didn’t stop and began to understand why the situation was the way it was. In the past, the services did not run on a regular basis and officials would not visit sub-centres due to the armed conflict. I believed that if I was doing good work, with the intention of helping people, then nobody would harm me. Therefore, I decided to go to the villages and visit each of the sub-centres. From doing so, I slowly gained the trust of the people and they started coming to the PHC.

During one of the government programmes that was being carried out in a village, when I along with a few others were kidnapped by the rebels. We were in their custody for around 4 hours and although they were armed, they released us without causing any harm. That was the only incident I had due to the conflict in the one year that I served there. I did not feel any fear, and in fact, it was exciting for me to be in that kind of situation. However, I did not share the incident with anyone, especially with my family and they still do not know that this happened. From the very beginning, convincing my family regarding my work in a conflict area was the most challenging task for me. Even after having worked in similar situations for 8 years now, they are still not convinced. I’m still struggling with this today.

Other than this, one year of my service went by without any other incidents. However personally, I struggled with intellectual loneliness. There was no one else to share my feelings or thoughts with. It was especially difficult during the days there was no telephone network. But I am glad that the scenario today is different, and there is good mobile connectivity even in the villages, which is an advantage for those serving in rural areas.

Sachin feels that the experiences of working in remote conflict areas enabled him to learn and grow on both professional and personal levels. He was able to identify his strengths and weaknesses and was able to understand that in order to provide good services in rural areas, he needed to improve his clinical and administrative skills. His work in these areas enabled him to travel widely, visit many different areas and interact with various people. Every experience gave him the knowledge and wisdom to move further and further ahead.

3) We will now move on to Sarinkumar, who is a medical doctor and has a great deal to share regarding his experience of working in a conflict area in India.
I had the opportunity to work in a situation similar to the one Sachin talked about. I was working on a primary healthcare delivery project with an international humanitarian organization in a district of an underdeveloped but heavily forested state in India. The district had a major problem with rebels, who were fighting against the government. The place was under the control of the reserve police force and under a high-security radar. Mortalities associated with clashes between the police and rebels were common. The district also had a very low literacy rate. Our base was located in the district headquarters which was a small town with basic facilities and could only be reached by road. The nearest railway station and tertiary level healthcare facility were around 180 km away.

As part of the project, the organization conducted daily mobile clinics to remote tribal villages. Teams consisting of doctors, nurses, translators, drug dispensers, lab technicians, health educators, and other support staff, together with equipment and essential drugs would go daily into the villages. The remote interior villages were controlled by the rebels and the government and security forces did not have access to those areas. On the other hand, people living in those villages did not have any government facilities for healthcare or education. The villages were located deep inside the forest without proper road connectivity to the town. For the tribal people, more than connectivity, fear of the ongoing political violence and strict security surveillance held them back from visiting the town and accessing essential healthcare services. They still lived a basic life without realizing the advancements that had been made in science and technology.

As vehicles could not reach the villages completely, our team would have to walk around 5 to 7 km carrying backpacks that weighed around 10 kg. Clinics would be set up under a tent, and most of the time the number of patients would be more than 100. The people were extremely simple and poor, which I had never seen before. I felt as if around 1000 years of human evolution had not occurred here. The villagers had fear on their faces and did not trust us, especially because they did not know who was trying to help them and who was exploiting them. Remember that pledge we used to say during school assembly, “All Indians are my brothers and sisters”? Unfortunately, I saw that some of our brothers and sisters were being neglected by our own country and other siblings.

All the children were malnourished, some severely. Most of the patients had malaria that was complicated with anemia or malnutrition, in addition to a variety of skin infections and bad abscesses. The dilemma I faced was the fact that I was totally helpless and had no idea how to help them. I really did not know whether our medical treatment was helping them as we were treating them for the illnesses and then sending them back to the same situations which made them ill.

As mentioned before, most of the interior villages were controlled by the rebels. Our organization had to face immense challenges to reach these villages, particularly because of the frequent fighting. Even though the organization had a system to assess and manage the risk involved, we had some horrifying experiences. There would be a security meeting every day before the teams left for the field. Everyone needed to wear the prescribed uniform for identification. Each team had a team leader, who was also the security focal person. There were also restrictions about traveling around and moving out of the residences after dark. I received an extensive security briefing before joining the project. To be honest, I was a little apprehensive about safety after hearing the possible dangers however once I joined the team and saw the wonderful work that was being done, I was able to get the confidence to face the challenges. The teams were alert and mutually supportive in all regards.

I would like to highlight one of the incidents that occurred whilst I was working. One day while our clinic was going on as usual in a village, we started to hear repeated gunshots firing in the background, a sign that fighting between the government and rebels was taking place. It is difficult to explain what I felt at that moment, but it was both a rush of adrenaline and fearful excitement. Thankfully, nothing happened to us, and we safely returned back to the base.

I also faced multiple other challenges. One was on account of the weather, as I reached there in the summer and it was extremely hot. That was the first time I was exposed to temperatures that high and even the bathing water was hot throughout the day. The house we were staying in often felt like a concrete box and like sitting inside an oven. The hot weather made me exhausted both physically and mentally. The mobile network and the internet were good for nothing and the connection extremely unreliable. Due to the ongoing conflict, there were often shutdowns of the network indefinitely. I remember that at one point, we did not have any way to communicate with the outside world for more than a week. Despite this, it was an experience that I will never forget and that made me grow and learn in many ways.

From looking back on his experience of working in an unstable situation, Sarinkumar feels that it made him much stronger from within. There were
times when he was emotionally depressed due to the difficulties he faced but at the end of the day, the single thought of ‘why am I here?’ gave him the strength to hold on and persevere. He is always eagerly waiting for the next opportunity to jump on and to experience the challenge again.

4) Finally, let us learn from Ayshwarya Revadkar who is an obstetrician and has worked as a medical officer in conflict areas. From her personal experiences, Ayshwarya has several thoughts on the challenges and advantages of working in conflict areas.

- It is difficult to get the authorities’ attention regarding the necessities to improve healthcare and public health infrastructure in these areas. In my experience, limited administrative support for the expansion of services can be very demotivating.
- Reaching peripheral areas for providing health services can be stressful. Sometimes there is a real risk, or in other cases, an assumed or perceived risk. Oftentimes, nobody can be sure whether it is safe to visit these areas or not and this leads to a lot of fear.
- As an obstetrician and gynecologist, I have observed that when female patients come to avail of different services, due to conflict and security issues, their husbands cannot accompany them. Therefore, the decision making on ethical and moral issues is often left to us and we have to take the best-suited decision for the women. This is not recommended ideally and fiercely fought against by many NGOs. Even while writing this sentence, I feel afraid of the judgment that I will receive.
- Due to a lack of resources, even human resources, sometimes the best treatment is not provided for the patient. This can cost a life and doctors have to carry this guilt. Particularly because in such places there is no luxury of referring patients to a higher level of care, mainly due to lack of accessibility.
- There are also delays in health-seeking, and patients come when they are at a very advanced stage of their disease or condition. For example, in the case of pregnant women, home delivery is tried as a first resort and she is kept at home for a long time. By the time the woman reaches the hospital, it would already be a very complicated case, and in many instances, the death of the mother or child could occur.
- It is important to keep in mind that there are no other specialists for help, and therefore doctors working in these areas need to be skilled and also stable minded. It does not matter how much experience one may have, it is a completely different experience working in remote and conflict areas.
- Working in these areas is emotionally challenging. It is common to feel intellectual loneliness and emotional exhaustion. People may think that a higher salary package is enough to retain a workforce in these areas, however, no amount of money can bring about happiness or cure loneliness. Doctors need to be mentally prepared, motivated and receive emotional support.
- Whilst working in these areas, doctors do not have as many opportunities to update their knowledge by attending conferences or training programs as travelling long distances is very difficult in terms of both time and money.
- Inadequate public transport is always an issue in such areas.
- A doctor’s own health issues can worsen, as finding specialist care can be very difficult in these areas.
- A doctor’s personal and family life can also get affected due to connectivity issues, the odd hours of working and mental strain that he or she is already under.
- However, working in remote, conflict areas is not filled with challenges alone. There are several advantages as well!
- The peripheral health workers are very motivated and can inspire doctors to do better and continue on with their work.
- Many government officials also do outstanding work that can serve as inspiration.
- One can also meet like-minded people. Personally, I met many people from different fields doing amazing work in these areas.
- Sometimes there is less corruption in the health facilities in these areas than in other parts of the country, which can provide hope for doctors.
- The work being done can be professionally and personally very satisfying.
- Doctors can develop their clinical and personal skills as well as gain new and varied perspectives towards their practice and life in general.
- Living in remote pollution-free, traffic-free areas can be very liberating.
- There is often free time to pursue other interests and hobbies.
- From this work there often comes positive recognition within a doctor’s family and society.

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MFC and the Young

One is tempted to go back to the past and understand what was the scenario when MFC was started. Very beautifully explained by Ashok Bhargav in MFC Meet of 2019, it depicts that MFC began to cater to a specific need of the youth in the country. Motivated social change-makers found themselves lost when they found that the ground realities were very different as compared to what they had studied and learned in colleges. And MFC worked as a very good support group in testing times over the years in difficult circumstances.

Going through some of the earlier literature published by MFC, we came across the article “MFC: Which way to go?”. It consisted of a discussion that took place in the 4th Annual Meet of MFC in Kerala, to settle the role and limitations of MFC. To quote from that article “…MFC found itself at the crossroads. The attempt at a deep analysis of existing socio-economic issues and the feeling in some quarters that without a socio-economic change, no change is possible in the health system, were not acceptable to all present. This was not the role of MFC, it was felt. If not, what is and what should be its role?” It was almost amusing to note that this could perfectly summarise the conversations we had with several young members of MFC, that are actively involved in working in public health, over the last 2 years in our attempt to understand their perception of MFC.

Going through some other literature put out by MFC, we came across similar discussions that took place several times over the years. The questions were more or less the same, but the answers have evolved according to the social context at that time, with the concept of a ‘friend circle’ remaining unchanged at its heart.

Today there are a different set of challenges. Or let us say that challenges/dilemmas in the past exist even today under different faces. There is a dire need for the youth to engage proactively in the social sector and take up challenges facing the country. However, a commercialized health system, the vicious circle of insecurity leading to mad race behind post-graduation, declining ethics and value systems and the challenging political environment all seem to be hindrances to health professionals today.

Can MFC still be a support structure for the confused youth in this country? Today there is a need for MFC to answer the following questions:

1. Does MFC feel the need to adapt itself to changing perceptions among today’s youth?
2. What are the steps MFC can take and have taken to be more inclusive of the youth?
3. Whose felt needs should define the future course of MFC?

At this juncture, MFC itself has to face a dilemma: To deliberately redefine itself as a youth-friendly organization or not. The following points emerged from the above-mentioned conversations –

Questions on the Bulletin

While the intellectual interpretation of problems is important it has to be kept in mind that the vocabulary one uses can be a big barrier to understand the core issue. Often the papers have been criticized to have complicated jargon and very few read and understand it. Therefore, the authors must make it a point to use simple language and attempt to explain the difficult concepts that they are emulating, or suggest references for reading and understanding the issues further. Any interested young member can thus improve his understanding.

Historically MFC has been a thought current in response to felt needs in the country and ground
realities. This made it a strong and immediate support group for the members to help them respond to the problem. Going through the earlier bulletins, it can be observed that it is a means of sharing real-life experiences, viewpoints, comments, and reports of who is doing what. It gave an impression of a group of friends talking to each other. Nowadays the bulletin has more objective analysis and scientific papers side-lining the personal touch of issues which was the predominant feature at the beginning of MFC. This is important no doubt, however, the personal touch is invariably lost if technicalities are to be given an upper hand.

Questions on Discussions During Meets

We have observed that several of the MFC members fall into either of two groups – one, those that study issues with an academic approach, and second those that work on the ground level. While both of these groups play very important roles in their own ways, they differ in their method of articulation and presentation of their points of view. MFC is an excellent platform for these two groups to interact and understand each other’s work.

As MFC is witnessing a rising trend of youth attendance in meets discussions must be made easy to follow for these youth who may be witnessing such discussions for the first time. That may mean that members have to take on a somewhat teaching role at a slower pace so that the younger members that are eager to understand the issue can follow and ask questions.

Questions about the Overall Structure and Working of MFC

Energy is one of the important characteristics of youth. The youth likes to engage with the issues first hand on ground. Therefore, intellectual discussions leading to a deeper interpretation of the issue may not be sufficient to invoke the interests of the youth. So, every issue must be discussed with pre-set objectives that can guide action, individual or collective.

MFC has members with extremely rich experience in matters of health at different capacities. It is a natural eagerness for new members to get to know them. For this, we believe the interaction between them becomes a part of the structure of the meet rather than be a mere desirable activity.

MFC is an excellent opportunity for networking among its various members from all over the country. The young members attending MFC are always in search of opportunities to volunteer or engage with various social organizations. So, there has to be an attempt to facilitate the discussions amongst members related to work interests.

An organization is a reflection of the ideologies of its members. MFC with many of its members inclined towards Leftist ideology does a lot of brainstorming and intellectual interactions over an issue. While these are important to understand any issue in-depth, are these discussions turning around the view that only a complete socio-economic change in the society can render any other health-related activity meaningful, thus encouraging a sense of inaction? This is not to belittle the possibility of a complete revolution in socio-economic systems however such an approach could discourage an enthusiastic young member from taking up any activity in his/her own capacity.

As MFC OC members of this year’s meet, it has been a privilege to work on designing the overall structure and content of the meet. We have realized in our experience that democracy is one of the strongest and most valuable characteristics of the structure of MFC. We have discussed, talked to various members and at times have very confidently demanded certain things and MFC members have helped us all along the way. It is our sincere hope that the discussions about the above-mentioned critique of MFC go along in a similar spirit and we democratically reach a conclusion.

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Personal Responses of Some Senior MFC Members

Ashok Bhargava and Lata Shah - Ulhas Jajoo - Narendra Gupta - C. Sathyamala - Saibal Jana - Lindsay Barnes - Prabir Chatterjee - ‘Chinu’ Srinivasan

Our Journey as Social Workers

-Ashok Bhargava¹

1. How did you get oriented towards the social sector in your younger age?

Our family faced hardships when I was a child. It gave me first-hand experience of marginalized people’s lives. Later when I was in college, I went to work in famine struck Bihar in 1967 where I saw the death of a Dalit woman due to hunger. This event forced me to devote my energies and skills for social transformation. I didn’t enter this field due to the attraction of any idol or ideology.

2. What were the challenges/dilemmas/problems which you have faced?

When raised in economic hardships, you are expected to earn money to improve your family’s standard of living. Despite pressure from my family and relatives to take this path, I chose to work for marginalized people, disregarding economic security.

3. What were the solutions you took in order to deal with these issues and move further?

Though individual efforts and initiatives are important social transformation requires social movements. I was part of an organization called Tarun Shanti Sena which brought thousands of young boys and girls together to work for social change based on values like - democracy, secularism, national integration, world peace, social equality and economic justice. Lots of young members followed the Gandhi’s maxim “Be the change that you wish to see in the world.” They preferred intercaste marriage to break the caste barrier. Some of them even chose partners from different state, language, culture and even religion. We put gender equality in practice, declined dowry, and declined to inherit parental property.

We raised our voices against the education system which failed to provide Life Skills and employment. Some of us burned our degrees - many left their studies half way in order to learn from life-experience. Medicos in Tarun Shanti Sena were under the impression that medical education is fine until one of them realised its shortcomings during his rural posting. A discussion on this topic gave birth to Medico Friend Circle.

When Mrs. Indira Gandhi imposed emergency in 1975 suspending fundamental rights of the citizens, we became part of the movement to restore democracy. Some of us who were arrested under MISA (Maintenance of Internal Security Act) remained in jail for one to two years. Some of us worked with the marginalized people to restore their rights related to land, forests, health, education, livelihood, etc.

4. Your work in brief

I am neither a leader nor an expert or a professional. I enjoy working with my hands and problem solving with my brain. I like to work as a team member. Most of my learning and training were results of responsibilities, tasks and challenges I got involved with. It is different from formal education where one learns first and apply it later.

I spent 4-5 years in strengthening Tarun Shanti Sena and MFC as their national convener. Stayed in villages of Gujarat for almost 12 years where I got opportunity to learn about health problems and behaviour of marginalized people (working as a Village Health Worker). Working with out-of-school children gave an opportunity to understand “how people (children) learn?”, pedagogy and epistemology. Construction of dispensary using local resources taught me low-cost architecture. Investigation of jaundice in Ahmedabad gave opportunity to learn some aspects of epidemiology and public health. Every learning helped in exploring and grasping other problems. Like, for instance, working as a VHW and understanding “how people learn” helped us in designing the health education material and training programs for rural people when Lata and I got involved in it.

Lata started her social work in Arunachal Pradesh after completing her MBBS. Afterwards, she worked with trust hospitals catering to minorities and marginalized women. We joined together to prepare health education material and training programs for rural people when Lata and I got involved in it.

¹Email: idealindia1@gmail.com
5. Looking back, what do you feel have been your achievements?

The role of a social worker is to facilitate empowerment of people among whom he/she is working. Going back to Gandhi’s talisman,2 Gandhi’s talisman: I will give you a talisman. Whenever you are in doubt, or when the self becomes too much with you, apply the following test. Recall the face of the poorest and the weakest man [woman] whom you may have seen, and ask yourself, if the step you contemplate is going to be of any use to him [her]. Will he [she] gain anything by it? Will it restore him [her] to a control over his [her] own life and destiny? In other words, will it lead to swaraj [freedom] for the hungry and spiritually starving millions? Then you will find your doubts and your self melt away.

] assessment of our work should be judged on: “Has s/he gained anything by it? Did it restore him/her to a control over his/her own life and destiny?”

(Examples of people’s empowerment can be seen in the abovementioned report.) Whatever learning and experience we acquired during our activities of preparing health education material and training of health workers we shared with other colleagues in MFC through workshops.

6. What have been the limitations of your work? Where did you feel you were not so successful?

We wanted to achieve health for all through strengthening the public health system but ended up in creating trust hospitals providing curative services. Not much has been done in preventive and promotive health.

While working with village people we lost touch with students and could not mobilise them for social change like we did in the Tarun Shanti Sena days.

7. What is that message you would like to impart to us who have just begun their journeys?

1. Journeys of young medicos of today will take place in a different world than that of us older ones. Always remember that you are not just doctors but human beings having many talents other than diagnosis and treatment of illnesses. Health problems are the products of social, economic inequalities, political and environmental problems.

2. Life is not a planned journey or a packaged tour itinerary. It is a journey to explore the untravelled world full of surprises and unknown challenges.

3. Our objective should be to empower the people to tackle these issues and take control of their lives and destiny.

4. The world is armed today with sophisticated technological solutions to every human problem, yet the majority of people suffer from malnutrition, unemployment and chronic illness. This obvious contradiction suggests that Gandhi’s plea for local self-reliance in the matter of basic needs deserves to be heard again. It requires creative and imaginative solutions.

My Journey

-Lata Shah

I was brought up in a well-to-do middle class family at a small town in Gujarat. I never faced any hardship but was sensitive to the needs of poor people. Imbibing good values from parents and teachers I decided to become a doctor to serve the needy people. After completing my MBBS, I went to Arunachal Pradesh in 1975 to work at health project started by the Tarun Shanti Sena. After coming back, I did MD in Obst & Gyn and served in a trust hospital catering to the poor women of minority community for 10 years. Thereafter I worked with trust hospitals working among very poor communities of Banaskantha and Sabarkantha district of Gujarat. I conducted clinics in remote villages and major surgeries in trust hospitals.

I came to know that most women suffer from iron deficiency anaemia and undernutrition. Women and village TBAs don’t have necessary understanding of reproductive system. I had to treat and operate several cases of prolapsed uterus which were result of TBA vigorously pushing uterus to expel the placenta fearing that it will ascend to lungs. They believed that the uterus is open from the top. We produced a life-size model of uterus to correct this notion.

Since 1998 I worked full time with IDEAL to prepare health education material and training of village health workers. Working with tribal women I found that they were very sharp and quick to grasp new information and could remember and recall important points without taking any notes. Their strategy of learning by doing was far superior than ours. (This common journey is covered in IDEAL: A Decade of Learning[ op.cit.3])

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Holistic Rural Health: A Sarvodaya Way

-Ulhas Jajoo

It (Ulhas Jajoo (2012): Towards Holistic Health, the Sarvodaya Way. MGIMS, Sevagram, Wardha 442102) is an experiential book written in the format of a story. The real hero, nay Ram, of this story, is the poor whom Bapu called daridranarayan. The real purpose of our experiment is to empathetically relate ourselves with the emotions and sufferings of the common man. Definitely, service is inherent in this experiment, but we don’t want people to go on seeking crutches and least of all to develop a dependency syndrome. Our basic premise has been that our work should not remain confined to ivory-tower discussions and thinking. Rather we should work together in close collaboration with rural society.

The basis and direction of our work have been inspired by the thoughts of Gandhi, Vinoba and Jayaprakash. The context of our work is also closely linked to the thoughts of these three great personalities. We would be more than satisfied as long as we are taking some steps towards the path shown by these great souls.

Health care was our medium for entering into village life. Our endeavour was to reach out to the poorest of the poor of the villages. Our attempt has been that nobody should die due to the lack of medical facilities. We got rid of vaccine-preventable illnesses. We could prevent the deaths of gravid mothers at home. The mathematics and logic of our 33 years of experience tell us that the amount being spent per head by the Government of India on health services would prove adequate to provide quality health care to the people if it follows the pattern of Kasturba Hospital, Sevagram. The only condition is that the whole amount must be spent in a systematic and scientific manner and the money should lie in command of Gram Sabha. But that requires strong political will coupled with a constructive effort to give it a practical shape. The control over resources and participatory decision making are the real pillars of such a structural transformation. Then alone we could move towards gram swaraj.

In the course of work, it has been our day to day experience that science doesn’t have complete cures for many diseases and human problems. Our medical knowledge is very limited. Unless we change the economic, social and political structure of society, many of our problems cannot be solved.

The mantra given by Gandhi and Vinoba for self-reliance and people’s awakening through Constructive Programme is the real path for us to traverse. By transcending the boundaries of health care and medication, we have launched projects like one latrine for every home, village dairy with the participation of every household and irrigation projects to take the water to the last agricultural plot of the village. All these projects were launched on the basis of the participation of villagers and taking the village as the basic unit of the society. We didn’t want to beg to finance our projects. We have successfully tried to raise a model of development based on self-employment. To that end, we have mobilised Government development funds including those of the Gram Panchayat and supplemented it by part contributions from the villagers.

In the process of successfully undertaking development work, we came to realise that economic prosperity breeds selfishness and cut-throat competition and many types of self-indulging addictions. All these prompted us to do self-introspection and self-evaluation. The search for remedial measures then began for preventing moral degeneration. We could fully understand that self-interest driven groups would promote selfishness. This realisation also inspired us to find ways and means to come out of such labyrinthine chakravyuha.

We came to realise that we have to shake and arouse a deep sense of devotion and faith hidden in the very depth of human beings. But it has to be tested on the touchstone of human rationality and in the process we have to move on the sacred path of action. We have to find devoted and sincere people for such an arduous journey. In the process, we could identify three constructive programs to move forward in the right direction. They were:

Self-Help Groups of Women

Women are the most oppressed section of society. They have to bear the brunt of immorality in society. Therefore, they are the natural custodians of morality and saner norms in society. We came to the conclusion that the moral fibre of society could be strengthened if women’s organisations became strong. It was with such an understanding and resolve that we started with SHGs of women. The group resolved that we would not depend on Government subsidy for its sustenance. Nor would it be a caste-based group. We would rather make it a system in which the poorest of the poor women could participate and all decisions will be taken by consensus. The group would attempt to achieve financial self-reliance by raising a collective fund.

In the course of time, the sufferings of women came to fore which led to the prohibition movement in many villages.

Organic Farming for Self-Reliance

Agricultural workers are being exploited by market forces. They do not get adequate and just value and recognition for their hard labour. Those agriculturalists who have taken the pledge for organic farming would not use hybrid seeds or chemical fertilisers. They further decided that they would go in for natural farming and would produce for their self-consumption rather than for the market.
Self-Reliance in Clothing

The cotton-producing peasant families prepared their own threads on the two-spindle ambar charkha for their clothing and thus learned a lesson of self-reliance in clothing. They could get clothes in lieu of their cotton and in the process, they discarded lafanga rupaya (the depraved currency) which is the means to exploit bread labour in the market. Thus they learned the lesson of vowful commitment.

We have found some friends who are socially committed and inspired to action in village society. They could firmly move forward on the path they had resolved to tread. We could easily identify sajjan shakti (the power of virtuousness) among these friends. Health Assurance scheme encourages and supports these committed people and constantly reminds them of their mission.

The ultimate purpose of this book is to prepare a kind of balance sheet for our work and record our experiences. All said and done, it is for our readers to judge as to how far we have succeeded in our mission. We would be happy if our readers and well-wishers join us in pointing out the shortcomings of our experiments and thereby strengthening our work by giving a better direction.

My response to your questionnaire

1. How did you get oriented towards the social sector in your younger age?

I was inspired by the Sarvodaya thought process from childhood. I had imbibed values from movements such as Kishor Shanti Dal, Tarun Shanti Dal, and Sangharsh Vahini. My grandfather Shrikrishnadasji Jajoo was an associate of Mahatma Gandhi working to organize constructive programmes for Khadi and village employment. So these values were also a part of our family’s lifestyle. The idea that medical science is the means and daridranarayan (the poor) the goal to fulfill one’s responsibility towards society took seat in my mind. The idea eventually took form when Medico Friend Circle started as a group of friends. To fulfill this, MGIMS served as a supporting structure and Dr Sushila Nayar, an inspiration.

2. What were the challenges/dilemmas/problems which you have faced? What were the solutions you took in order to deal with these issues and move further?

It is natural to come to crossroads on the path of experiments. But one needs to have faith that it is not the end of the road. The ability to separate the difficulties one faces in one’s social life and not let it affect one’s personal life varies from person to person. We must remember Gandhi’s words, “My life is my message.” There must be clarity as to what one wishes to accomplish and what can’t be achieved in the limited duration of one’s life as a human being. Also, an awareness and understanding of one’s surroundings are required. Then every obstacle becomes a learning opportunity.

3. Your work in brief

After completing my education in Nagpur GMC, I joined MGIMS in the capacity of a lecturer. Since then my job has been primarily of a clinician, a teacher of Medicine with also administrative responsibilities in the Department of Medicine. At the same time as part of MFC Study cell in Sewagram, we started to work in some villages around Sewagram, which evolved over time. It began as a local clinic for the villages later gave birth to a unique Jowar Health Assurance Scheme. The scheme was designed with the support of KHS Sewagram to render low-cost emergency and IPD care for the insured population. The whole village is insured under the scheme, which is still functioning. This scheme helped us to get acquainted with the village population and their problems on which we could work together. This included vaccine-preventable illnesses, maternal and child care, sanitation, irrigation, and microfinance.

4. Looking back, what do you feel have been your achievements?

We got rid of vaccine-preventable illnesses. We could prevent the deaths of gravid mothers at home. The mathematics and logic of our 33 years of experience tell us that the amount being spent per head by the Government of India on health services would prove adequate to provide quality health care to the people if it follows the pattern of Kasturba Hospital, Sevagram. The only condition is that the whole amount must be spent in a systematic and scientific manner and the money should lie in command of Gram Sabha. We could facilitate movements within villages in the form of programs like Self Help Groups in Women, organic farming for self-reliance and self-reliance in clothing.

5. What have been the limitations of your work?

In the process of successfully undertaking development work, we came to realise that economic prosperity breeds selfishness and cut-throat competition and many types of self-indulgent addictions. All these prompted us to do self-introspection and self-evaluation. The search for remedial measures then began for preventing the moral degeneration. We could fully understand that self-interest driven groups would promote selfishness. This realisation also inspired us to find ways and means to come out of such labyrinthine chakravyuha. We came to realise that we have to shake and arouse a deep sense of devotion and faith hidden in the very depth of human beings. But it has to be tested on the touchstone of human rationality and in the process we have to move on the sacred path of action. We have to find devoted and sincere people for such an arduous journey.

6. What is that message you would like to impart to us who have just begun their journeys?

No message. You should find your own paths.

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Towards Equity in Health in an Impoverished Situation

-Narendra Gupta

1. How did you get oriented towards the social sector in your younger age?

I completed my graduation in medicine in December 1976 from Medical College, Ajmer. I was the youngest in my batch. I could not secure any seat for post-graduation immediately and hence began to look for some job. I got to know that a voluntary organization working in the villages is hiring a doctor for their community health project. I went there and joined them. It is only after joining this organization I began to understand the social aspect of medicine. But I worked with them for about four months before I got a call to join post-graduation in general surgery in my college. But, having seen the other side of the society, I now had an urge to work for communities who are most deprived and inaccessible. So, I could not continue my post-graduation residency beyond one year and began to look for something similar. This motivation saw me getting to one of the most remote areas of the south Rajasthan to work through the voluntary organization Prayas. I was 25 years old when I landed at village Devgarh in 1978 — a village that had no electricity, no all-weather roads, no secured source of drinking water and no proper dwelling to live or work.

2. What were the challenges/dilemmas/problems which you have faced?

The first challenge after getting to the village was to find a place to live and also to set up a clinic to treat patients. Everything had to be makeshift as the village was small and amidst a tribal community. Equally challenging was to raise funds for sustenance of self and the clinic as asking patients to pay would have been pushing them into further extreme deprivation they were already in. So Prayas was created and some funding agencies agreed to support though with a very little amount, to begin with. However, the biggest challenge which I confronted with was about convincing the communities that I am a doctor, can treat human beings for their illnesses and can treat rationally. Most people in the area at that time would not seek any treatment on falling sick, but would approach a faith healer or go to a quack to get injection/s and a drip to gain strength. The common belief among most people of the area was that oral medicines are useless and ineffective. The advice of the faith healer was very important in health as in most matters of conflict. I could establish my credentials as a doctor, after in a couple of cases I was required to give intravenous infusion and stitch wounds. While getting to the area, I had believed that patients would throng in large numbers once they get to know that a formally qualified doctor is available round the clock for treatment and that too they won’t have to spend much of money, but nothing of this sort happened. Only very few patients would turn up and many during non-clinic hours but not generally in the night. The Government primary health care system at that time had one PHC for a block comprising about 100,000 population. But plans were afoot to establish mini PHCs for every 30,000 to 40,000 population. Knowing that a doctor is voluntarily working in this extremely remote location, the Government of Rajasthan decided to handover a newly created mini PHC to Prayas in December 1982. This was perhaps the first time an arrangement of this kind was evolved. Certainly, local politicians and Government health officials were not very happy about this. One interesting instance I should recall here is about our drive to improve immunisation in the area. Before doing the DPT vaccination we explained to parents that children will get a mild fever and they should not worry about it as its the sign of the success of the vaccine. We also provided antipyretics to parents to be given to the children. But, the day after the immunisation, there was a big noise, including in the local newspaper, that adulterated vaccines by untrained persons have been administered to a large number of tribal children and most of these children are now suffering from fever. The CH & HO of the district immediately constituted a committee to investigate the matter. It was good the chair of the committee was a senior specialist of surgery who understood how a DPT vaccine causes mild fever. So, there was clear despair both from the side of people and from the side of the public administration including the health department. Any health targets of the districts not being met would be put to our inability and non-cooperation.

3. What were the solutions you took to deal with these issues and move further?

However, my colleagues and I soon realized that health is intricately linked to livelihood and hence if livelihood is in any kind of threat then

1Email: narendra531@gmail.com
the health will certainly be. So, we began to look into other issues which had a bearing on health – land alienation, people in the grip of bondage, restriction over access to forest resources, and related issues. Any advocacy by us on behalf of the local residents put us up in conflict with the existing power structures of the administration, politicians, forest department, police, traders, excise officials, contractors and distant big landlords who had many people as their bonded labourers.

4. Your work in brief?

So the choice before us, though not the only one, was to silently carry on the work to provide medical services and health education – the latter was most of the time meaningless because almost all families had no required resources available for living a healthy life - or assist people of the area to take on the injustices perpetrated on them. However, we opted for the latter and restricted our medical work to health awareness and entitlements. We decided to work towards mobilization around health and other livelihood issues. This ranged from repossession of alienated agricultural land of people, better access to forests, food distribution, etc. The other set of work was to sensitize Government health functionaries and improving access to public health services. This work led to us being branded as Naxalites and a CBI inquiry was instituted against us which we got to know from the Government affidavit filed by them in the High Court of Rajasthan in 1986. We began to refocus on health issues both from policy and operational perspectives in 1998.

5. Looking back, what do you feel have been your achievements?

In terms of achievements, I cannot think really of any major one but there are many small ones. The first achievement has been that I feel extremely satisfied to have chosen this path, a path that was quite stressful physically, mentally and socially in the initial decade, but not so strenuous physically thereafter as I shifted to living in a town. But I thoroughly enjoyed the stress and still feel that inviting stress willingly is a good marker that helps you think, evolve and move ahead. Managing a mini PHC with outreach health activities from 1982 to 1986 in 15 villages was quite a rewarding experience essentially because the State provided the liberty to shape the interventions rather than strictly follow their directions. It helped us innovate since the area topographically, and in terms of people’s beliefs in modern medicine, was very challenging. Another good experience has been our contribution to the design of the NRHM in 2004 especially the provision of untied funds at every public health institution including at the revenue village through VHSNC which was not easily acceptable to the Government initially. The provision of untied funds in public health institutions has helped make a quantum improvement in enhanced services. Another good experience has been the inclusion of “Reduction in Out of Pocket Expenditure” as a new indicator in the list targets to be achieved in the 12th Five-Year Plan, following a national study conducted by us in 2010 and presented to the Planning Commission of India. Yet another good experience was the launch of free medicines and diagnostics to all in the State of Rajasthan in 2011 and 2012 as a result of our campaigns, and appointment of a very committed and capable bureaucrat to roll it out. Our current attempts to convince the State of Rajasthan to have a Right to Health Act may also materialize.

6. What have been the limitations of your work? Where did you feel you were not so successful?

About limitations and failures, there have been many: the most significant is the inability to build any significant people’s movement around health and equity. Raising resources both financial and human to carry on the work also has been a challenge all along.

7. What is the message you would like to impart to us who have just begun their journeys?

Based on more than 40 years of work in the area of community health mostly at grassroots, my advice to younger colleagues would be to set goals for themselves which help build social, economic equity, including health equity, in our society, our nation and/or globally. The aim should be to envisage how my actions and services support the last person to come out from his/her penury. One of the ways, this could be done is by securing their access to quality and rational health care services. It is not so difficult to do it. The only requirement is to limit our economic ambitions and be ready to take on challenges. Work to be done must be guided by analysis of the social determinants of health of everyone as these could be different for different segments of people. This is all the more essential because the morbidity burden of people in the lowest monthly per capita income category - certainly not less than half of the population of the country are in this category - is very high and they are in dire straits. There is need to reach out to them.

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A Commitment to Justice and Equality

-C. Sathyamala

I trained in an institution whose stated objective was to prepare doctors to work in rural areas. The art of asking questions and the art of listening were central to history taking and woe betide anyone who skimmed over the socio-economic part. Perhaps it was this training that made us sensitive to the economic hardships that families suffered as a consequence of ill health. An incident during my PG training turned out to be one of the defining moments in my life. It involved a thirty-year-old patient with a brain tumor who had been brought from the village by his younger brother. After many hours of surgery, he was wheeled into the recovery room. Two days later he died in the middle of the night without regaining consciousness. As the resident in Neurosurgery, I had to fill in the death certificate. The man’s brother sat down and wept that they had sold their small piece of land to get the brother admitted to this famous hospital. They thought it was their only hope. Now he had to look after his brother’s family as well as his own with the only source of their livelihood gone and a huge debt to pay back. I put down my pen and listened to him until he gathered himself to go and pay the bills without which the body would not be released. I did not dare ask him where he was going to find the money. That was in 1977. Fast forward to 2019 and an article, entitled, "'We sold the buffalo to pay for a brain scan’ ...", is published and goes viral. [1] These two stories, separated by more than four decades, tell the tale of the state of health care in our country. The more things change, the more they remain the same! But what we are witnessing today is, ‘the more things change, the worse they become’.

Back to my story: Dropping out of PG, a move that shocked all except the head of my department who promised to take me back if I decided to return, I set on my journey to bring medical care to the rural poor. A few months of working in a rural set up demonstrated that the medical training I had received had little to offer for the diseases of poverty and that transferring high-quality curative care to the villages was not the most effective answer. Where There is No Doctor by David Werner, the Aroles’ health workers from the lowermost rung of the socio-economic hierarchy, appeared to mock the expensive training I had been privileged to receive. [2] But then with the Alma Ata declaration of 1978, there was a promise of ‘Health For All by 2000 AD’! Heated debates on the demystification of medicine, ‘going to the people and learning from them’, [3] health care which way to go, to be or not to be – all fundamental soul-searching questions formed the flavour of the day. Those were heady days when, over cups of chai and sutta, and a jhola for comfort, we contemplated the revolution that was just around the corner.

The quest for answers culminated in the book Taking Sides.[4] Health care, we said, was about taking sides and a sensitive person who wanted to work as a ‘health’ worker, positioned at any level of the hierarchy, had to make choices. In the concluding chapter, we placed contrasting choices, and ended with a question to the health worker: are you willing to go through the personal struggle such choices involved?

Even as we were completing the book, disaster struck Bhopal (1984). Ravi Narayan, who was then the convenor of MFC, persuade me to join the mfc team that was conducting an epidemiological and socio-medical survey on the aftermath of the Bhopal disaster. I went reluctantly, realising the enormity of the task that would face the affected people in the years to come. But moved by the suffering I ended up being closely involved with the...
struggle of the victims for the next several years. On behalf of the MFC, in September 1985, I coordinated a population-based survey on pregnancy outcomes.[5] Later in 1989, when the Bhopal case was unlawfully settled by the Supreme Court, as the convenor of the Bhopal Gas Peedit Sangharsh Sahyog Samiti, a coalition of over 30 Delhi-based organisations, I coordinated the protests in Delhi. Subsequently, with two other colleagues, I coordinated a study challenging the categorization of injuries in the processing of claims. Later, as an independent researcher I intervened in the Supreme Court case challenging the settlement. It was during this time that I felt the need to equip myself with epidemiological skills and was fortunate enough to get a fellowship to do a master’s in epidemiology from the London School of Hygiene and Tropical Medicine.

Looking back at my life, I think I have successfully straddled scholarship and activism. One of my first experiences in activism came with the campaign against the high fixed dose estrogen-progesterone combination drugs (EP drugs). As part of the efforts to raise awareness against the marketing of hazardous drugs and the pharmaceutical industry, several of us from the Voluntary Health Association of India (VHAI) organised a workshop in Pune. As a first test case, it was decided to campaign against the EP drugs, and I was entrusted with the coordination of the campaign. Launched on 8th March (International Women’s Day), 1982, it was highly successful as the then drugs controller banned it within three months. However, the drug manufacturers got a stay order. During the public hearings ordered by the Supreme Court, it was shocking to see many renowned gynaecologists give ‘evidence’ to support a useless and hazardous drug. I witnessed firsthand the nexus between the pharmaceuticals and the medical profession. It was the beginning of the process of politicisation. On behalf of women’s organisations, the petition that I helped draft against the hazardous injectable contraceptive Net-en (norethisterone enanthate), exposed the underbelly of the World Health Organization and its link with the drug companies and the population control lobby. I followed it up with a monograph on Depo-Provera published by MFC and Forum for Women’s Health as a strategy to buttress the struggle.[6]

There have been some successes but mostly the outcome has been disappointing and often heart-breaking. It is not for want of evidence, but one is fighting against great odds.[7] Today the challenges have multiplied. But wherever we are, and whatever we do, a commitment to justice and equality will choose the path for us. This journey has not been without cost, impacting on all levels (physical, emotional, psychological, and economic). Support of co-travelers, ‘like-minded’ friends from within and outside MFC, has been critical for survival. But it has been intellectually rewarding, emotionally satisfying, and personally empowering; and it has also been fun!

References
[2] I adapted Where There is No Doctor for India and worked for a while in Arole’s health programme at Jamkhed.
[3] This is from a Chinese poem, ‘Go to the people, live with them, learn from them …’
[5] The study was designed by MFC with help from faculty at JNU, Centre of Social Medicine and Community Health. It was carried out amidst great tension. Several women’s organisations participated and for details of the survey team, see the report, Medico friend Circle (1990). Distorted Lives: Women’s reproductive health and Bhopal disaster. Pune: MFC.
A Dialogue and Message to Youngsters

How did you get oriented towards the social sector in your younger age?

In 1967 there was a huge food crisis in Bengal and we were a part of a massive protest against the Congress-led government and the insensitive remarks of the then Chief Minister who advised people to eat bananas if they had no rice. I was in Class 8 then. I participated in the agitation against the government. Since then I was very active in student movements. I was in Presidency College which was a very live centre for discussing and debating left ideas and also the then raging Naxalite movement. I was admitted to medical college and we again organised medical students to think and work for the masses. We started running clinics, working in the slum, etc. We started a group in medical college called Social service and Survey Association. We started a magazine called Health & Society to discuss issues on health and social determinants. We wanted to find ways to change the system and make it work for the betterment of people. Slowly we organised network of students from other medical colleges and other colleges. We ran the college elections and I was leading it. We won the elections. I then decided to work on other aspects. So next time round, I declined to lead the elections but a panel ran and elected in our name and we again won. We had to lead the work.

During my student years, we ran clinics in slums and villages, we did a survey about the health of people, we worked closely with jute mill workers.

There was severe flooding in Andhra Pradesh during my final year of MBBS in 1977. And we went to the public for funds to work. We found that the rich were indifferent to the trouble of sufferers. We then went to the slums. We talked to the people there, sang, did other simple work and through contributions from poor people and the working classes, we raised a fair amount of money for our flood relief work.

After my MBBS, I visited Delhi, Jharkhand and other places and then came to Chhattisgarh to join the Shaheed Hospital. So that’s how we spent our years during MBBS and got a glimpse of the endless possibilities while working for health and its determinants.

What were the challenges/dilemmas problem which you have faced?

PG: The decision to not do a PG was tough. It took a lot of effort to convince parents, relatives, friends, et al. I explained to them the work I wanted to do and the ideology which I supported is for the betterment of the people. Ever since, they stopped worrying and complaining, and in fact, supported me through all possible means.

Finances: I joined Shaheed hospital which was run by the mine-workers’ union. They were poor people. So we never had enough funds, even for our salaries. I was in dire need of money but the hospital could provide none. I was promised Rs 1000 a month when I joined but never actually got that salary! We managed to run the hospital somehow. For years, we had one common kitchen where daal and chawal, lentils and rice, were the only thing

1Email: saibal.jana@gmail.com
available to us. But the workers reminded us that this is what they too eat and we stopped complaining about it. We never compromised on our values. My parents, though they were not so well-to-do, never expected huge monetary contributions from me. Their support was very crucial. And also crucial was the support of each common worker who worked towards running the hospital.

Human Resources: We had several instances of human resource crunch. But other doctors would come and join us during times of crisis. They also helped me learn many skills. There is a lot of goodness remaining even today in the medical fraternity.

Language/Cultural: When I joined, I couldn’t understand the local language and culture. I often thought of quitting and going back. But after 6 months, I started learning the local language and started understanding the local culture. I met so many workers’ families and middle-class families, who were humble and supportive of our work. They also taught me many things. And then I decided to stay on.

What were the solutions you took in order to deal with the issues and move further?

While tackling all these problems, I was very positive. I never let the dream and optimism die. I took calculated risks and tried not to panic at the situation.

People would come and go, now money would not be there and now it would be, and likewise so many other problems too would come and go. But we continued to believe in ourselves and continued to work for the people.

Your work in brief?

We started working for Shaheed Hospital and also tried to go to the people and help them understand about health, hygiene, disease, etc. We worked on deaddiction, superstition, health education, nutrition, etc.

Today our hospital has grown, It has more than 120 beds with services for medicine, surgery, paediatrics, gynaecology, and also the newly re-started community work.

Looking back, what do you feel have been your achievements?

Ours is the first hospital in India of its kind, started and successfully run by downtrodden people. We could keep it sustainable without outside funds. We could show a model in which a strong agitation can lead to a change and empowerment of people - and by which people could build their own assets to serve their needs. But then the struggle needs the participation of all.

What have been the limitations of your work? Where did you feel you were not so successful?

The new generation is not sensitive to people’s issues. Students and second-generation new workers do not feel attached to the cause.

What is your message you like to impart to us who have just begun their journeys?

The situation will be more or less the same as in times before. Only the ways of exploitation and autocracy will keep changing. We must keep ourselves ready to fight back and be strong.

Even if people are with us or not, we need to keep working – towards our ultimate goal of equity and equality for all.

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Looking back

1. How did you get oriented towards the social sector in your younger age?

Before coming to India in 1982 I was involved in the socialist-feminist movements in both England and Australia. Whilst I was at university in England, I had no idea of what to do post my graduation. I wasn’t really academically oriented, so I approached VSO (Volunteer Service Overseas). (I had selected the university I completed my graduation from since it had a ‘social work’ option in the 3rd & 4th years, and I would become a qualified SW along with my degree – but that option got cancelled in my first year of study.) Since I had a degree in Sociology I was told that I had no skills that developing countries needed! Still I was interested in ‘seeing the world’, and if I was not competent to ‘help the world’, then I could ‘study’ it. I visited Pakistan – Lahore University; and in Delhi – DU and JNU. JNU was the place I felt most comfortable with. The liberal atmosphere, the earnest and passionate arguments, which was the character of JNU in the early 1980’s was exciting for me. At this time I had no idea that women’s health/childbirth would be in my future.

Whilst in JNU I met Ranjan (Ghosh) who invited me to the coal mines of Jharia where he had lived and worked. Meeting the women colliery workers had a major impact on my life, and the choices I made. These amazing gutsy women were the subject matter for the PhD I completed from JNU in 1989.

From 1989 to 1993 I was busy with research, writing and having two babies. I was living in a village in Chandankiari – Chamrabad – and getting more and more immersed in the day to day problems of the villagers around me. In between writing and having babies I realised that health – especially women’s health – was a huge problem. I stuck my head in the sand as far as childbirth was concerned. I needed to look after myself and my children, so I equipped myself with ‘Where There is No Doctor’. Villagers saw this, and soon came to me for help and suggestions. The biggest jolt, though, was being asked to help a village woman during childbirth. I was way, way out of my depth, and though I was a much well-read mother-to-be during pregnancy, it’s very different to be at the other end of childbirth.

2. What were the challenges/dilemmas/problems which you have faced?

Oh, so many! Where to start? I’ll mention only a few….

- Finding a place to learn
- When the women’s organisation decided to pay for the training of ‘nurse-midwives’ for their health centre, there was no place for them to learn in ways that I was happy with. This has been a constant challenge, and I have often had to ‘unlearn’ many negative things our women have picked up from other hospitals.
- Getting the right people here
- It would have been ideal had we been lucky enough to host dedicated, motivated, like-minded medicos here to help in the orientation and training of our health centre team. Only in the last few years have we managed this, though that too only for a few weeks in the year. No such medicos came here for the first 15 years or so.
- We have had to rely on local doctors, who are often not in sync with our ways. Younger, less experienced doctors might have been more interested to come if there was a ‘senior’ to help to teach them.
- Financial support

This is a constant source of worry. On the one hand I feel that health care is a right, and ought to be free and be provided by the public sector. But here the poor get poor care. Quality health care – even when the services are being provided largely by the community they serve – is not always cheap. We have relied heavily on grants, most recently from the Tata Trusts, to provide quality health care at a subsided cost. With the withdrawal of their support next year, I am in panic mode!

3. What were the solutions you took in order to deal with these issues and move further?

Some of the above problems are intractable and unsolvable. But still we struggle on. Some of the ‘solutions’ we have taken are:

- Teach myself as much as possible. As a non-medico I need to be more updated in our area of ‘specialisation’ – pregnancy and childbirth. By

1Email: lindsayranjan@gmail.com
dint of this many local doctors accept that I know what I’m talking about.

- What our health centre lacks in ‘medical qualifications’ is more than compensated by the highly motivated team of local women. Health care – and especially childbirth care – is more about ‘care’ and ‘nursing’ – not just knowledge of drug protocols and passing exams.

- Reach out to other networks and try not to be isolated. I have been a member – though not always as active as I should – of several nationwide networks. I have deliberately maintained cordial relationships with the ‘powers-that-be’ – there are always well meaning and supportive individuals in the administration and bureaucracy. As a result we have agreements with the health department, and have been accredited for JSY, empanelled for sterilisation services, and for ultra-sonography.

- To deal with the problem of financial support we have cut costs (mainly by reducing doctors’ time – and money) and increasing charges (though I’m not too happy with this). I am also reaching out to many other donors and individuals for financial help – especially for the more costly services – long term care in the neonatal unit; caesarean sections; treatment of severe anaemia. So far we have been fortunate to receive many small donations from friends and well-wishers in India as a result of my appeal. I hope it continues!

4. Your work in brief

My work at the moment involves:

- Supervising all the health-related activities of our organisation.

- Overseeing all the clinics in the women’s health centre, this provides care to nearly a thousand women and children each month. On some days we have doctors, but mostly not.

- Ensuring all women who are admitted for childbirth get the best possible care. We have around a hundred births each month.

- Arranging doctors for c-sections. During c-sections, I become the ‘neonatologist’ due to my experience in neonatal resuscitation!

- Provide support and advice to the health centre team when complications arise.

- Training of new health centre trainees, community health workers and our ‘swasthya sakhis’.

- Communication with donors, developing proposals and report writing (our Annual Reports and Newsletters).

5. Looking back, what do you feel have been your achievements?

- Establishing normal delivery care. Our ‘normal’ deliveries are really normal. Not normal as in the highly medicalised version in many hospitals. Our C sections rates are low – less than 7% - and our outcomes are positive. Our complications rates are lower too – PPH and eclampsia rates are much lower than many other tertiary level hospitals.

- Proving that village women can be main care providers for women during childbirth. Our positive outcomes have not been achieved by highly qualified medical professionals, but by relying heavily on local resources: women, families, knowledge.

- Poor women are not willing to accept poor quality care. Many of the women who access care from us are extremely poor. Yet they are unwilling to accept the poor care provided by the public health system, and are highly critical of the unethical practices in the private sector.

- During pregnancy and childbirth many negative traditional practices have stopped, and many positive ones have been retained.

6. What have been the limitations of your work?

Where did you feel you were not so successful?

- Inability to develop the next generation of leaders in our organisation.

- Inability to motivate medical professionals to join us in our endeavour.

- Getting the message out. I have written many pieces and have an enormous amount of data regarding pregnancy and childbirth, but due to my preoccupations with all my other activities I have failed to get this published.

7. What is that message you would like to impart to us who have just begun their journeys?

- There is no short cut if you want to make meaningful changes in the lives of the poor. It takes a long time, and you need to be in it for the long haul.

- Practice what you preach. The advice you give to the poor ought to be the same advice you adhere to at home. Duality is quickly perceived and your advice will be ignored!

- Rewards are huge. Making a difference for the better is the biggest reward you can expect. Most poor people will respect and love you – but not all. Do not expect anything! Sometimes the people who have been most benefitted by your interventions may turn on you and give you abuse! You need to keep your head and heart clear.

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Challenges faced by Young Health Workers in Late Twentieth Century in Santal Parganas, Yelagiri Hills, and North Bengal

-Prabir Chatterjee

1. How did you get oriented towards the social sector in your younger age?

Some events that affected me:

- Bangladesh Liberation movement when we were Class 4 in school affected life and ‘adda’ in Kolkata (1971)
- Emergency and Janata government affected India (1977)
- Visits to Okersa village (near Katwa in West Bengal) with a granduncle (1978 summer)
- Visit to Jaffna in late 1978 where my Mama (cousin of my mother) introduced me to issues there
- Sent by Meghnath from college to NSS camps in 1979 and 1981 at Ashram Schools in Laudaha in the area beyond Kharagpur in Midnapore district. It is on the Subarnarekha River- we met Santosh Rana (first CPI ML MLA) and Dilip Bagchi (first SFI student leader to support the new movement). Meghnath later made the films Development Flows., Iron Is Hot, Gadi Lohardaga Mail (with Biju Toppo and Akhra, Ranchi).
- Weekly village clinic at Sembeddu in Medical College student days
- Spent 4 months with a Siddha practitioner in Nemur (in South Arcot District) in 1984 with permission of Medical College (CMC Vellore)
- Visit as a medical student to Kainchi Chhola Gully 3 described in Days and Nights in Bhopal: A Doctor’s Diary (See 361-362 medico friend circle bulletin, March-December 2014 on pg 14)

2. What were the challenges/dilemmas/problems that you faced?

- NGOs that failed.
- Attempts by local political parties and state governments to take over different NGOs.
- Loss of funding.
- Overwork (especially in the hospital) when other doctors left.
- Bureaucracies of all types.
- 9 attacks of falciparum malaria.
- Lack of electricity and transport.
- Late salaries.

3. What were the solutions you took to deal with these issues and move further?

- Worked for multiple NGOs on different days (since I always fought with my boss sooner or later).
- Took government projects where possible.
- This of course meant that government funds ran out too.

I slowly realized that funding cycles depend on elections (Indian for government, American for many funding agencies and World Bank). Also, funding priorities keep changing (usually these too are cyclical!) Only big or longstanding NGOs can force funders to adapt to local issues as and when they arise. Finally moved to UNICEF and then to quasi-government jobs - panchayat, municipality, SHRC (NHM funded)

4. Work you have done in brief?

- Mostly training village level workers
- CRHSE in Tirupattur and Yelagiri (Tamil Nadu)
- St Luke’s CNI Hospital Hirampur (Children’s ward and then Maternity hospital posting), Jharkhand
- Lots of Malaria, TB, Kala Azar (See mfc bulletin, Issue 217) and Issue 219 (reply by Yogesh and team)
- Sidhu Kanu Gram Unnayan Samiti, Memari (Burdwan Distt) West Bengal
- Community Project for Rehabilitation of Children, Pakur (with multiple clinics for NGOs), Jharkhand
- MD at CHAD Vellore
- NPSP (Polio) Godda, Jharkhand
- UNICEF (Routine Immunization), Raiganj (U.Dinajpur), W. Bengal
- Bochadanga, GP under Zilla Panchayat (See mfc bulletin, Issue 357-360, pg 60, 62.
- Municipality, Kaliaganj
- IMA (Private Public Mix) TB project
- SHRC, Raipur, Chhattisgarh

5. Looking back, what do you feel have been your achievements?

- Learned Tamil (my mother’s language)
- Learned Santali and am friends with many accomplished Santal doctors and workers
- Improved my Bengali (my daughter’s mother tongue) and Hindi
- Grasped Malto (the language of Sauria Paharia PVTG)
- Trained mid-level health workers who still work in their home areas
- Trained a laboratory technician who is now a Consultant with Evidence Action
- Helped set up the West Bengal Immunization Cell
- Encouraged start of Health Impact Assessment in Raigarh and Korba, Chhattisgarh

6. What have been the limitations of your work?

Where did you feel you were not so successful?

Could not save any of the collapsing NGOs. I could not continue in Santal Parganas. I had to do a lot of non-clinical and non-training work. Am still very bad-tempered and very poor in medical learning.

7. What is that message you would like to impart to us who have just begun their journeys?

Roads are made by walking!

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1Email: prabirkc@yahoo.com
It is a kind of luxury to be asked to write about oneself and even be told that this will inspire others. So what follows is a narrative that is a recollection of memory, a memory that makes me sound possibly good in retrospect.

The task has been made easy by the members of the organising committee by asking us to respond to the following questions - not exclusively though.

1. How did you get oriented towards the social sector in your younger age?

I really don’t know how. I always felt one has to do some good to society. I had naïve ideas of doing so by making some great inventions/discoveries as a physicist. When I was 4-5 years old, my father told me when taking a tour of our village in Thanjavur district, Tamil Nadu, that when I grow up, I should pass the IAS and become the Collector and bring electricity to the village. That was in reply to my question of why there was no electricity or running water in our village. No one fought in the freedom movement as far as I can recall in our extended family. But certainly, like everyone we revered our freedom fighters and the icons.

My father (and mother and grandparents) - like many adults in my family - were proponents of single cause/event, great person theory of change to reduce some inequity in some corner of society. He, my father, meant well, and most importantly, he trusted me in spite of his constraints and limitations. My school textbooks, especially the Hindi and Telugu ones, were full of excellent narratives of being a good person and doing good to society – and my school teachers did a great job of getting it across to us. It did not occur to any of my even mischievous classmates – by and large, that is - to question the narratives. It was simple, if simplistic, a world bereft of class, caste and gender, and any definitive politics. And religious differences were submerged and subsumed in shlokas like there are many paths, but the destination is One. In Class 1, half of my class consisted of poor and rich Muslims – the half became a quarter by the time we left school 12 years later.

Somewhat helpful, now that I look around, was some kind of loose family emphasis on doing well in whatever one undertakes, but there was no pressure on earning money, or I chose to interpret it as such, by the sacksful. I grew up somehow thinking we will make ends meet later in life, with no planning but hoping for serendipity. I realise in retrospect that this was not true of many of my childhood nor college friends.

2. What were the challenges/dilemmas/problems which you have faced?

The major dilemma that I like to think I faced, post teens, were mostly existentialist – probably after the favourite philosophers of the times like Sartre and Marcuse and Schumacher – what is life about, how to be a good person, and how to lead a good life by doing good ‘challenging’ work. Schumacher has written a book too called Good Work. And of course, what means good?

The second challenge was to realise that the real world cannot be quantified in mathematical equations – you may laugh at this but if you were a physics buff like I was, you would think so. Reality has an enormous number of variables. Even a simple question as to how to answer somebody who calls you a fool requires consideration of many variables. A good analysis of reality can be qualitative without math. A folly to think so in these data infested times.

The third and fourth are related and somewhat behavioural and perceptual. They deal with issues like self-esteem and finding a zone of peace, a kind of humility without arrogance and impatience and know it all attitude. The lack of it is particularly true of upper caste, English medium types/graduates of ‘professional’ courses from elite institutions, and of yours truly too. Your education does not equip you to learn from so-called common men and women.

Another related challenge – this is not a simple function of your family and class background – is to be able to work with others in a team. Subsuming your ego and understanding others and still making progress at work and outside work – is a big challenge. One has seen so many outstanding people and NGOs crumble because of not being able to do this. I am neither ashamed nor disappointed to say that I have way to go in all these even as the first two challenges/dilemmas have dissipated over time.

3. What were the solutions you took to deal with these issues and move further?

I had the good fortune of being exposed to some personal growth workshops in my late twenties and of meeting a fun person of outstanding insight into people – who could affirm you even while exuding
a healing presence. I also came to know from her – a Catholic nun, as I write pushing her 95th year - the meaning of unconditional love and acceptance as the highest form of spiritual grace. Structured methods of looking into oneself through her and other friends were very important. Another thing competition and excelling for the sake of excellence does not teach you.

4. Your work in brief

Initially, I worked with the application of management principles I had learned at the IIM to apply in work situations in health care settings – I was part of a vibrant group that did this. We even wrote a book, and some, about all this. Subsequently, for the last 36 years I have been associated with LOCOST, where we manufacture medicines and market them at low prices – and the immediate last 20 years I have been involved with public advocacy and policy issues in pharma through PILs, writing and speaking about them, etc. Somewhere along for 2-3 years I actively worked with the inimitable Dr. Zafarullah Chowdhury and his team at Gonoshasthaya Kendra, Bangladesh.

In between for 20 years I also wore another hat and worked with pedagogy of poor children, and on life and survival issues of poor urban communities in Baroda; and a most exciting experience was my working on pedagogy of science education of children in government schools, thanks to some of our great team members and to large-hearted friends in organisations like Eklavya, Bhopal. I learned more hands-on science, learning by doing, in these years than at the IIT that I studied. In these 20 years, my colleagues and I, helped run a children’s books and toys shop, published low priced quality children’s books (and discovered that quality books like quality medicines can be low cost), mostly in Gujarati, and organised several big books and toys exhibitions which brought in milling crowds.

Being part of a civil liberties group (PUCL) in Vadodara in troubling times was a big learning and humbling experience. It meant a lot to me that I worked with eminent seniors in public life of Vadodara and that we took stands on issues without fear, especially in 2002.

5. Looking back, what do you feel have been your achievements?

Not being particularly ambitious, but task-oriented and hardworking in spurts, I never expected to have arrived at a stage of life when younger people are curious about me. My achievements such as they are, narrated here unabashedly, are because of the courtesy and kindness of others. Thankfully I had the good sense to perceive kindness when proffered. Having a better half, occasionally demanding, mostly supportive and indulgent, and with similar values, and with a sense of balance I often lacked, is a great, well, if not achievement, but a good fortune. The same would go for my immigrant Punjabi in-laws in accepting with a big heart a Tambram son-in-law, worlds apart one would think.

Being able to look after my father, along with my siblings, in his last few years helped me repay my debt to him such as it is.

Being allowed by friends, colleagues, family, natal and marital, to be part of the above journey and having, if I may, earned the acceptance and indulgence of peers I value. Almost all my friends, many from the mfc, and various stages of life continue to be friends. And I have been able to accept, forgive and mostly forget, and respect, to a large extent, those few I did not see eye to eye.

I would especially think it has been a good fortune to get level headed, problem-solving friends at LOCOST, chief of them is my younger-by-a-dozen-years colleague, Srikrishna, without who the occasional paean to LOCOST would not have been sung.

The other great good fortune/achievement is meeting some outstanding human beings as part of work in the last 40 years – many of them from the mfc.

6. What have been the limitations of your work? Where did you feel you were not so successful?

I am concerned with the longevity of LOCOST – after the present crop of senior staff take a bow. We have not been able to solve the issue - as of yet. More is my limitation at not being philosophical about it.

I have been successful in the sense that I could do some useful work when opportunities presented and thankfully do not have any regrets. I have generally very little active memory of the dismal aspects of the past. The past is past, I would like to believe.

7. What is the message you would like to impart to us who have just begun their journeys?

Life is an adventure. Be open to possibilities. Hankering after security must be low in priority. At least when you are young.

There are many issues to critically engage with and contribute to society – ours is the most interesting country in the world, even if a bit messy.

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Medico Friend Circle

Bulletin
Mistreatment of Women in the Labour Rooms of India: A Call to Action

-Durga A. Vernekar & Sangeeta Rege
Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

“The discourse on motherhood has many hidden places that have been very little studied, analyzed or criticized. These issues are, nonetheless, very influential with respect to our values, our worldviews, and our forms of life. The importance of such a topic as the dehumanization of birth for the research on values is certainly worth considering.” (Villarmea Requejo & Fernández Guillén, 2011)

There is mounting evidence, globally and in India, of mistreatment of women at the time of childbirth in health facilities. Women in labour are beaten, slapped, physically restrained, verbally abused and humiliated by healthcare providers (Bhattacharya & Ravindran, 2018; Patel, Makadia & Kedia, 2015; Khanday & Tanwar, 2013). Indian policies and schemes to address maternal health have historically been directed towards arresting the maternal mortality rate and enhancing birth outcomes; the quality of healthcare provided has often been overlooked. For example, the Janani Suraksha Yojana under the National Rural Health Mission (NRHM) aims to increase the rates of institutional deliveries in order to prevent maternal deaths (Ministry of Health and Family Welfare, 2016). However, an evaluation of this scheme shows that whereas there was an increase in the rate of facility-based childbirths following the scheme, women were also subjected to abusive practises such as denial of privacy, verbal abuse, administration of fundal pressure, and being made to lie on floors immediately after delivery (Khan, Hazra & Bhatnagar, 2010). Whereas maternal health policies have thus far remained silent on the conduct of healthcare providers in labour rooms, the LaQshya (Labour Room Quality Improvement Initiative) guidelines released by the government in 2017 attempts to address it (Ministry of Health and Family Welfare, 2018).

Most research studies on the issue of disrespect an abuse of women in childbirth have been conducted with women, and have aimed to assess the prevalence of abusive behaviour. CEHAT (Centre for Enquiry into Health and Allied Themes) conducted a study to understand healthcare providers’ perspectives on mistreatment of women in labour rooms, and the causes they attributed it to. The study was carried out in one tertiary care hospital, and one secondary care hospital in India. The three cadres of healthcare providers namely doctors, nurses and class four staff members (i.e. hospital orderlies) were interviewed, as they invariably came into contact with women in labour. Following are findings of the study.

Physical and verbal abuse to obtain women’s compliance: Shouting at the woman or threatening her with discontinuance of care if she did not comply with instructions was a common practice in the hospitals. Furthermore, women were frequently physically restrained to make them take the delivery position desired by healthcare providers; class four workers were usually called upon to perform this task. The practice of ‘nil-by-mouth’ was practised indiscriminately for all patients without any prior risk-screening process. Whereas the deleterious effects of fundal pressure on the woman and the foetus are well-documented and the practice forbidden (WHO, 2018), the study found that this practice had not been completely eradicated from health facilities, and fundal pressure was administered to hasten delivery. Episiotomies were virtually a standard practice for all primiparous women, without any assessment of whether it was required; many a time, episiotomies were administered without the use of local anaesthesia.

It is an on the spot decision. ...In the midst of the (labour) pains even if you give a cut, she does not understand. Some women don’t get to know even if there is no anaesthesia. For some patients, even if you do not give anaesthesia, you have to give an epi (episiotomy), because the baby’s head is big, and there is very little space.

(Staff nurse)

1Email: durga@cehat.org, sangeetavrege@gmail.com
Respondents denied the occurrence of any form of sexual abuse of the woman during childbirth, although some respondents recounted isolated complaints of sexual abuse against doctors at the time of conducting vaginal examinations. They however stated that it was the women who had misunderstood the situation, and that there was nothing of sexual in nature involved in the doctor’s actions.

**Denial of ‘violence’ in labour rooms:** Whereas healthcare providers openly acknowledged the aforesaid practices, they did not perceive these practices as violence or abuse, but as a necessity for better birth outcomes.

*You have to do it for the baby. And we have to hold their feet and force them (to push harder). It also becomes necessary to give pressure on the fundus—Then we have to tie up their legs. Such cases have happened... Such experiences are plenty in the labour ward, they are routine, actually.*

(Staff nurse)

Respondents largely opined that pain was an integral part of labour. Providers believed that though it became essential to use measures such as physical force during childbirth, women soon forgot these adverse interactions on the birth of the child. They derided and dismissed the usage of the term “violence” for such practices.

*See, the baby has to be delivered within that short period of time. ...At that moment, it (physical and verbal abuse) becomes necessary. But after the baby is delivered, they say sorry, and we say sorry. Once the baby is out, everyone is relaxed. Otherwise during delivery sometimes even four staff members are required to pin the woman down....*

(Resident doctor)

**Consent-taking as a mere formality:** Whereas informed consent-taking entails the client being an integral part of the decision-making process and understanding fully what he or she is assenting to, the study found that consent was equated to mere signatures or thumb-impressions on the consent form. Decisions regarding various childbirth procedures were taken primarily by the healthcare providers on women’s behalf as they believed they understood medical procedures best. These decisions were typically put forth to the relatives of the woman rather than the woman herself. Seldom was communicating the potential risks and complications of delivery practised in the antenatal period. Obtaining the signatures superseded the need to make patients and their relatives understand the implications of the procedure.

Consent was not taken before administering episiotomies, and they were considered “a part of the normal delivery process”. As a staff nurse stated:

*No, not (consent is not taken) for episiotomies. Because that is a must. This procedure is a normal procedure and there is no need to take consent. Ninety per cent of primis need episiotomies. They may be anaemic and therefore may need help through episiotomies.*

Consent for insertion of the intrauterine contraceptive device copper-T was taken when the woman was on the delivery table and had just delivered her baby; this was carried out intentionally as providers were aware that the woman was not in a mentally or physically conducive state to make informed decisions.

*Yes... it (copper-T insertion) is stressed on more during labour. Immediately post-delivery we do stress upon it. ...Because the patient is now tired after delivering. (She already has) two children. She is more receptive during labour.*

(Senior doctor)

**Financial abuse of women and their families:**

The practice of class four workers demanding money from women and their families for services rendered, or for passing on the ‘happy news’ of the child’s birth was rampant.

*Yes maushis take money. This happens a lot. We have strictly told the maushis not to take. But the maushis take during shifting the patient. ...It is prohibited. But they don’t take it in front of us. So we don’t get to know.*

(Staff nurse)
Neglect of quality in maternal healthcare provision: Though the LaQshya guidelines by the Indian government broadly aim to improve the quality of care provided in labour rooms, their thrust area once again is reducing preventable maternal and new-born mortality and morbidity. The component of respectful maternity care is overshadowed by technical aspects of childbirth care such as facility-level infrastructure and equipment, human resource management, and clinical practices to prevent infection and morbidity. Hence the guidelines, for the most part, do not view childbirth care within the framework of reproductive rights, but as clinical case management. Nevertheless, whereas the LaQshya guidelines were released more than a year before this study, it is significant to note was that neither were the healthcare providers interviewed aware about the guidelines, nor was any training conducted to acquaint them with the same. Whereas the guidelines speak about providing women a fulfilling childbirth experience, and put forth provisions such as birth companions, partitions for privacy, and confidentiality of client information, the study found that these aspects were conspicuous by their absence.

Implications

The findings of the study underscore the institutionalization and routine practise of disrespect and abuse during childbirth in health facilities, and lack of recognition by healthcare providers thereof. There must be recognition of the fact that maternal and reproductive health policies cannot work in silos. There is an urgent need to adopt a human rights-based lens while charting policies and guidelines to address maternal health. This is a call to action for the Indian health system for providing healthcare during childbirth which is judicious, dignified, and rights-based.

References


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“There are unanswered questions about vaccine safety. We need studies on vaccinated populations based on various schedules and doses as well as individual patient susceptibilities that we are continuing to learn about. No one should be threatened by the pursuit of this knowledge. Vaccine policy should be the subject of frank and open debate, with no tolerance for bullying. There are no sides – only people concerned about the well being of our children.”

-Dr Bernadine Healy, MD, Former Director, National Institute of Health (NIH)

On 17th January 2019 the WHO while unveiling its new 5 year strategic plan, The 13th Global Programme of Work, declared vaccine hesitancy among global public health threats alongside Ebola. On 21 March 2019 in a meeting at Geneva to decide the post 2020 vaccine strategy, it talked of deep and broad engagement of stakeholders to take forward the vaccination agenda globally and Kate Gilmore, UN Dy High Commissioner Human Rights, stated, “There is no such thing as the right to refuse vaccines.” The intent is to neutralize a growing movement that has been raising critical questions regarding vaccines since the 18th century spurred by a broad range of issues like vaccination scandals, ill advised mandates and breach of civil liberties, refusal to acknowledge adverse effects, lack of oversight and unresolved issues on matters of vaccine safety and efficacy, conflict of interest, and collusion between the industry and regulating agencies.

Vaccination has a controversial history. Prior to vaccination there were three practices; olfaction, inoculation and variolation. These failed because they led to serious adverse effects, increased the death rate and helped the disease to spread among populations where they were practiced.

Jenner’s small pox vaccination was accepted upon a single case of James Phipps who after operation in May 1796 survived a disease challenge, deemed unethical by many and it was assumed the immunity was for life. However the incidence rapidly increased and the promised period of immunity reduced progressively from a lifetime to six months. Repeated revaccination was suggested which suited those implementing the practice for a handsome fee.

Opposition to the vaccine grew as people witnessed deaths and very serious adverse effects from “the most dangerous vaccine” that Dr Paul Offit acknowledges “has an adverse effect profile we would not accept as a vaccine today”. An article in the JAMA attributes the deaths to serious adverse effects and specifies not only those vaccinated but the contacts too were coming down with the disease. Parents preferred to pay fines and even accept jail terms rather than having their wards vaccinated, particularly as they had previous children who had succumbed.

As adverse effects were ignored people organized to form anti-vaccination groups. France banned vaccination after unrest in 1763. Growing rejection of the vaccine and protests against it led to mandates in 1853 in Leicester, England and protests led to the launch of the Anti-Vaccination League in 1870. The Anti-vaccination Society of America came up in 1879. Two other leagues, the New England Anti Compulsory Vaccination League (1882) and the Anti-vaccination League of New York City (1885) followed. In India Mahatma Gandhi opposed the small pox vaccine, advocated measures adopted by Leicester and declared himself anti-vaccine. In 1955 the Governor General C Rajagopalachari published a booklet titled, “BCG - Why I oppose it” leading to ICMR’s Chingleput Trial that proved the vaccine to “offer no overall protection”. The well organized and documented Indian opposition to vaccination considered it to be a fallacy, sacrilege, betrayal and conspiracy.

The members of the anti-vaccination groups were stalwarts from all sections of society and received inputs from the medical profession and public health officials who engaged in documenting vaccination harm, designed pamphlets warning the public, analysed statistics, and submitted detailed petitions to governments against mandates. Public meetings were held where political leaders pointed out mandates went against the right to liberty and bodily integrity; a point relevant to this day.

Protests led to results. The Royal Commission gathered evidence for seven years and repealed England’s compulsory vaccination law in 1907. Statistical analysis showed the epidemics increased dramatically after 1854 - the year the compulsory vaccination law was imposed. In England and Wales, 44,840 people died of smallpox when official estimates showed 97 percent of the population were
vaccinated. By 1919, England and Wales had become one of the least vaccinated countries and had only 28 deaths from smallpox out of a population of 37.8 million people.

In 1941 Dr. C. Killick Millard, Medical Officer of Health (Leicester, England) published The Vaccination Question and admitted that the city of Leicester, with a population of around 300,000 at the time, had for 30 years abandoned infantile vaccination and yet miraculously experienced an enormous decline in smallpox mortality.

The National Anti-Vaccination League of Britain exposed statistical manipulation, “The Ministry of Health has admitted that the vaccinal condition is a guiding factor in diagnosis.” If a person who is vaccinated comes down with the disease he was protected against, the disease was recorded under another name. Chicken pox, measles, rash and eczema were diagnostic options. This increased the efficacy of the vaccine.

The same phenomenon was observed in Philippines as recorded by Ian Sinclair, “In the Philippines, prior to U.S. takeover in 1905, case mortality [death rate] from smallpox was about 10%. In 1918-1919, with over 95% of the population vaccinated, the worst epidemic in the Philippines’ history occurred resulting in a case mortality of 65%. The 1920 Report of the Philippines Health Service stated ‘hundreds of thousands of people were yearly vaccinated with the most unfortunate result that the 1918 epidemic looks prima facie as a flagrant failure of the classic immunization toward future epidemics.’

Many regions including Leicester rejected the vaccine and adopted sanitation, hygiene, isolation and nutrition and the disease rate declined remarkably. Ironically small pox when it disappeared all over the world disappeared also in regions where people shunned the vaccine and adopted them. It is known the WHO too was forced to adopt isolation, sanitation and hygiene alongside. Incidentally what virus was present in the vaccine still remains a mystery leaving the space wide open for debate.

The anti-vaccination movement, its accusations and alternative solutions were vindicated.

The wave of a future movement was sown in 1943 when Dr Leo Kanner, a psychiatrist, made a case study of children who suffered from a novel disorder he termed Autism. Documenting details of these thoroughly unresponsive children he mentioned they were vaccinated for small pox and DPT.

However it was an epidemic of encephalopathy observed in children leading to deaths and a lifetime of disability that spurred parents in the USA to question vaccines again. Their anger was not unfounded. As early as 1933 the DPT vaccine was linked by Dr Madsen to deaths in children. In 1947 Dr Brody linked it to brain damage. A 1948 study by Dr Byers et al linked it to deaths, blindness, deafness, spasticity, convulsions, and other severe neurological disorders. There was open admission of guilt by eminent immunologists in a US TV show DPT: Vaccine Roulette by investigative reporter Lea Thompson broadcast in 1982 where children who had turned into vegetables after receiving the shots were also featured. The US vaccine industry faced bankruptcy paying compensation to parents who went to the Court against them. The manufacturers shifted to the acellular pertussis vaccine, the DTaP as it was found the pertussis component was guilty.

The anti-vaccine crowd was proven right again.

This second wave was dealt with in the most brazen manner possible. The industry approached the US government and pleaded they needed protection or they would go out of business. The government of Ronald Reagan provided limited liability to vaccine manufacturers in October 1986 and set up a federal compensation programme to be funded by an excise duty on each vaccine component that would be borne by the purchaser. As on February 2019 this programme has paid out $ 4.06 billion to 4,172 cases decided by a Vaccine Court.

The New York Times of 15th November 1986 reported, “The increase in the cost of liability insurance and the unpredictable nature of such liability has forced some manufacturers to consider abandoning production of vaccines.” Also, “Mr. Reagan’s action came after heavy lobbying in favour of the bill by a broad-based coalition including drug companies, physicians.”

There still remained a possibility that parents could opt out of the system to sue manufacturers. This loophole was blocked when the US Supreme Court supported the US Congress view in the Bruesewitz v. Wyeth case of 2011. The Court judgement noted, “No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, if the injury or death resulted from side effects that were unavoidable even though the vaccine was properly prepared and accompanied by proper directions and warnings.”

In short it agreed that vaccines were “unavoidably unsafe” and therefore awarded absolute immunity to vaccine manufacturers.

The pro-vaccination group won and left the industry with no incentive or intention to produce safe and
effective vaccines. The US Department of Health and Human Services (HHS) was consequently instructed to submit safety reports to the government every two years according to public concerns. “The Informed Consent Action Network (ICAN) and Robert F. Kennedy Jr. sued the US government in an attempt to reveal the safety reports that received the response, “The Departments search for records did not locate any records responsive to your request”. According to a legal document entitled, “Mandate for Safer Childhood Vaccines,” Health and Human Services (HHS) openly admitted to not having filed any vaccine safety reports in over 30 years!”

Thus vaccine safety depends upon clinical trials of the manufacturers. How capable are they for revealing adverse effects? “According to the “2013 WHO Expert Consultation on the Use of Placebos in Vaccine Trials”, the following replacements are used in lieu of a true saline placebo: “In place of a placebo, a vaccine against a disease that is not the focus of the trial is given to participants who do not receive the trial vaccine.” or, an “add-on” vaccine can be used: “In this design, the trial vaccine or placebo product is mixed with an existing vaccine not studied in the trial, and the subjects are given either (a) the trial vaccine mixed with the existing unrelated vaccine or (b) the combination of a placebo and the existing unrelated vaccine.” Thus the trials can never provide a genuine risk assessment.

The WHO admits: “A methodological disadvantage, however, is that trials using these types of placebos provide a less perfect control. It may be difficult or impossible to assess fully the safety and reactogenicity of the trial vaccine.” The reasons offered are vaccines are classified as biological – therefore they do not require stringent safety tests, and it would be unethical to deny the control group the use of a vaccine.

This is the same WHO which considers those questioning vaccines to be the greatest public health threat, which has decided to launch a vigorous grassroots campaign to promote vaccines involving all its stakeholders and feels there should be no right to refuse.

Clinical trials are also known to obfuscate troublesome data. In September 2017, a report titled “Infantis hexa and sudden death: a review of the periodic safety update reports submitted to the European Medicines Agency” published in the Indian Journal of Medical Ethics alleged that GlaxoSmithKline (GSK) apparently excluded certain cases of infant deaths in their official report to the European Medicines Agency. GSK stated that the deaths reported after the vaccine is “coincident” and not related to the vaccine. However analysis by Puliyel and Sathyamala, authors, showed that 83% of the reported deaths occurred within 10 days of vaccination and another 17% occurred in the following ten days. “Glossing over of the deaths after vaccination has potential to result in more, unnecessary deaths which are difficult to justify ethically,” they observed in a Press Release. The same vaccine and an MMR vaccine have also been embroiled in serious contamination scandals and the list grows by the day. In yet another shocking incident the Government of India preferred not to release clinical data of an indigenous Rotavirus vaccine that showed a very high incidence of a potentially lethal intestinal obstruction in vaccinated children under the plea that revealing the data would “alarm the public”.

The third wave of the anti-vaccination movement was focussed on autism discovered in 1943. It appeared in children all over the globe and became unmanageable by the 1990’s. The severity is reflected by the fact that in California the prevalence increased 600% in the period 1990 – 2002. It was the parents who raised their voice only to be ridiculed and demonized. They were asked to deny their own eyes as they watched and even video recorded their children regress after taking vaccines.

A lot happened during this period. In 3rd April 2000, a study titled “Autism, a novel form of mercury poisoning” by Sallie Bernard et al found 200 symptoms of autism to exactly match mercury poisoning and ascribed it to the use of the mercury containing compound Thiomersal in vaccines. Published in Medical Hypotheses in April 2001 after a thorough review, it created quite a stir and was vehemently criticized.

The din refused to fade and became shriller still when a freedom of information act petition by Congressman David Weldon exposed the minutes of a high profile meeting of 51 officials belonging to the CDC, vaccine manufacturers, and highly placed government officials who had met in Simpsonwood, Northcross Georgia, USA on 7th – 8th June 2000 to discuss two CDC studies that found undeniable association between mercury containing vaccines and autism. The relative risk found in both the studies was 7.62 any figure above 1 being a sure indication.

CDC correspondence between the author Thomas Verstraeten and top notch scientists revealed he had manipulated the data at his level from a RR of 11.35 and unable to do so any further sent an SOS for help, “The association will not go away.” Consequently the meeting was held where the guests decided to bury the association even as a member conceded...
his grandchild would not receive vaccines, another expressed concerns over targets to be met, while a third highlighted a similar role of the vaccine adjuvant aluminium which he felt had equally disastrous consequences. All of them agreed that these results should not reach the public.44

Verstraeten left the CDC to join the vaccine giant Glaxosmithkline, and one study published in the November 2003 issue of the journal Pediatrics concluded, “No consistent significant associations were found between TCVs (thiomersal containing vaccines) and neurodevelopmental outcomes. Conflicting results were found at different HMOs for certain outcomes”; in short, nothing to worry.45 Researchers examined this and 15 other studies purporting to show Thiomersal is safe and uncovered malfeasance and cover ups.46 The other Verstraeten study showing the same 7.62 association remains with the CDC and is available in its archives.

Faced with opposition the US Government decided in 1998 to remove mercury in drugs and pharmaceutical products47 but old stock was allowed to be administered up to 2006. Mercury was allowed to remain as “trace amount” and vaccines like the Hep B and the annual Flu vaccines continued to have 25mcg of mercury in them.48

Researcher Neil Z Miller pointed out that yet another neurotoxin aluminium replaced mercury, “Prior to the mercury phase-out (pre-2000), babies received 3,925 micrograms (mcg) of aluminium in their first year-and-a-half of life. After pneumococcal and hepatitis A vaccines were added to the immunization schedule, babies began receiving 4,925 mcg of aluminium during the same age period—a 25% increase. In 2011, CDC recommended that pregnant women receive a pertussis vaccine (Tdap), which also contains aluminium. Studies show that aluminium crosses the placenta and accumulates in fetal tissue. Thus, millions of babies in utero, infants, and young children were injected with, and continue to receive, unnaturally high doses of neurotoxic substances—mercury and aluminium—long after unsuspecting parents were led to believe that vaccines were purified and made safe.” In developing nations the mercury compound continues to be present in all non live virus vaccines on the plea removing mercury would make vaccines costlier.49

CDC provided a grant to Dr Poul Thorsen of Denmark to conduct the famous Danish studies. They found that Thiomersal in vaccines and the MMR vaccine were not associated with autism. The studies came under a cloud when a CDC insider squealed that Dr Thorsen had misappropriated the grant. The case was investigated and Thorsen was found guilty of 22 counts of money laundering and wire fraud in April 2011.50

US Attorney Quillian Yates remarked, “This defendant is alleged to have orchestrated a scheme to steal over $1 million in CDC grant money earmarked for autism research. We will now seek the defendants extradition.”51 Thorsen remains on the “Most Wanted” list of the Office of Inspector General, US DHHS, and awaits extradition as Denmark does not have an extradition treaty with the US.52 The CDC feels his financial misdemeanour has not affected his scientific integrity and defends the studies.

Another investigation was conducted on September 18, 2017. “The new evidence, uncovered by Children’s Health Defense, showed that Thorsen and his collaborators did not obtain permission from an Institutional Review Board (IRB) to conduct their research, which was published in the New England Journal of Medicine in 2002 and Pediatrics in 2003. In 2009, when CDC discovered that Thorsen never applied for the IRB approvals, staff did not report the errors and retract the studies. Rather, FOIA documents show that CDC supervisors ignored the missteps and covered up the illegal activity.”53

The next CDC study to run into a controversy was when Dr William Thompson, CDC Immunization Safety Researcher, turned whistleblower and handed over 10,000 documents he was asked to destroy to the US Congress that revealed gross incongruities in the CDC DeStefano study published in 2002 that investigated the role of MMR vaccines in autism in a bid to refute the 1998 investigation by Dr Andrew Wakefield. After Dr. Brian Hooker’s requests through the Freedom of Information Act for original MMR study documentation Dr. Thompson, the co-author, buckled under the pressure of his conscience to hand over documents he was asked to destroy that demonstrated a 3.4 fold increase in the incidence of autism in African American boys, expunged from the final study results in an act of scientific fraud.54 Dr Brian Hooker accessed the raw data to confirm the allegations. The matter is currently under Congress investigation.55

The studies that strongly deny the vaccine autism connection are thus weak in their foundations. It must also trouble us that of the cases of vaccine injury compensated under NVICP, there exist 85 cases of autism awarded for encephalopathy.56 The association is denied under the plea that they only resemble symptoms of autism. But autism is a symptomatic diagnosis.

In January 2019 The Hill reported, “Pediatric neurologist Dr. Andrew Zimmerman who originally
served as the expert medical witness for the
government, which defends vaccines in federal
vaccine court signed a sworn affidavit. During a
group of 5,000 vaccine-autism cases being heard in
court on June 15, 2007, he took aside the Department
of Justice (DOJ) lawyers he worked for defending
vaccines and told them he’d discovered “exceptions in
which vaccinations could cause autism.” “I explained
that in a subset of children, vaccine-induced fever
and immune stimulation did cause regressive brain
disease with features of autism spectrum disorder.”
His opinion was based on scientific advances and
his own experience with patients.” However his
confession was disregarded and the cases dismissed.57

The anti-vaccine movement spread worldwide when
the HPV vaccine against cervical cancer introduced in
2007 became associated with clinical trial fraud,
and numerous cases of deaths and serious disabilities.
These cases received huge media publicity in Japan,
Sweden, UK, Ireland and the USA. The vaccine adverse
effect reporting system (VAERS) of the USA
accessed by Sanevax reveals up to 14th March 2019,
61,552 adverse events that include 480 deaths and
9070 cases classified as serious.58 It is estimated that
VAERS records 1 to 10% of actual.59

Activists in India filed a case which was admitted in
the Supreme Court in January 2013 when it emerged
that PATH and the ICMR had conducted an illegal
clinical trial in the year 2009 that killed seven tribal
girls and sickened almost every girl that it was
administered to defying informed consent norms and
local laws.60

Afrikaners were jolted in November 2014 when the
Catholic Doctors Association found evidence from
reports of nine accredited laboratories that beta hcg, a
birth control hormone, was present in tetanus vaccines
being used by WHO and Unicef in Kenya targeting 14
to 49 year old women. “In February 2018 the Kenyan
president Raila Odinga made a public televised
statement acknowledging a tetanus vaccine given in
2014 – 2015 to approximately 500,000 women was
confirmed to contain a sterilization hormone. The
licence of the manufacturer was cancelled.”61

In 2017 Philippines erupted in anger when it was
revealed that the Dengue vaccine manufactured by
Sanofi approved in the country and administered
to 800,000 children had ignored a warning it could
increase the cases of severe dengue in persons
previously exposed to the disease. The official death
toll is 154 as on Sept 26, 2018.62 Severe internal
haemorrhage has been found in many cases. “Legal
authorities have revealed there is a clear case against
six Sanofi officials, mostly country representatives of
the firm, and 14 current and former Philippine health
officials including former Health Minister Janette
Garin for 10 confirmed deaths.”63 Meanwhile the
parents of the 800,000 children and 100,000 more in
Brazil dread the day their wards would come down
with dengue.

What is the strategy being used to push vaccines
into an increasingly unwilling population? It starts
with naming vaccines to be “immunization” whereas
100% of the suffering population can turn out to be
“fully immunized”64 and the discovery of cell
mediated immunity by Merrill Chase in 1942 has
all but negated this claim.65 Portraying vaccines to
be about “public health” and “preventive medicine”
when vaccines have been linked so far to 248 diseases
and disabilities including death by scientific published
studies66 and research proves most infectious diseases
have therapeutic benefits.67 The concept of “herd
immunity” used to jack up vaccination rates has been
argued to be a “dishonest marketing gimmick”.68

The study of the human microbiome points to the
fact that vaccines and antibiotics can lead to a
whole host of illnesses. Prof Ruth Ley remarks on
the BBC, “Where work on the microbiome comes in is seeing how changes in the microbiome, that
happened as a result of the success we’ve had fighting
pathogens(with antibiotics and vaccines), have now
contributed to a whole new set of diseases that we
have to deal with.”69 A study in April 2018 found that
environmental genetic changes termed epigenetic
changes can travel 14 generations.70 Is it a wonder
that people turn against vaccinations?
What should be done to stem the crisis? Dr Pushpa
Mittra Bhargava, founder director of The Institute
of Cellular and Molecular Biology, had suggested
some steps to the author to ensure safe vaccination
programmes when he was interviewed in the year
2009 at Secunderabad.

“There is a system for introducing vaccines into
India. Many factors have to be considered. What is
the incidence of the disease in the country; are there
some regions where it is concentrated? Does the
incidence justify a vaccine?

What is the mortality rate from the disease? Is it
high enough to justify a vaccine? What is the safety
profile of the vaccine? Has it been tested on Indian
populations and found safe? What safety issues are
being ignored? What are the alternatives to the
vaccine? Can other safer public health measures
control the disease better than the vaccine? Is the
disease easily treatable at a lesser cost? Vaccines are
a costly measure as they also involve logistics and
staff to administer. Is there a cost benefit in using the
vaccine or by avoiding it?
“Who are the children who should receive the vaccine and who should not? What are the contraindications of the vaccine? Must the vaccine be given to all or can it be restricted to regions of high incidence? Is there a mechanism in place to monitor the above process that consists of capable members free from conflict of interest? Is there a system of monitoring adverse effects and addressing them in a transparent manner and which too is free from conflict of interest? Is there pressure from international agencies to introduce the vaccine and influence the process?

“All these are important non-negotiable issues whenever a vaccine is introduced into the country. I protested the oral polio vaccine because it is a hasty decision considering that the vaccine has a history of causing paralysis. We also do not know how it will affect the gut microbes. Are the cases of encephalitis we are witnessing in regions where intensive drives are on because of the vaccine?

“I am not opposed to vaccines but systems and procedures must be in place if we are to behave responsibly. Vaccines cannot be included in any schedule simply because someone somewhere is manufacturing them.”

These sage words must reverberate in all members of the scientific community who are interested in vaccine safety. We are aware of vaccination warnings being ignored in India. Dr Vipin Vashishtha, senior executive committee member of the IAP voiced his concern about 15 additional vaccines being given by IAP members and that “pharma money is corrupting paediatrics academy”. He alleged that the amount of Rs 25,000 to 30,000 per child that led to annual revenue of Rs. 8100 crores was driving the urge to vaccinate.

Dr Vashishtha was physically assaulted at an IAP function and expelled from the IAP for his voice.

Doctors in India have expressed concerns about the Pentavalent vaccine in the Indian Journal of Medical Ethics, and suggested it could be behind around 8100 deaths annually in Indian children. The WHO responded to the global reports of deaths by revising the reporting system such that the deaths could not be ascribed to the vaccine making Dr Jacob Puliyvel lament, “Even deaths are no longer a contraindication to vaccination.”

An RTI query in 2018 made the Indian government concede 10,612 deaths after vaccinations provided under the universal immunization programme from 2008 to 2018. It also revealed upwards of 600,000 adverse effects are reported every year. Government officials hint at coincidence. The OPV vaccine being given with religious fervour in India has been attributed to 491,704 cases of paralysis in Indian children from 2000 to 2017 and the criticism against the study methodology has been countered effectively. Such figures do not inspire confidence, nor does the response. The private sector in India that vaccinates 2.7 million children or more annually has no monitoring system.

Parents in India have approached two High Courts; at Kerala, and New Delhi after children started dying and were hospitalized in hordes after being vaccinated with the measles rubella vaccine in a school-based campaign. Deciding on the petitions the clear judgement in both cases has been, the parents can object to vaccination and that the risks have to be revealed and informed written consent taken.

Preparations are on to challenge the decisions. It has been acknowledged by government sources that vaccination campaigns cannot succeed unless the parents are kept ignorant and the vaccines forced on the children.

Our children are today in a deplorable state. According to a report, 54% of children today suffer from chronic disorders. 1 in 10 children have asthma. 1 in 13 suffers from food allergies. 1 in 6 children suffer from developmental disorders. 1 in 8 suffers severe neurological disorders. The CDC’s latest report released in April 2019 reveals 1 in 59 children suffer autism. In the past 8 to 10 years: juvenile diabetes increased by 23%, cancer increased by 29%, ADHD increased by 43%, food allergies increased by 50%, asthma rates rose by almost 50%. Autism increased 150%. Where is the healthy childhood that vaccines promised? All independent studies that have compared the health of vaccinated and non-vaccinated so far have found the non-vaccinated groups to be healthier on all counts studied.

The collusion between the WHO, big philanthropies, the vaccination industry and the media cannot be denied. A FDA medical advisor has stated, “The (US) Congress is owned by Pharma” Can the vaccine industry that has paid billions of dollars in fines and is involved in felonies be trusted? Can the CDC that holds 50 vaccine patents and has a for profit wing be an impartial body free from conflict of interest when it recommends vaccines? The industry on record donates to political parties to lobby for vaccine mandates.

Must a campaign that raises crucial issues, seeks scientific interventions, and expects the medical profession to ensure health be attacked just for being anti-industry? We can no longer ignore the elephant in the room.
Vaccination mandates being imposed in the USA in response to anti-vaccination sentiments and the censoring of social media is not the solution. The scientific society must proceed on observation, evidence and facts and not be swayed by the manipulations of the vaccine industry and its lobbyists. History will judge the custodians of children according to what their response will be at the present moment. Let that decision be sane and scientific. We need courage and determination to face the bullies. Our children are precious, not the profits of an industry that stands exposed.

(The author is grateful to Dr Sathyamala for critical comments on an earlier draft.)

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Comment on Jagannath Chatterjee’s
“Anti-Vaccination; Pro-Science; Pro-Health; Anti-Industry”
-Yogesh Jain and Naman Shah, JSS, Bilaspur

Vaccines are a powerful health technology that has saved countless lives and prevented much disability. Like any technology they are imperfect, as are the programmes which deploy them and as are the individuals who would evangelize any technology at the expense of a broader socioeconomic perspective on health and the causes of illness.

To understand and state this is both banal but also an oft forgotten point among their reasonable critics, who appropriately seek incremental improvements of their technological, programmatic, and policy imperfections, and their unreasonable critics, who, largely absent of any practical experience in vaccines or the care of vaccine preventable diseases, commit various errors of attribution and logic and sadly a wholesale disregard for their realized, ongoing, and future potential for health improvement and equity.

This article by Chatterjee touches on elements of the former areas for critique, but is unfortunately dominated by the latter.

1Email: jethuram@gmail.com

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The Organising Committee, of Shrinidhi, Mohammed Khader Meeran, Savithri, et al, for the MFC Annual Meet 2020 at Sewagram undertook the initiative of requesting and compiling the articles for this issue of the Bulletin.
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