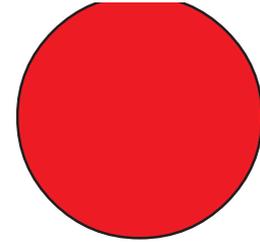


medico 320 - friend 321 circle bulletin



December 2006 - March 2007

Concept Note

Public Health Education in India

-Ritu Priya¹

History and Current State

India has had a long tradition of public health education, training and research. A large network of public health related research institutions developed over the 20th century, some having been set up in the colonial period and most others added post-Independence. The All India Institute of Hygiene & Public Health, the ICMR and its various institutes, the NICD, NTI, NIHF, the CSMCH at JNU and the PSM departments in medical colleges have been engaged in public health education, training and research for periods ranging from over hundred years to thirty years. PHNs, ANMs, SIs, male MPWs and laboratory technicians are being trained by centers specifically created for the purpose.

Need for Public Health Personnel

Yet the understanding of medical professionals, nurses and other health workers about public health is inadequate, both at the policy-making levels and at the various implementation levels. At the planning and policy levels, the lack of expertise in public health is evident from the national health data-base, policy documents and programme formulation/evaluation processes. On the other hand, with emphasis on processes of decentralization and district level planning, there is increasing requirement for public health expertise, both to analyse the epidemiological situation and to use the analysis to do health systems planning and programming. The increasing attention to prevention of ill-health at individual level among the middle class, the international focus on disease surveillance systems, on 'pandemics' such as SARS and Avian flu, HIV, and campaigns such as Polio

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eradication, have all highlighted the importance of public health for the country's policy makers and the general public. Cost-effectiveness exercises by the World Bank and other economists in their concern over rising medical expenditures, the Millennium Development Goals which have a large component of improving health related indices, have all brought recognition about the importance of public health and health systems research among policy makers. There is growing consciousness about the complexities of health research, policy analysis and public health practice. Hence there is the growing articulation of need for public health education and training (even though some of the reasons for the concern may seem hyped up to many of us, and the estimates of public health specialists needed may seem a bit exaggerated).

Currently what seems to be happening is that public health trained persons from universities in first world countries are engaged in coordinating and developing plans, generally as 'consultants' to the national or state governments or to bilateral/multilateral international agencies (UN agencies or aid agencies of other countries), or even directly to other governments such as the CDC, USA. PSM departments and PGs in PSM from medical colleges are engaged in implementation of health programmes at various levels or in doing the data collection for the research required to implement them. Often they recognize the flaws or limitations of what they are being asked to do, yet they continue to be a part of such exercises since it gives them an opportunity to be part of a large effort which takes them out of the routine, meaningless rut they have been in for years. The argument for such a parallel system of planning is that the government

system, at the centre or in the states, does not have the 'competence'. Is there really a lack of public health competence in the country? If so, what is the nature of lag?

Is it that the public health education of leaders in the health sector, the doctors (the degree-holding senior nurses having largely been marginalized in the health system hierarchy) engaged in administration and technical advisory roles, is inadequate because clinicians are put in such roles for which they have not been trained? Would strengthening the public health component in under-graduate medical education help? Is the PSM education at PG levels itself inadequate (since the largest number of medical professionals get public health education through PSM departments in medical colleges)? Is it a question of the adequacy of number of doctors and nurses specialising in PSM/Community nursing? Or is it of adequacy of the educational programme in terms of its content and perspective? Is it a combination of all of these? Each of these questions needs to be answered by reconstructing the history of public health in India and analysing the developments in this field of policy and praxis.

Another issue is whether public health planning and practice needs medical graduation, or can social scientists do it as well? Epidemiology is being taught to persons from both streams in the 'first world'? What has been the contribution of the economists, sociologists, geographers and political scientists who have taken to public health analysis and planning? While they bring non-medical social perspectives into the discipline; are they able to get out of the bio-medical paradigm? Are they able to incorporate the lay people's perspectives better? Are they able to give adequate place to the biological and epidemiological processes and critically examine the technologies available?

Boundaries and Content of the Discipline

Public health, social medicine, community health, community medicine, preventive and social medicine are all terms used interchangeably by various streams within medicine and public health. The nuance of each one, as it defines the discipline somewhat differently, is important, and probably what seems most wide-ranging and inclusive of all these is 'public health'. However, it needs to be defined clearly, with consideration of the contemporary needs of the country and experience of the last six decades.

Diverse Perspectives

Different perspectives and schools of thought exist within the discipline. Therefore, even with the same objectives, the approach to health services development, disease control programmes, epidemiological research and data analysis, may be varied. The current debates, such as on role of the state in healthcare, the technological options and criteria for prioritization, the role of community, forms of governance, of systems of medicine other than the dominant one, all reflect the diversity. Discussions on public health education will have to consciously spell out the kind(s) of perspective(s) that are to be communicated through the educational programmes. While the whole range of options is presented to the student, the strengths and limitations of each comes from value positions that will have to be articulated as the social consensus. For instance the principles agreed to by consensus could be: equality of health status and access to services; prioritisation to be from the perspective of the vulnerable socio-economic sections; self-reliance and sustainability as issues for governance; low cost need not mean low quality services, and low cost-effective services are desirable, etc., etc.

National and International Discourse and Context

International public health is producing analysis and priorities based on global data and first world perspectives. The comparative picture across countries and regions is useful in allowing for identifying determinants of good and poor outcomes of interventions. However, these cannot substitute for national and sub-national analysis and planning. Lessons from global analysis can help if used critically and as appropriate for local contexts. But they can also distort priorities and service systems development if followed uncritically. Therefore all countries must develop capacities to do their own analysis at all levels, and decide their own priorities as well as modes of intervention. At all levels – international, national and local – the power equations in society (in international politics; the politics of knowledge, of caste, class and gender; the political economy of healthcare, of the medical industry and the medical professions) will only be replicated within development of health services and their provisioning unless conscious measures are taken to break through them to the benefit of health of all. Public health education must sensitise the personnel to these issues. In fact, public health education itself will have to be structured with due consideration to them.

Social and Technical Basis of Public Health Personnel

Part of the reason for alienation of the public health personnel from the community and of health policies from the needs of people has been stated to be the social distance between them and the majority they are meant to serve. This alienation is then further aggravated by the nature of professional education they receive and the attitudes it builds. Therefore also important is a consideration of the social base from which the professional students are to be drawn and appropriate recruitment processes adopted. Avenues for well-performing health workers to go into medical or nursing graduation (and for medical officers performing well in peripheral public institutions to be given preference in PG admissions) is one means of doing so, while simultaneously strengthening performance of public health personnel as well. Reservations in seats for intake from traditionally deprived sections are another.

Positive attitudes that affect the performance of health care providers and planners need to be identified so that they can be consciously nurtured through the process of professionalisation. Team work, responsiveness to life and worldview, an epidemiological understanding of health and disease, due importance to the social determinants of health and disease.

Issues of Pedagogy

Technical knowledge can be imbibed as information, as scientific methods of research and planning. But equally important is the ability to use it to the best possible results, to be able to solve problems in diverse situations. This requires pedagogic methods that build capacities of critical thinking and sensitive analysis. Simultaneously, they must also inculcate the attitudes and values that are considered significant for positive performance. This requires developing appropriate textbooks, other reading materials, and teaching methods. The apportioning of time and emphasis on theoretical learning, bedside learning, and community experience is one dimension. The public health perspectives to be developed that give concrete shape to the chosen professional attitudes and values are of even greater significance. Inputs from the social sciences are crucial, eg. in understanding the social determinants of health, the political economy of health services, issues of governance, philosophies of knowledge, etc.

Funding of Public Health Education and Research

Does the source of funding of public health education shape its content and the perspectives underlying it? Or is it more a matter of the dominant knowledge discourse, which is, in turn, shaped by the larger social, economic and political milieu of the times? Do the two reinforce each other, unless conscious efforts are made to give consideration to the 'non-dominant' perspectives within the discipline and to the worldview of the socially marginalized sections? Is state the financing source that can allow for some neutralizing of existing social power equations? What are the implications of Public-Private Partnerships with international backing in public health education? The IITs and IIMs are believed to have brought 'excellence' into engineering and management education. Is this model of elite institutions for a few, appropriate for public health? Or can even PPP institutions be innovative and not tow international standards of excellence but develop them organically from the local context?

Intimately linked to public health education is the issue of demand for their services – both in quantum and the nature of work, which will be determined by the public health service structure in the country. Besides the state-run services, are private enterprises going to enter the public health arena? PPP and involvement of NGOs in delivery of services of national health programmes is already under way. What implications will this have for employment and conditions of work of public health personnel?

The quantum of expenditure incurred by the individual student on professional education will certainly shape the nature of practice of the students in later life. High inputs will demand high returns. However, will low inputs not result in the desire for high returns? If the larger social and professional system is placing prime value on material benefits alone, can public health be practiced in a scientific and humane way, whatever be the education imparted? Can it still remain a positive force by the very nature of its objectives?

Background Material for the MFC Annual Meet

To address the issues outlined, an analysis of India's present situation and past experience is required. Assessing current needs and projecting for the future is important. Lessons from other countries that are relevant for the diverse contexts in India should also be drawn upon. Perspectives in public health education can play a crucial role in shaping the health system of the future and thereby the extent of suffering it will reduce.

Public Health Education in India - Some Reflections

-Ravi and Thelma Narayan¹

I. Context: Public Health Education Policy: 1946 to 2002

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

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

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

sanitation measures and higher training of MD/PhD to support public health system policy and development were also recommended.

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

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

¹ This paper is based on Power Point presentations – presented recently at a CHC Workshop on the Community Health Fellowship Scheme in July 2006 and an earlier seminar at the London School of Hygiene & Tropical Medicine on Public Health Education of India, in June 2006. Email: <ravi@phmovement.org>, <thelma@sochara.org>

intelligent and dedicated public health workers and bringing them together to form a 'critical mass', which could strengthen the key institutions for practice, research, education and training in public health."

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

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

The same report (ICHI 1997) also recommended that "all major states should have at least one school of public health, along with modern public health research laboratories, smaller states may collaborate and have common public health schools." It also recommended that Institutes of Health and Family Welfare established in many states be developed into Schools of Public Health.

The analysis by Deodhar (2004) of the regression of public health education in India in the last three decades is particularly relevant – since it focuses on PSM departments that were primarily set up to strengthen public health. "Departments of Preventive and Social Medicine have been the victims of neglect, assignment of lowest priority, low prestige, poor quality of staff, inadequate facilities, the staff full insulated themselves from the practice of public health and even of preventive medicine."

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

The National Health Policy document of 1982 identified three significant problems:

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

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

The National Education Policy for health sciences in 1989, which grew out of a response to the NHP 1982 identified the problems as:

1. Medical bias in the entire process of health systems planning and health manpower development.
2. Inadequate continuing education for updating existing skills and facilitating acquisition of new skills and knowledge by health team.

It recommended the following strategies for action relevant to public health education:

1. Efforts to produce adequate number of first level of specialists in medicine, surgery, paediatrics, OBG and public health/community health.
2. Essential to recognize the specialty of health management and an appropriate step be taken to produce good health managers.
3. Mandatory establishment of linkages between health care delivery and education in health sciences to make the whole system efficient and effective.

The most comprehensive analysis of needs assessment and strategies for action was by the Expert Committee on Public Health System 1996, constituted by Government of India, which included public health stalwarts like Dr. Harcharan Singh (Planning

Commission), Dr. Jayaprakash Muliyil (CMC Vellore), Dr. N.S. Deodhar, (MOHFW), Dr. K.J. Nath (AIIHPH-Kolkata) and Dr K.K. Datta (NICD). This report, which unfortunately did not receive attention it should have received, was significant in its findings and recommendations.

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

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

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

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

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

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

- Limited success of the public health system in meeting preventive and curative requirements of general population.
- Financial resources and public health administration capacity far short of needs

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- Public health machinery inadequate in quality, efficiency and too vertical and inadequately decentralised.
- Public health expertise non existent in private health sector and far short of requirement in public health sector.

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

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

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

- **Medicalisation of public health** by preventive and social medicine departments, and their aloofness from state health programme managers, as well as the fact that these post-graduate degrees have been available only to medical professionals, though this trend is now beginning to slowly change.
- **Devaluation of public health as a discipline** in the 1960s and 70s by generalist administrators and clinicians becoming public health managers and state HRD policies not requiring public health degrees as job requirement for public health managers. This trend is also seen in a more subtle way in the NGO / civil society sector as well.

- **Disintegration of public health systems** by vertical national disease-oriented programmes rather than sector wide approaches and externally funded projects focused on single disease programmes rather than on strengthening public health systems. New economic policies also reduced social sector expenditures including health budget further distorting the public health systems.
- **Dialectics of National Health Policy:** The challenges of balancing public health/ primary health care system development with the present trends towards privatization of health care and medical tourism and unregulated private sector development and commercialization of health care has led to inadequate focus on public health human resource development. This is also linked to new economic policies that focus on the needs of 'India' rather than of 'Bharat'.

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

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

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

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II

Overview of Public Health/Community Health Education Initiatives in India since 1970

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

involvement of the community in the organization of the action as a right and a responsibility.”

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

a) Mainstream Initiatives

Institutes/Courses

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

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

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

Networks

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

a) The Indian Public Health Association (IPHA), which is a very old network of public health professionals meeting annually and producing the *Indian Journal of Public Health*. They tend to be mostly public health professionals working in the Government Public Health system with some exceptions.

b) The Indian Association of Preventive and Social Medicine (IAPSM) which is the national association of Teachers of PSM departments with some exceptions.

c) The Indian Clinical Epidemiology Network (INCLEN). This is a network that emerged through a Rockefeller initiative that stimulated and strengthened the training of clinicians in epidemiology and field-based research, making them more public health-oriented.

Some Issues Relevant to the Mainstream Sector

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

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

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

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

d) There are no national standards for faculty requirements, course contents, methodology of teaching, requirements of field centers and field experiences for these newer MPH and DPH courses. MCI has recommendations for PSM departments and

the undergraduate and MD curricula. WHO-SEARO has just started this process since 2000 AD through the SEAPHEIN network (see details later in the paper).

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

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

b) The Alternative Sector

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

Short-Term Training Programmes

i) These include community health training programmes of Deenabandhu Medical Mission (Tamil Nadu), Christian Medical Centre (Miraj), Christian Fellowship Hospital (Ambilikai, Tamil Nadu), Institute for Rural Health Management (Pachod, Maharashtra),

International Nurses Service Association, INSA (Bangalore), THREAD (Orissa), and the Child in Need Institute, CINI (Kolkata). Many of these courses were particularly popular in the 1970s to 1990s. Some of them have now been discontinued.

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

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

Long-Term Training Programmes

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

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

Some Issues Relevant to the Alternative Sector

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

i. The courses experimented with an alternative philosophy of education that was participatory, experiential, learner-centred and action-oriented.

ii. They used small group techniques and methodologies.

iii. They had a strong community orientation, since most of the training was community-based and non-hospital oriented.

iv. They had a strong social analysis, exploring broader determinants of health.

v. There was a focus on skill development for

community-based work.

vi. There was a greater learner-centredness with participants giving feedback and evolving the curriculum further course by course.

vii. The focus of training was on cognitive and affective aspects of training and on work-related skills as well.

viii. Many of them evolved innovative case studies, simulation games and problem solving exercises.

ix. While the orientations of the courses were very different the overview suggested that they focused on two sets of roles: the first as alternative service providers or programme managers and the second as enablers and empowerers of the community or process managers.

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

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

c) Other Developments

While the earlier sections focused on courses and training centres in the mainstream and alternative sector, two processes of networking in the region, since 2000 AD, are beginning to have an important impact on public health/community health dialogue and health human power development in the country. This includes a) a public health demand creating movement - the People's Health Movement- Global and Indian. b)

A public health education network – the South East Asian Public Health Education Institution Network (SEAPHEIN).

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

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

The Charters, both global and national, have a series of recommendations of great significance to public health, public health system development and public health education in India and abroad (PHM 2000 and JSA 2000). Members of the JSA are now actively involved with advocacy initiatives with the Ministry of Health and Family Welfare, Planning Commission, and other national bodies and also participating on task forces of the National Rural Health Mission and other schemes.

ii. *The South East Asia Public Health Education Institutes Network (SEAPHEIN)* is an initiative that has evolved as an outcome of the regional conference of "Public Health in South-East Asia in the 21st century" in 1999, hosted by the IPHA which led to the "Kolkata Declaration." The Declaration had four major strategic directions relevant to India as well:

- a) Promoting public health as a discipline and as an essential requirement for health development in the region;
- b) Recognizing the leadership role of public health in formulating and implementing evidence-based healthy public policies;
- c) Strengthening public health by creating career

structures at national, state, provincial and district levels; and

d) Strengthening and reforming public health education and training and research.

Five consultations have followed in the South East Asia Region in which some of the existing public health institutes in India have participated especially CMC Vellore; Sri Chitra, Trivandrum; AIHHPH-Kolkata; IHMR Jaipur; and NIE-ICMR-Chennai; and more recently CHC and PHFI. These consultations have focused on:

a) Accreditation guidelines (b) Curriculum structure (c) Networking (d) Future directions (e) Regional Guidelines for public health education standards and accreditation (WHO-SEARO 2000, 2005 and 2006).

This overview of development in public health/community health education in the main stream and alternative sectors and related developments of key networks would be an eye-opener for many of us in mfc who may have been unaware of all these diverse, plural and anarchic nature of development of public health and community health courses in India. Very few reviews or overviews are available on them except those undertaken by CHC and mentioned in this paper earlier. Five consultations have followed in the South East Asia Region in which some of the existing public health institutes in India have participated especially CMC Vellore; Sri Chitra, Trivandrum; AIHHPH-Kolkata; IHMR Jaipur; and NIE-ICMR-Chennai; and more recently CHC and PHFI. (See for instance "Accreditation Guidelines for Educational/Training Institutions and Programmes in Public Health" published elsewhere in this issue of the *mfc bulletin*), an outcome of the Chennai Consultation, Jan-Feb 2002)

There is need for a more evidence-based and standardized assessment of the content, methodology and relevance of all these ongoing experiments and initiatives even as we focus on the newer developments like the PHFI. Many institutions — like AIHHPH, NIHFJW JNU/CSMCH, CHAD/CMC Vellore, NIE Chennai, IRHM Jaipur and Sri Chitra Trivandrum — have contributed to the challenge of public health education in India. By focusing on the practitioners who have been trained by these institutions and feedback from them on the relevance of the training, we can help build an evidence-based national consensus on what works and what does not from a people's health and a Health for All perspective. This is an urgent imperative and the MFC dialogue could be the initiator of such a process especially if we want to move from being a "thought current" to also being

an "action current".

d) Policy Recognition of the "Alternative Sector"

In 2004, CHC was invited to the First National Consultation on Schools of Public Health organized by the Ministry of Health & Family Welfare, in New Delhi, to reflect on the contributions of the alternative sector of public health/community health education in India. Taking an overview of the sector and building on all the previous studies and reports (see Annexure 2), Narayan, R (2004) identified some of the key challenges faced by the alternative sector, which included: the experience of building capacity from grass-roots workers up to reorientation and skill development of health professionals: community capacity building including strategies for system development and demand creation; the evolution of the concept of a "new public health" with strong focus on community dynamics, social and development determinants and alternative pedagogy: and various efforts through campaigns and movements to counter distortions and market deviations in public health policy and action.

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

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

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

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

Partnerships with Alternative Sector

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

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

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

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

2. When the Public Health Foundation of India was set up in consultation with the Ministry of Health and Family Welfare, the Planning Commission and the PMO’s office, in February 2004, a representative of the alternative sector of public health/community health was included as a stakeholder in the Governing Board and it is in that capacity that CHC is represented on the Governing Board. This is therefore, an opportunity for all of us in the alternative sector to engage with the initiative and make its academic, research and policy endeavours more India relevant and pro-people

oriented. By this active engagement we may be successful in countering other agendas that any such multi stake holder initiative is bound to be subjected to. This opportunity rather than threat is described in the next section.

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

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III

2006: Challenges, Opportunities & Threats

In this final section, emerging challenges, opportunities and threats are explored in the current context, which includes the development of initiatives that affect public health capacity building in the country. As opportunities increase, new challenges and threats arise. The anarchic and multi-stakeholder nature of present policy processes are not adequately grounded in public health principles, values of equity and of health being a fundamental human right. There are continuing dialectics and tensions between strengthening primary health care and public health systems on the one hand, with accelerated commercialization of the health sector on the other.

Initiatives such as the National Rural Health Mission (NRHM); Public Health Foundation of India (PHFI); multiple schools of public health and MPH courses mushrooming in the country; the Right to Health Care campaign (JSA); and various movements linked to other determinants of health are significant developments. Increased engagement and dialogue between the alternative and civil society sector and the mainstream, in trying to make the government and the health system more responsive to public health needs of people, have had some influence. The work by WHO-SEARO to strengthen public health in South Asia, the South-East Asia Public Health Education Institutes Network (SEAPHEIN), and efforts by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) to respond to public health needs

in the region, are also initiatives impacting on the situation.

The launch of the Public Health Foundation of India (PHFI) in March 2003 as a new public-private partnership for public health capacity building provoked an active debate on opportunities and threats to public health in India. Several authors raised important issues (see references 1-9) such as:

- The need for public health capacity building, and a separate public health cadre;
- Quantity and quality of public health human resources required;
- Types of courses and strategies of education;
- Numbers and types of institutions required ; and
- The nature of curriculum and skills and capacities required.

However, since all these papers focused on the PHFI initiative in particular rather than on public health education in general, fears and questions were raised, such as:

- Are we creating a cadre of elitist "managerial physicians" distanced from primary health care?
- Are we promoting a technology-driven biomedical model of public health?
- Are we producing public health professionals for an export market?
- Are we going to adopt foreign models of education?
- Are we going to neglect existing public health institutions and ignore PSM departments of medical colleges?
- Are we bypassing the Medical Council of India (MCI), the Ministry of Health, Planning Commission and Parliament – thus affecting the accountability and transparency of these new initiatives?
- What type of students will be able to avail of such training courses, if they are based on self-financing principles?
- Are we privatizing public health?

As challenges to efforts towards public health capacity building in the country all the issues expressed as concerns are legitimate and relevant – even though the tone and nature of many of the papers have been doctrinaire, presumptive, hypothetical and not adequately evidence-based. By focusing on the policy conspiracy theory, they tend to over exaggerate some agendas and documents and do not reflect the concerns and initiatives of many public health professionals in

the country in the last few years. Several of these initiatives were presented in a national consultation on Public Health in India, organized by the Ministry of Health & Family Welfare in 2004.

While some unfounded fears, many based on sensational media reports, have been responded to by the PHFI team, the dialogue must continue by separating real policy issues from extraneous issues and stereotypes. Since papers on both sides of the debate are included in this bulletin, we do not propose to respond to all issues in this section. In the context of the PHFI and other initiatives to strengthen public health capacity in India outlined in the earlier section, we will reflect on (1) engagement with the PHFI; (2) teaching-learning for public health; and (3) the need for a public health movement – leaving other issues for the mfc meeting and other fora for dialogue.

Engagement with PHFI

a) Readers may not know about letters from deans of five public health schools in the US some years ago, saying they had formed a working group to set up an International School of Public Health in India, supported by NRI and other groups. Many of us identified as public health professionals and consultants were invited to consider collaborative research proposals for the first phase as a method of identifying local faculty to join the School. From CHC, we sent a letter replying to the Dean of Berkeley suggesting that the proposal seemed rather neo-colonial in the absence of any Indian involvement (eg., MOHFW, ICMR, Planning Commission, public health institutes of repute, public health professional associations, etc.). We also shared the difficulty of collaborating with academics who were preoccupied with vertical disease approaches, when many of us focused on cross-cutting issues and integration; public health system strengthening and human resource development. These issues were stumbling blocks in the country's ability to handle public health challenges. This letter was widely circulated. It so happened that the proposal fell through in the subsequent dialogue between the US institutes and the NRI donors - who discovered that their interests were different.

b) A few years later, a young professional working with McKinsey, who had started an overview study on public health capacity building in India at the request of the Ministry of Health and Family Welfare, got in touch with CHC. As this study progressed, apart from giving him an orientation to public health history and challenges in India, he was put in touch with several resource persons and public health experts from the mainstream and alternative sector in the country. This process among others led to the evolving of a PHFI

strategy that was flexible and responsive to the situation in India. Thus, PHFI is evolving its strategy to strengthen public health systems and human resource development at state level; on public health capacity building policies within government and NGOs; giving priority to health systems research; social determinants; health impact assessments; and health financing. This is through an evolving tripartite strategy focused on curriculum development, research, policy and advocacy.

c) Around this time, CHC was invited by the Health Secretary to a dialogue with two representatives of the American Association of the Schools of Public Health – who were interested to support the initiatives of the Indian government in strengthening public health in India had been enunciated in various policy documents including the National Health Policy, 2002. The Indian team included ministry officials and representatives of the All India Institute of Medical Sciences and the Voluntary Health Association of India. At this meeting, a national dialogue was suggested in order to pool different perspectives and build consensus around the nature and process of the capacity building exercise. The publication *Perspectives on Medical Education* printed by VHAI as an ICHI health policy series report, and written by CHC, was circulated.

d) The Ministry of Health and Family Welfare then organized a National Consultation in 2004, at which CHC was requested to share perspectives from the alternative sector. Other invited members from this sector participated very actively to evolve the initial framework later developed by the Health Ministry, Planning Commission, and the Prime Minister's office into the PHFI initiative, in consultation with the finance ministry, philanthropists and funding partners.

e) The outcomes of the CHC inputs have been described in the previous section. WHO-SEARO included many recommendations of this paper in their South-East Asia public health education initiative. The Ministry - especially the Health Secretary kept CHC informed of the evolving steps towards the new initiative and Ravi Narayan from CHC was later invited to join the founding governing body of the PHFI.

f) CHC used this opportunity to include a large number of alternative sector representatives in the founding workshops - so that the concerns and suggestions by the sector would be strongly articulated from the outset (mfc website for a summary of the suggestions from the PHFI inaugural workshop, prepared by CHC).

g) The efforts since then have been to gradually raise these concerns in the meetings of the governing body and in the processes of planning and evolution of the PHFI agenda. The full time Director who took

over from August 2006 has an impressive track record of epidemiological research, policy work on tobacco control, besides being an active member of the health unit of the National Human Rights Commission. Subsequent to his joining this dialogue has increased. Already PHFI is considering guiding principles which include “promoting equity, excellence and efficiency without sacrificing commitment to universal outreach, inclusivity (with adequate firewalls against conflicting special interests), transparency and accountability.” From an earlier focus on developing a few PHFI institutions, the strategy has expanded to networking, strengthening existing institutions and building collective approaches and partnerships.

h) As the PHFI evolves its curriculum, research and advocacy strategies, it plans to involve public health teachers, practitioners and researchers in the country from the mainstream and the alternative civil society stream. There are several challenges and opportunities ahead for all of us in the process. The nature of this interaction will decide strategic shifts in public health planning and policy in the country leading to healthy debates. These could include issues and questions such as:

- Whether the public health curriculum will include farmers’ suicides; decreasing nutrition and food security; increasing health inequity; and weakening public health systems; or will the focus primarily be on diseases of development and lifestyle change, SARS and avian flu, in an increasing public-private partnership mode?
- Whether the intention to make the curriculum more India relevant will include social determinants, public health ethics, public health system development and public health impact assessment of current development strategies; or whether the focus will be on conventional research and vertical programme development for the new diseases, with a drugs and vaccine focus?
- Whether the training will focus on public health capacity building for state health systems including distance learning and continuing education in public health for existing health cadres including public health doctors, ANMs and other workers, or only on public health specialists and higher level programme officers?
- Whether the training will have a strong practitioner basis or will it be research and national/international programme management oriented?

i) These and many more are the debates ahead. It poses a challenge for the alternative sector to network and reflect on its own achievements, strengths, capacity building strategies, ideas for curriculum development and abilities to translate the vision of its

charters and declarations into people sensitive and people responsive training, learning and praxis initiatives.

Reflections on “Public Health Teaching, Learning and Competency Building”

For over three decades, we have facilitated teaching, learning experiences in public health, preventive and social medicine, occupational health and community health. Since the 1970s, we have had “real life” experience and engagement with all aspects and dimensions of the topic being discussed. This includes being students of post-graduate courses in India and abroad; teaching in India for a decade in St. John’s Medical College as faculty members of the department of Community Health; Ravi has been an overseas lecturer of the London School of Hygiene and Tropical Medicine (LSHTM); a visiting professor for a year each at the School in mid-80s and mid-90s; during the years in CHC evolving the “alternative paradigm” of Community Health (the new public health) we have been involved through praxis and engagement with movements and health systems – both alternative and mainstream; and have lectured and facilitated teaching sessions in public health schools in India, and several countries. More recently, we have taught modules on public health policy and public health system management at the National Institute of Epidemiology, Chennai and interacted with public health faculty, students and colleagues in the PHM from all over the world at conferences, the International People’s Health University (IPHU) and at the annual Global Forum for Health Research (GFHR). From this more global and “praxis” perspective, we wish to highlight issues that may be relevant for discussion.

1) Public health with a community health perspective (the new public health) is not only an attitude of mind and a perspective - but also a discipline. While an undergraduate, clinician, general practitioner or allied health professional can develop attitudes and perspectives, the discipline needs periods of discipleship to develop skills and competencies based on public health principles and methods. Public health practice requires academic rigour, the capacity to analyze a public health problem not only bio-medically and techno-managerially, but also to consider the social, economic, political, cultural, and environmental roots of the problem, and thereby evolve responses and systems that address this complexity with the involvement of the public or the community.

2) Knowledge of the discipline can be built to some extent through didactics and classroom teaching, utilizing new pedagogical approaches like problem solving methods, case studies and simulations, audio-

visual aids and computer assisted learning. However what is more urgent as a prerequisite is “hands on” learning by involvement in programmes/systems at field level. This involvement should include:

- meeting, observing, interacting and working with the community supported by “mentors” involved in “public health system building” or “public health movement building.”
- Learning from practitioners of public health, at different levels of the system, tackling public health problems in “real life” situations;
- listening to their sharing in a spirit of learning and identifying the strengths, weaknesses, opportunities and threats of their action at community level, system level, or policy level.

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

The Community Health Fellowship Scheme of CHC - which recently concluded its first four-year phase and was externally evaluated and reported in July 2006 was based on these principles. We are confident that this method is capable of creating in young public health/community health students, a passion for this discipline. Further work is progressing to develop modules and frameworks of learning that can build further skills and capacities. CHC now has nearly 40 young people who can share about this initiative from their own diverse learning experiences.

3) The academic environment in which public health and community health skills and capacities are best developed are also environments which foster a spirit of self-learning and a capacity for analysis by the student. To sharpen this skill, it is also necessary to expose students to different streams of thought, different types of public health action, and new paradigms and new approaches. This is important even if the trainers have a certain definitive point of view or preference for a certain paradigm.

We have surprisingly discovered this more in academic environments and public health schools abroad - rather than in teaching/training centers in India (both mainstream and alternative). The culture of hierarchy together with dependency, part of our wider social traditions, prevails, greatly affecting the learning process. We need to actively encourage a culture of interactive, participatory discussion; of student feedback completing the full loop of educational

planning; learning that challenges gender bias, caste and class hierarchies even within our institutional ethos; and a culture that allows the teacher and taught to discover and analyze perspectives together. All these need to be internalized in training programmes, teaching methodologies, assessment and examination systems in order to produce practitioners and personal and social transformation.

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

5) We often hold on to some notions of reality based on past situation analysis and not necessarily grounded in today’s complex and changing situations. We just share a few examples.

- There is a continuing belief that public health/community health is still low priority in student careers choice in India. While this may be true of the 70s or 80s, the situation has changed dramatically. Many good students, keen and competent, are now opting for a post-graduation in public health. While cynics may link this to increasing job opportunities in international health, or to a back door entry into the US medical system (since public health courses do not require medical registration to begin with), close interaction with many students in recent years shows that this is not always true. Even if 25% of those who are starting this journey are serious, we still have the prospect of a very large number of public health professionals arriving on the scene, seeking training, research and work opportunities. Already in many schools abroad, Asians including Indians and not only NRIs, are a substantial percentage of the student population. Similarly, there is the phenomenon of NRIs increasing on the faculty of these schools. Both these factors are also additional pull and push factors for initiatives such as the PHFI.

- We have been tracking interesting public health training programmes and research projects in many

parts of the world – both North and South, developed and developing countries – trying to learn from praxis everywhere. The older and new public health institutes and departments of public health in India need to be open to a wide variety of ideas which include initiatives such as the National School of Brazil; modular courses of the University of Western Cape, South Africa, which starts with rural nurses and offer credits and courses to health team members at different levels; distance learning initiatives in many countries; special courses in socio-epidemiology, inequalities in health and health care, social determinants and human rights in universities in the USA and other countries.

▪ In many parts of the world, alternative and mainstream public health professionals are also much more in dialogue with each other through professional associations and meetings unlike in India. If we, in the alternative sector, feel we have evolved knowledge or alternative skills and capacities, we need to share them with the mainstream more proactively. Our recent experiences as part of the PHM team, in the World Public Health Congress at Rio or in the Global Forum for Health Research meetings since 2002 show that dialogue is possible and necessary [see report on Research Priorities for Schools of Public Health in the Global South and the Social Vaccine on the CHC and PHM website, <www.sochara.org; www.phmovement.org>]

Evolving a Public Health Movement

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

a. Public health capacity building, including establishment of a stand alone public health cadre, is long overdue in the country, in order to strengthen public health systems and make them responsive to complex public health challenges. The introduction of PSM in under-graduate medical education and growth of post-graduate courses in PSM have not produced enough numbers of public health physicians with adequate practical skills and capacities to tackle challenges in health and the health system, currently under further assault by neo-liberal economic policies. The issues are not of tension between generalist vs. specialists; doctors vs. health workers; primary health care vs. public health; clinicians vs. public health; communicable vs. non communicable diseases; bio medical vs. social community models. These are old debates and will continue, though they mask deeper more difficult societal conditions that produce ill-health. The situation of public health and health systems is so bleak that we need action on all fronts

with a strong “new public health/community health movement” that can support “demand creation” with a rights based perspective among the disempowered on the one hand; and support development of public policies and systems, that are responsive and relevant to the demands of the people on the other. In other words, a pincer strategy is required for a public health movement and a public health system development policy initiative. It is only when this complexity is understood in the context of today's political economy of health that these debates will lead to concrete action. Already many people's health movement activists have dual involvements – proactive watching as well as critical engagement.

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

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

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

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

- Banning medical college expansion;
- Strengthening MCI – making it more professional and socially oriented;
- Setting up a National Human Power Development Commission with a strong multi-disciplinary focus to evolve need based and evidence based change;
- Strengthening existing medical education efforts

including medical education cells and social and community orientation;

- Examination reforms towards rational and ethical systems;
- Promoting creative autonomy for experimentation towards primary health care, community health and general practice;
- Strengthening continuing education of health and allied professions involving IGNOU approaches and expertise;
- Strengthening public health capacity building and development of public health cadre;
- Research in health human power development including implications of privatization, brain-drain and new economic policies;
- Regulation of privatization and commercialization of medical education and health;
- Promoting training of health worker training ; and finally,

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

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

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

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A Few Additional Issues for Discussion at the MFC Meet

-Anant Phadke¹

(For the purpose of this discussion, we gloss over the distinction between Public Health, Community Medicine, Community Health, PSM, etc., and lump these together; for the sake of convenience of expression we choose one of these names - Public Health – to indicate that we are not talking about health of individuals but about health of the society, social groups.)

Ritu Priya in her Concept Note has outlined a range of issues related to the teaching of Public Health in India. I would like to raise some additional issues in the form of a few explicit questions directly relevant to Public Health Education in India. There is some overlap with her very well conceptualized note; I have raised a few issues in a little different way.

- Is under-development of Public Health Education compared to clinical medicine a worldwide phenomenon? Is it because in capitalism, curative medical service becomes an expanding industry focusing on the helpless individual patients and hence a lot of interest in individualist clinical medicine with concomitant neglect of Public Health? What has been the experience of the 'State Socialist Societies' like Soviet Union and the People's Republic of China?
- In India is the neglect of Public Health Education due to the under-development of Public Health sector in India (Public Health institutions account for only 20-30% of health care in India and a large proportion of this is spent on medical care) or is it also because of the fact that all the strategy-making for India is done by the Western experts, and Public Health personnel here have the role of only implementing these strategies uncritically?
- Is it true that Public Health Education in India is of a lower quality in India compared to the quality in the advanced capitalist countries and compared to the quality of teaching of clinical subjects? What is the evidence?

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- Many controversies in Public Health keep surfacing. During the last couple of years a few such issues have been discussed publicly – compulsion of iodized salt, universal hepatitis-B vaccination, intra-dermal anti-rabies vaccine, failure of the Polio Eradication Campaign, compulsion to use helmets, and so on. Why is it that the teachers of Public Health in medical colleges have hardly intervened in these debates? Why is it that the Indian Academy of Pediatrics - a clinicians' body - has been the leader in the debate about universal hepatitis-B vaccination with very little intervention by Public Health experts?

- Is it merely a question of improving the quality of Public Health Education in India or also critically examining the ideological assumptions of the content of what is being taught? Is the dominant current in Public Health teaching veering towards teaching technological solutions for social problems?

- Is there a need to build bridges between teaching of clinical medicine and Public Health? Why is that clinical teaching today hardly takes into account the Public Health angle of the disease in question? (For example, Professors of Medicine would not generally include in his/her teaching, use of primaquine in all cases of malaria in hyperendemic areas to interrupt transmission; or the need to advise a case of dengue to use mosquito net during the illness to prevent transmission to others or the need to advise the family to look for mosquito breeding sites near the house.)

- To what extent would the Public Health Foundation of India (PHFI) proposal be useful in this context? Is there any plan to enhance the quality of Public Health education in all relevant institutions in India and in which direction? Will PHFI help to solve some problems and at the same time accentuate others? Under the garb of Public-Private-Partnership are we heading towards privatization of Public Health Education in India or is it an opportunity to regulate the private initiatives in Public Health?

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Education of Public Health Workers

- *Debabar Banerji*¹

NTI (National Tuberculosis Institute) has been my Karma-bhumi (1959-64). The approach to deal with tuberculosis as a public health problem that we developed there has been the foundation of my work in the subsequent 42 years, which includes development of 'community diagnosis and treatment' in the practice of 'community-side' medicine in NIHA and building up of an alternative body of knowledge for teaching public health, at the Centre of Social Medicine and Community Health (CSMCH) in the School of Social Sciences of the Jawaharlal Nehru University, after it was recognised (eg., by the Srivastav Committee, for instance) that the then conventional public health education had not risen up to the challenges faced by the country. The temptation was therefore strong for me to mobilise my physical capacity and attend the MFC meeting at NTI. However, after having an idea about the background of the participants and the background material produced so far, it occurred to me that even if I manage to take the strain of the travel and stay, what I would say will cause inhibition among some of the veterans of MFC. I am therefore writing this brief note as a way of coping with the dilemma.

What is Public Health?

As early as in 1920, C.A.E Winslow had articulated the classic definition of public health: "Public health is the science and the art of preventing disease, prolonging life, and promoting physical and mental health efficiency through organized community efforts for the sanitation of the environment, through control of communicable infections, education of individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for maintenance of health." Edward McGavran had condensed this definition by calling it "practice of community-side medicine" to distinguish it from bed-side or clinical medicine. Community diagnosis and the formulation of community public health practice requires use of a wide range of disciplines, such as epidemiology, health social sciences, political economy, economics, biostatistics, and interdisciplinary research methodology apart from

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the so-called bio-medical elements such as bio-chemistry, nutrition, choice of technology and strategy for intervention in the epidemiology of community health problems of various kinds. Hugh Leavell had molded Winslow's definition in the context of what he calls 'natural history of a disease in an individual.' This has a pre-pathogenic phase, before the disease is detected to apply (1) promotive and (2) specific preventive measures; the pathogenic phase, which encompasses (3) early detection and treatment; (4) disability prevention; and (5) rehabilitation.

Considerable space has been allotted to definitions to underline that academic approaches adopted in many of the background article on public health education in India have not taken into account the wide dimensions of the interdisciplinary field of public health. The reference to predominance to what is mentioned as 'bio-medical dominance in public health thinking' in India betrays inadequate academic analysis of the situation in India. It is not adequately recognised that NTI was the first institution in the entire world to have separate sections for such areas as sociology, public health nursing, biostatistics and radiological engineering, who participated as equal members in the Technical Coordination Committee of NTI. In fact, the All India Institute of Hygiene and Public Health had a position of a full professor for social sciences even earlier than NTI. There have been, besides, positions for substantial groups of social scientists in key institutions such as the National Institute of Health Administration and Education, National Family Planning Institute and the Central Health Education Bureau. Many of the departments of preventive and social medicine in medical colleges had positions for one or more social scientists. A critical question before the Bangalore MFC Meet is to consider the outcome of such interdisciplinary work. Many of the key institutions are lying in a comatose state. The Meet may deliberate on the political economy of the decay of these institutions. As it is expected to have participants from the Achutha Menon Centre for Health Science Studies, in the Meet, the group can deliberate on this experience, including having visiting faculty from Arizona and Minnesota and other parts of the US and from India.

Work at NTI

Perhaps those who gather at NTI will be interested in knowing the seminal work that has been carried out at

NTI.

During 1961-64, interdisciplinary research work done at NTI received worldwide attention. Perhaps the most remarkable feature of its work was to give primacy to people, and the workers at NTI actively resisted imposition of a prefabricated technological package on them (countrywide use of mass miniature radiography, for example) from the West as a way to deal with tuberculosis as a public health problem in the country. Imparting sociological dimensions to epidemiological issues, developing people-oriented technologies and formulation and use of an operational research approach in public health can be cited as instances of some other features which laid the foundation of India's National Tuberculosis Programme (NTP) developed at NTI. NTP was designed to sink or sail with the general health services. Halfdan Mahler, then DG WHO, had pointed out how some of the ideas generated at NTI contributed to the formulation of the concept of Primary Health Care within WHO.

I believe some more attention may be paid to the important 35-year old experiment of setting up the CSMH in the School of Social Sciences in JNU. This was done in the wake of realisation that serious limitations in the then existing education of public health workers in the country. The ideas developed in the country were consolidated to develop a new approach to study of public health, which is specially tailored for a country such as India. Development of new concepts (e.g., social orientation of medical education and practice and interrelatedness of cultural perception and meaning of health, access to services, and community health behaviour), in-depth analyses (e.g., political economy of health, health services, nutrition and population control and family planning), field surveys (e.g., health behaviour of people), operational research and systems analysis (e.g., optimising health systems), are instances of some of the distinguishing features of the formal academic programmes of studies leading to degrees of Master of Community Health and Master of Philosophy in Health Social Sciences and subsequent doctoral work. Sciences basic to these programmes, such as epidemiology, social sciences and health administration provided the foundation. These "seeds" are preserved in the form of textbooks. They can be used by concerned persons to "remind" the rulers about the health problems of the "forgotten" masses. They can also flourish wherever or whenever the soil becomes conducive to them.

Mind-Boggling Venture

I will end up by pasting what I have said about the Public Health Foundation of India in the C.Ramachandran Memorial Lecture at the Nutrition Foundation of India on September 29, 2006:

It is simply a mind-boggling venture. A registered body – the PHFI – plans to tackle the formidable problems relating to public health education, research and standardisation, when it takes its final form. The Charter of PHFI reads:

1. Establish new institutes of public health.
2. Assist the existing institutes to enhance their capacity and their output.
3. Promote research in prioritized areas of public health, to inform policies and empower programmes.
4. Facilitate policy development, programme evaluation & advocacy on public health related issues.
5. Enable development of standards & adoption of a credible accreditation system for public health courses.

It is most astonishing that the Foundation was inaugurated by the Prime Minister of India in the presence of speakers and audience carefully chosen by the organizers of the Foundation. This amounts to a public admission by the government of India that it was unable to cope with the problem, notwithstanding all the commitments made in the Common Minimum Programme of the ruling alliance to pull the country up from the unenviable position of being among the lowest five countries of the world in terms of the percentage of GDP expenditure on health services. It was as if the Prime Minister throws up his hands in despair, and entreats the private sector to join it in a Private-Public Partnership to overcome a critical problem in the health service system of the country.

Even if the strong protestations by the authorities about their being fully transparent in reporting on decisions concerning its growth and development of PHFI is taken at its face value, very much more information and clarity about the Foundation will be required to comprehend how it is going to work on the lines laid down in its Charter. Conflicting and confusing reports appearing in top English newspapers will be ignored. Only reports of the address delivered at the Inauguration Ceremony by the Prime Minister on March 28, 2006 and dialogues in academic journals will be taken into account to discuss the genesis of setting up the Foundation and

its ambitious agenda of work.

Rajat Gupta of McKinsey and Purnendu Chatterjee of the Chatterjee Consultants (or Group?) have been the moving spirits behind the idea of the PHFI. They got this from some top public health academics from the Schools of Public Health at Harvard and Johns Hopkins and many office bearers and individual members of the Association of American Schools of Public Health. As pointed out by Mohan Rao and K R Nayar, Gupta and Chatterjee did not realize that the USA does not offer a particularly attractive model of institutions of public health practice, research and training. The record of the institutions in Europe and elsewhere is only marginally less inappropriate.

Apart from the dismal outcome of the very expensive Khanna Study referred to by Rao and Nayar, there has been an earlier failed Harvard study, called Communication Action Research Study on Environmental Sanitation at Najafgarh in 1957 and the still more extensive and long-term study of rural health and medical education at Narangwal by Carl Taylor and his group from Johns Hopkins, with its final report coming in 1978. As mentioned earlier. In his book, *Birth Control and the Foreign Policy: The Alternative to Family Planning*, Nicholas Demerath Sr had laid bare an extensive network of cloak and dagger activities of major US government agencies and NGOs then involved in influencing India's Family Planning Programme. In the true McCarthy style of intellectual fascism, Harper and Row had to hastily withdraw the unsold copies from the market.

Very few still "remember", least of all the prime ministers and health ministers of India that under President Truman's Point Four Programme, a large number of public health personnel in medical colleges and health administration from India were taken to the US for education in its schools of public health. This made little impact on public health practice in India. This has an uncanny resemblance with one of the key first steps that had already been taken by the PHFI – sponsoring selected students from India to get educated in public health in schools in US. What are the academic credentials of the self-styled India specialists in the US? It has to be brought home to the globalisation and GDP driven political leadership in India that they should act to find Indian solutions to Indian public health problems, as has so often been done in the past.

Typically, the PHFI found a square peg for a round hole in choosing an erstwhile head of the department of cardiology at the prestigious All India Institute of Medical Sciences, who obtained a Master's degree in public health from Canada, K S Reddy, to head the army of "knights in shining armour" to find a solution for the predicament of the Prime Minister and his team. This included, apart from opening four or five brand new institutes of public health, for which the sites are yet to be finalized, intention to resuscitate the long comatose All India Institute of Hygiene and Public Health, National Institute of Health and Family Welfare, 150-odd almost invisible departments of social and preventive medicine in medical colleges and the paralytic public health research agendas of the ICMR and the National Institute of Communicable Diseases. It is clearly a doomed venture; a quixotic venture.

Public health scholars like C.Sathyamala have sent a message to the Prime Minister that despite what amounts to a long neglect and at times their systemic "McCarthy" ostracisation, there are still public health scholars in the country who could be instrumental in rejuvenation of the moribund public health system. Sathyamala was prompt in calling into question the political and scientific premises of PHFI. She has rightly pointed out: "PHFI and its institutions – albeit located in India with blessings of the Indian government – will in effect function as an extension of American interests. It is to be governed by technocrats/bureaucrats and nominated NGOs and will be subjected to little or no accountability/scrutiny by the Indian polity." In an earlier contribution, taking strong exception to the way the leadership has given in to the power brokers, Imrana Qadeer, professor at the Centre of Social Medicine and Community Health of Jawaharlal Nehru University, has wryly observed "PHFI seems to be important to both American and Indian governments, one needing the markets and the other needing more resources to increase the middle-class consumption patterns."

In responding to the criticisms, Reddy has exposed his public health professional limitations in confronting the formidable challenge undertaken by the Foundation. The Prime Minister and the PHFI have been deafeningly silent over the critical question of competence and suitability of the bureaucrats and high officials from the Central Health Service and other state cadres who occupy key public health positions throughout the country. It is intriguing that Reddy calls for creation of more public health posts in the government health

system. If one goes by the definition of public health mentioned above, personnel of the entire health system of the country - from the Director General of Health Services down to the Auxiliary Nurse Midwife, including those in hospital administration and medical care, are public health workers. It did not strike Reddy that public health posts at higher levels at the Centre have been filled by unsuitable bureaucrats from the IAS and clinicians from the CHS.

Had Reddy made a deeper study of the process of setting up a nationwide network by pioneer officers of the erstwhile Indian Medical Service (IMS), he would have discovered that each state had an "orientation training centre", like the once famous ones at Singur, Ramanagaram, Poonamallee and Najafgarh, where the entire team of primary health centres were given in-service training, before their postings. Indeed, there was a tradition in the IMS that prior to succeeding as the as the Director General of the IMS, the officer spends two years as the Director of the All India Institute of Hygiene and Public Health. The National Institute of Health Administration and Education (NIHAE) tried to revive that tradition through a resolution at the Central Health Council to encourage officers at the centre and in the states to attend a specially designed three-month Staff College Course,

before they are allowed to take up key positions in health administration. What a far cry it is from the ministry- hopping bureaucrats of IAS and hospital-bound clinicians of the CHS.

Incidentally, one of the many critical shortcomings of the National Rural Health Mission is that it has totally ignored the vital question of the human resources needed for fulfilling the Mission objectives. The PHFI documents too do not mention it has any link with meeting the public health professional needs of the NRHM; in any case, the gestation period of the PHFI is too long, even assuming that there will be no abortions or stillbirths or maternal deaths!

Conclusion

When MFC is setting out to discuss the highly pertinent question of developing public health education in India, it has to cultivate the needed academic depth to articulate its views. Above everything else, it ought to avoid glorification of mediocrity, not only within the country, but, much more importantly, the public health scholarship in Western countries, particularly in the USA. I think I have provided enough evidence to show that we can find Indian solutions to Indian problems. NTI, where the Meet is taking place, is one such example.

Singur: "Truth cannot be subverted with power"

The CPM status report on Singur (is called): Truth can not be subverted with power ...

... let us comment and critique the CPI (M)/ West Bengal Government report.

1. The report is only on land acquisition and rehabilitation and there is nothing on the Tata Motors Project itself, neither the economics nor the MOU agreements and process of finalisation, except for a list of a handful of meetings.
2. All the nine meetings held within four months at the most have been held with the party representatives and Panchayat members (not much different from the former) but not with any Gramsabha, the community with all the Project Affected. Why? The 74th Amendment of the Constitution and the faith in democratic rights and process of planning would require this. It must happen, even now, with transparency.
3. It is clear that there are no details of the project, its cost and benefits, provided also to the Gram Panchayat and consent of the Gram Panchayat is also not sought, as reported to our panel for Public Hearing held at Gopalnagar on October 27th 2006, by Dhud Kumar Dhara, a member of GP.
4. The report is truthful about no consent granted by the local

bodies and elected representatives and the fact that it was without any consensus that the land acquisition and the Project was and is being pushed ahead and hence the use of police force.

5. As we were saying all the time and were informed by the villagers, farmers, Bargadars, labourers, others themselves through many sources including personal hearing, there is opposition to the project by 45% to 50% of landholder-cultivators and a few thousand families of other workers dependent on them, who are opposed to giving away their land. This was all through denied and ridiculed by the official sources, right up to the Minister for Industries and CM, who projected a picture of total consent. To quote CM himself, there is hardly 1% resistance. The same we found was informed to the President of India, the Governor of West Bengal and also probably the Tatas.

This status report brings out the reality to be different.

Out of 997 acres, it was for 620 acres that consent was granted before passing the Compensation Award. We cannot accept this as given and will like to see the documents, under the RTI Act. Why not? In any case, it's not 100% or 99% families' consent.

1 We also have affidavits recently proposed and submitted to us by individual farmers who have not and do not want to give

away their land totalling 347 till now.

1 Our number of landholders too was being challenged. This report itself shows the landholders number for 635 acres to be 9020. This shows the small size of landholdings in the area as we claimed.

1 What does post-award consent mean? It means consent under duress, when you complete acquisition under law, declare the same, it is not 'Free Prior Informed Consent', a pre-condition that is recommended for large dams and development projects in our Report of the World Commission on Dams, which I was a member of, and is also demanded by all democratic organisations. We must be allowed to look into the consent papers and have copies and get those checked with the villages themselves, please.

1 Many of our friends and some of the LF partners too were asking for even a single case of dissent. More than this report our affidavits bring out many which can surely be checked and compared.

1 The fact not mentioned is that most of those dissenting have not even accepted land acquisition notice under section 4 of the age old Land Acquisition Act, (which LF friends too challenge, as in their note on SEZ to the UPA) and hence acquisition in their case is ex-parte, on paper.

1 It is also clear that there is no Rehabilitation Policy or package clearly put forth. except for cash compensation. As we know, there is no state level rehabilitation policy, either. Training for any vocation, in any technical work does not guarantee employment.

1 To offer such training as a complementary economic development activity is appreciable since there is underemployment and unemployment within the agriculturist families, but not destroying the existing employment in the agricultural sector. In any case the 189 trainees are not a big number.

1 What would the families do with cash? The absentee landlords may invest in some trade etc., but will the cultivators be able to purchase alternative land of the same quality, of what magnitude, where and when? The experience of cash swindled away leaving families impoverished has occurred in all the past projects; hence we demand land based rehabilitation in the Narmada dam too (where it is policy and hence 10500 families have got it. not without problems, though thousands remain deprived). We demand in West Bengal a state level Rehabilitation Act for the minimum displacement that may occur for projects that would be justified and conceded to, by the affected people. We have already drafted a National Policy on Development Planning and the Advisory Council to UPA chaired by Sonia Gandhi, has already approved the National Draft. Let the LF take it up as our supporters and get enactment with one more consultation and finalisation, the earliest possible.

1 We will certainly like to check on the trainee's list and the training offered, which is not fully possible in the present circumstances and atmosphere of intimidation.

1 Our brief investigation and the status report itself show that

many of the training programmes are yet to begin while occupation of their land has started. Whatever little programme has commenced, some of the trainees are from the project affected families and others are not. So why should the families face displacement to get such training which is a need of women and youths all over?

1 It is also no guarantee of employment. The application forms filled by the trainee youths, state clearly that training does not mean the guarantee of a job! One knows from experience of industrialisation all over that the oustees don't get absorbed, they do not get a share in the benefits. The reasons, politico-economic, cannot be ignored.

1 The report claims development works to have been undertaken in the affected area. Are these a part of rehabilitation? Installing bore wells, excavations of silted water channels, building roads etc. are regular development activity and why should it wait for some big industry to acquire the area? The industrious population is to be deprived, agriculture with further potential for agro industry and harnessing water in this Damodar Valley Command area is to be lost..towards what end.

1 Even the cash compensation affected seems to be high to an outsider - Rs 6 to 9 lakh per acre as basic price and 9 to 13 lakh per acre paid price with solatium etc. We are told the actual market price for these two quality lands is actually almost double. Also, the land adjacent to the Durgapur Expressway is too expensive. In today's world especially the urban, when land is gold its value is ever escalating. This is land near the metropolis and hence the Tatas want it too. Why should the resident farmers part away with the same?

1 The questions of course go beyond the rates and the market. First, should the displacement be imposed on people living with agriculture for generations? Second, what is our experience with rehabilitation? Narmada and such tens and hundreds of projects are known but so are those in West Bengal. Damodar Valley Corporation affected too, and is yet to be rehabilitated. The research by Walter Fernandez of the Indian Social Institute, now at the North Eastern Social Research Centre, Guwahati, brings out that in West Bengal as other states, at least 70 lakh persons got affected due to the projects since 1947 till 2000, and only 9% of them are actually rehabilitated. This is too low a percentage compounded to that for other states (AP- 28%, Orissa- 33%, Goa - 34% & Kerala - 13%).

1 There is no doubt, therefore that farmer- cultivators, registered bargadars to labourers in Singur are not for displacement, nor for rehabilitation. The report only mentions their numbers but not any opinion survey or referendum has been conducted. The numbers given by the official and the non-official also differ. The registered bargadars cannot be 237 and one must note that the 'operation barga' the popular land reform exercise was to be completed, not only registering all bargadars but as a second phase, granting them land rights too. This has not happened yet. That the land records are not updated, was accepted by Mr Nirupam Sen, Minister for Industries himself, who admitted that updating work is being done simultaneously...

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Training of Primary and Paramedic Workers and Public Health

– *Shyam Ashtekar and Dhruv Mankad*¹

Introductory

Primary/community care workers in the Indian situation include ANM, MPWs, the variants of CHW to ASHA in NGO and Government (public) sector, dais, the huge Anganwadi worker community, and we are tempted to include the 'lakhs of quacks' providing care to rural population more than any other sector. The paramedics are by definition assistants or supplements to doctors or emergency medical care providers. This category includes, the hospital & lab assistants, radiological assistants, and home care givers.

Public Health component of their 'training' (education?) is what they learn and practice that is of public health importance, and apart from overtly public health actions like sanitation and spreading nutrition awareness, collection of blood smears and sputum-slides etc. it also includes the 'clinical' tasks they perform-like the presumptive treatment of malaria, assistance in home birth, first aid, or early detection of high BP and cancers. Therefore broadly, all primary and paramedic workers are doing bits of public health practices in several ways. In a way the primary care agenda is itself a public health agenda in this context.

Current Scenario of Primary and Paramedic Workers

Every good health system needs primary care to ensure access to user friendly first contact care, cost economy, and to avoid overburdening of hospitals. Paramedic workers have a significant role to play in hospitals and other medical establishments, and they also reduce costs, can augment quality of care. They also reduce dependence of costly expert time/resources. Both primary and paramedic workers need to be the base of the health care pyramid. Their training is an important issue in itself.

However, Indian health-medical education system has centered on medical, nursing and few allied programs. There are hardly institutes and systems to train other cadres, except what is dished out through the executing departments or their associated agencies. There are no exams, and no accreditation and therefore no talk of quality or monitoring. For instance, the huge cadre of Anganwadi workers has often received 'training' only on their jobs. If we look closely at their training institutes, there is little substance therein. However,

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this gap has been recognized and several AWW (Anganwadi Workers) are going through training in Integrated Management of Neonatal and Childhood Illnesses (IMNCI).

And yet, these very workers have fought back small pox, leprosy and are fighting several public health challenges, as complex as RCH, malaria, malnutrition and TB.

Education versus Training

We often use the word *training* for all health workers, while we speak of *medical education for doctors*. The difference is that training is not much about the Knowledge (K) and Attitudes (A) parts but linked mainly to the *skills* part. This differential usage speaks for the hierarchy. In reality primary and paramedic workers also need knowledge and attitudes and are not just running errands. Hence it is necessary to restore the K & A parts in training of all primary and paramedic workers.

Training versus Learning

This word splitting could have been unnecessary only if the realities were different. However, we have often seen *training being imparted* to health workers in several situations while actual learning takes a backseat. The trainer-dominated agenda—often 'manned by doctors'—is a typical scene we have seen in CHW programs. And the irony is that CHWs are supposed to liberate others from several shackles. This calls for a change in attitudes of policy makers and program managers.

Locating Primary Paramedic Workers in Public Health Education

In China there is a distinct paramedic school for each county Headquarter (equivalent to half of our district) serving barefoot doctors, nurses etc. In India there is only the meager ANM outfit in the district hospitals. The Maharashtra macro plan of medical university speaks of medical colleges in each district, but nothing about paramedic institutes. In fact, barring nurses, all the paramedic education is outside regular institutions. The arrangements are ad-hoc and there is no serious thought of learning environment. When YCMOU (Yashwantrao Chavan Maharashtra Open University, Nashik) set about doing this task, we had to invent contact learning centers for this purpose, putting together facilities and trainers from different sources.

Obviously the economics of primary and paramedic institutes is far too poor as compared to medical education.

Training Systems and Institutions

Resources, costs and inputs

Most paramedics get their training hands-on, which is therefore bereft of anything except *do as directed* stuff.

The employer is usually the teacher. Barring some elite paramedics such as optometrists, there are no regular institutes. Often there are no separate cost calculations. But even if such costs were calculated, they amount to fraction of what it costs to train doctors. When YCMOU did a costing of paramedic and primary care programs in the ODL (Open & Distance Learning) system, the direct costs to the learner are given in table below.

Table of Program Costs

Primary		Program title	University Fees (Rs)	Training center fees (Rs)	Total (Rs)
	1	Acogyantra (CTW)	800*1Y	2500	3300
	2	Dai (birth attendant)	500*1Y	1700	2200
	3	Anganwadi sevika	1000*1Y	2500	3500
	4	Skilled Birth Attendant *1y	2000*1y	8000*1y	10000
	5	Home care attendant	300*1Y	500	800
Para- medic	6	Rugmasahayak (hosp assistant)	1500*1Y	5000	6500
	7	Massage & Acupressure (1 year)	1000*1Y	5000	6000
	8	BSc Med lab asst (3 & half year)	4000*3Y	8000*3Y	36000
	9	Ophthalmic asst (2 & half year diploma)	4000*2Y	8000*2Y	24000
	10	BSc Optometry (4y)	6000*4Y	24000*4Y	120000
	11	PG diploma in hospital & health care mgmt 1 year	4000*1Y	16000*1Y	20000
	12	MPH one year [#]	10000	30000	40000
	13	Sanitary Inspector [#]	4000*1y	20000*1y	24000

[#] proposed

1. Includes in registration, books and exam costs

2. Excludes lodging and food/travel

All this information is available on the website: <<http://www.ycmou-its.com/>>

The operational costs of these programs are affordable to the institutes if the training activity is a small part of that institution's activities. The fees collected may just about meet the running costs. Capital costs are generally not factored in ODL (Open & Distance Learning) system. There are exceptions where the professional education institutes run the programs like PGDHHM, BSc (Optometry) or MPH.

Legalities and Accreditation

As yet there is no board/council for primary and

paramedic workers barring the nursing profession and physiotherapists in most of the states. There is ambivalence regarding 'recognizing these workers' into the mainstream health system, which is basically shaped after the doctor-nurse dominated European model. A paramedic council is now mooted by the Government of India. The lack of a council, paucity of institutes, and accredited courses has created adverse conditions for paramedics. In addition, the Nursing Council is always threatening the institutes running 'nursing assistant' courses. Since it will be impossible

to enforce any regulation for nursing homes in absence of enough nurses to fulfill the norms, there is some narrow space for recognition of paramedics.

Madhya Pradesh is the first state in the India to have enacted a Paramedical Council Act in 2003, which covers about 31 paramedical professions other than nursing. The list includes physiotherapists, optometrists, ophthalmic, dental assistants, etc.

As for primary care, providing legal space is nearly impossible in the Indian situation in clinical practice. On the contrary, governments are reluctant to include medicines in their curricula to steer clear of legalities. The recent ASHA program had allowed just 4 medicines (chloroquine, paracetamol, iron-folic acid and ORS) and some more additions are now allowed. The infant mortality goal requires use of some antimicrobial for management of sepsis and pneumonia. For all practical purposes, such usage cannot be allowed under current legal provisions except by issuing GRs. In this situation, ignoring or pushing the issue under the carpet is the only possibility. However the Government of India can make specific provisions if it wants: like it allowed for specific public sector paramedics, eg., chloroquine for presumptive treatment or mesopristol for severe bleeding after delivery or prostaglandin for skilled birth attendants/ANMs.

National Efforts and Policies about Primary and Paramedic Workers

As we are closely studying the primary programs and paramedic workers, we see the following problems regarding primary and paramedic training:

No clear policy and syllabus exist for most of these cadres (Except in MP State)

No training whatsoever to even senior cadres like Lady Health Visitors, on even basic concepts in Public Health, epidemiology, etc.

Institutes are scant. (There are abundant for specific occupations but irregular - about 850 nursing schools and 120 nursing colleges in India)

There is no serious pedagogic consideration of their needs and aspirations. This is especially true about the primary care sector.

Faculty Training for Health Professionals is not considered important except in certain reputed institutions. There are sound theoretical principles behind pedagogy, which need to be internalized while

teaching, assessing and examining the students. This is unlike being a trainer, which is more a skill-based profession.

Lack of proper payment to the paramedics and course - recognition is a major demotivating factor. 'What next after training' is always a question on their minds.

There have been some systematic attempts in the NGO sector on the training of CHWs: Dr. Arole, the Bangs and Jan Swasthya Sahyog (testing clinical role of CHW, dais), Bharatiya Vaidika Sanstha (manual preparation and training of CHWs), VACHAN (formal evaluation of CHW), FRCH (CHW training through National Open School), SATHI (SNDT university-recognized curriculum) are some examples. But the government has neglected these efforts. The ASHA program in the NRHM is a prominent example wherein we see all the dilemmas, indecisions, lack of pedagogic approach, and an ad hoc training strategy. The Mitandin, the precursor of ASHA, has suffered similar problems in Chhattisgarh and the JSR (Jan Swasthya Rakshak) in MP was no different. There seems to be some planning done at AP in training Women Health Volunteers This neglect is so common that it is becoming the most common feature of primary care programs.

State Govt Programs and Expenditure on Training PPWS

The training of ANMs (new candidates and retraining), dais, health visitors, etc., is supported through Family Welfare budgets. The MPW scheme is supported from the same source. In Maharashtra, the annual expenditure on all this is about 10 crores. The HFWTCs (Health and Family Welfare Training Centres) and CHC PHCs are the main institutions. In Maharashtra, the DTT (District Training Teams) is an additional establishment for each district and the annual budget is about Rs 2 crores. The total training expenditure (Rs 12 crores) covers about 8000 ANMs, 4000 MPWs, 2000+ LHV's (as per IPAS, there are 1,20,000 nurse midwives in Maharashtra and as per <www.hetv.org>, there are additional 60,000 MMPWs) and dais. The training for the dais is of two types: new (10 days) and reorientation (1 day per 3 months). This is hardly conducted.

This is what the State Government is spending on its own staff. The cost of AWW (Anganwadi Worker) training is not calculated here since it is done by WCD (Women and Child Development Department).

The Department of Technical Education offers 2

programs for paramedics: the 1 year Postgraduate Diploma for Medical Lab Technology (PGDMLT) and one certificate course for ward boys. At the level of Board exams, the vocational option for lab technology and ophthalmic assistant is available.

Primary Paramedic Workers: Significance in Public Health.

The Numbers Game

As observed earlier an estimated 5 lakh plus people work in primary and paramedic sectors in the state alone. The Government training is limited to its staff and dais (which is the weakest component). The rest take training in their own ways and often it is hands on. There are neither institutes nor accredited programs for them. These workers cannot afford long institutional stays or days off from their work. The lack of accredited programs has made them vulnerable for several risks including low pay and no protection. In the interest of public health, services to patients, and easing pressure on doctor-nurses and hospitals, we need a major effort of training and retraining in this sector.

A New Witch Hunt: The Neglect of Dais

The RCH (Reproductive and Child Health) agenda, the MDG (Millennium Development Goals) and the foreign public health advisors have jeopardized the home birth and dais in the hope of bringing all birthing events (and thereby reduce MMR) into institutions, no matter that our so called institutions are hardly prepared to receive them. This 'demand' side strategy and pushing families for institutional birth has started. This has suddenly knocked out the bottom of village birthing practices. The ANM is for long minus her midwifery skills thanks to her peripatetic job spread over several kilometers to do more important 'public health tasks'. This also was the result of our policies of putting government needs and priorities above peoples' needs. Now to save the 'institutional' initiative, ANMs are being retrained and dilapidated subcenters without any additional facilities required for EmOC (Emergency Obstetric Care) are seen as birthing institutions. Why can we not decide our policies and design nuanced programs? Primary and paramedic programs are too often victims of sudden shifts and changes thanks to international advice. The states need to assert, make

their own policies and programs, and use their constitutional prerogatives. Few states exercise these freedoms. The humiliation of dais and ANMs for institutional births is a case at point.

Role and Status of Primary and Paramedic Workers in Public Health

Apart from the number – shortage or abundance – factor of the paramedics, perception factors about their public role, utility and needs influences the personnel policy (see Appendix 2). Training is important but creating demand for those trained, e.g., for paramedics in private sector or the ASHA amongst the community is an important need. This is essential to make public health services effective and efficient.

Conclusion

Primary and paramedic workers are immensely important to both the public and private health sector, rural as well urban. Lakhs of workers are employed in each state. They need proper academic support through programs, recognition through a council and continued educational support. We also need awareness among the community and public health policy makers. This will not only enhance the quality of services and public health and bring empowerment to this rather underprivileged section of the health sector. We have neglected the issue too long. In the days of compulsory registration of facilities and modernization of the health sector, we need to act on the matter soon.

ODL Fits the Bill

The health sector needs to look for fresh solutions for this. ODL (Open Distance Learning) fits the bill for covering the needs of these sectors. It is need based, participatory, learner-centric by design, accredited if not exactly legal, low cost for all parties involved, upgradeable and implementable on large scale. The use of IT fits the needs perfectly, but is an additional means to print materials and conventional modes. The most important is its shifting emphasis from training-teaching to learning. ODL uses the work stations into training venues and thus holds a key to upgradation of institutes as well. YCMOU (Yashwantrao Chavan Maharashtra Open University, Nashik) has made a small beginning. YCMOU can share the programs with other states and ODL institutes. All the relevant information is available on our website <www.ycmou-hs.com>.

The Factor of Public Health Education for Various Health Workers

Area/SAHP	Subtopic	Example ²	Community level workers							Clinical settings		
			ASH	PHW	DA	ASH	ASH	Home care	ASH	Hospital	Specialty health workers	
Health Interventions	Behavioral	Gender & HIV	1	1	1	1	1	1	1	1	1	
	Biological	Spread of malaria infectious	2	1	1	2	2	1	2	2		
	Core infrastructure	Fluoresc	2	1	1	1	1	1	1	1	1	
	Sanitation-water	Open-defecation & sanitation LBA	1	1	1	1	2	1	1	1		
	Nutritional	malnutrition	2	2	1	2	2	1	1	2		
A) Preventive programs	Occupational/safety issues	Alcoholism	1	2	1	2	2	1		2		
	Specific protection	Caution for child at	1	1	1	2	2	1	1	1	1	
	Early detection/screening	Cancer detection	1	2	1	2	1	1	2	1	1	
	Health	Positive exercises	1	2		2	1	2	2	2	2	
B) Clinical & Supportive	Preventive clinical	Risk factors	1	1	1	1	2	1	1	1	1	
	Diagnostic	Checking BP	1	1	1	1	1	1	2	2	1	
	Curative	Fever treatment	1	2	1	1	1	1	1	1	2	
	Nursing	Wound care	1	1	1	1	1	2	2	1	1	
	Emergency care	Cardiac resp resuscitation	1	1	1	1	1	1	1	1	1	
	Contraception	Choice of contraception	1	1	1	1	1	1	2	1	1	
	Care	Care of aged	1	1	1	1	1	1	1	1	1	
	Follow up	Post-partum visit	2	2	1	2	2	1	2	1	2	
	Data/reporting	Daily/monthly report	3	3	1	3	2	3	1	1		
D) Health services	National programs	Immunization	3	3	1	3	2	1	1	2	2	
	Local programs	Epidemic control	3	3	1	3	1	1	2			
	Private sector	PNDT/JSY ¹	1	1	1	1	1	1	3	2		
	NGO	Domestic violence	2	1		1	1	1	1	3		
Health education	Mass/groups	Water-sanitation	2	2		2	2	1	2	2	1	
	Personal	STI spread	3	3	1	3	3	1	3	2	2	

¹ Skilled Birth Attendants ² Prenatal Diagnostic Tests/Janani Suraksha Yojana

Annexure 1: Overview of Primary and Paramedic Personnel and Training Facilities

Category & Sub-Category	Public Health Imp (0-3 Scale)	Estimated Numbers in Maharashtra	Recognized Courses	Institutes	Problems	YC/DCU/P
Primary Sector (First Contact Care)						
Community HW (ASHA)† Govt+NGO	3	13000	None	Through MCG/ANMs	Substandard	On
Anganwadi Health Workers	3	15000	Govt Program	Limited NGOs	Substandard	Pr
Multipurpose Health Workers	3	60000	Govt Program, NGOs, Govt Instt.	HPWTCs ³ -State, Pvt	Intensive	
Auxiliary Nurse Midwives/Female H Assistants	3	1 lakh 20 thousand	Govt Program NGOs	District Hospitals	Intensive	
Data Village Birth Attendants*	2	42000	?	Thru ANMs	Substandard	On
First Aid Assistants-Home guards/Ambulance Worker	2	(?)	BVA	?	Occasional	
Home Care Clinics† Others	1	10000 (?)	None	Private Hospitals	Variable*Too Little	On
Yoga Teachers	1	3000		Several NGOs/Voluntary		On
Paramedic Sector (Assistants)						
Nurse Midwives Govt Sector	2	6000	Well Established	Govt+Private	Several Instt.	
Recognized Nursing Personnel in Pvt Sector	1	10000	ONGM†-Established	Govt. + NGO	Too Few Institutes	
Public Health Nurses	3	100	Well Established	Govt. + NGO	Limited	
Hospital Workers* Pvt Sector	1	100000	None	None	No Formal System	On
Ophthalmic Assistants*	2	4000	Vocational Dept	None	No Formal System	On
Optometrists*	1	1000	None	Some Colleges	No Council	On
Ward Ayahts Ward boys*	1	100000	None	Limited If Any	None	Pr
Dental Assistants	1	1000	None	None	None	
Medical Lab Assistants	1	10000	Few		Steady	On
Sanitary Inspectors/ Food Inspectors	3	5000	Formalized	Few	Substandard	Pr
		250000				

³ Health and Family Welfare Training Centres ⁴ General Nurse Midwifery

Annexure 2: Weightage Index of Primary Care and Paramedics Personnel for Public Health

	Category	Location/Work	Type of Role	Public Health Program	Primary Care Public Health Index Score	Public Health Score	Public Health Score	Weightage Index
Health Care and Hospital Manager	Health Care Manager	Hospitals	Professional	Public Health Mgmt	2	4	4	0.67
ASHA/MPW	Primary Care Provider	Community HC	Public Service	RCH	3	2	3	0.67
Nurses in Govt Hospital	Primary Care Provider	Hospital	Public Service	RCH	3	1	3	0.60
Nurses in Pvt Hospital	Paramedics	Hospital	Service Provider	NA	2	1	4	0.60
Public Health Nurses	Primary Care Mgmt	DHO, PHD	Public Service Professional	RCH-Public Health Mgmt	2	1	1	0.60
MPH	Public Health Manager	NDCs, PNDGs	Professional	Public Health Mgmt	3	1	1	0.60
Ophthalmic Assistants	Paramedics	Hospital	Service Provider	NHCP ⁵	2	2	3	0.53
Optometrists	Primary Care Provider	Hospital, Optic Clinic	Service Provider/Professional	NHCP	3	1	2	0.53
Massage, Acupuncturist	Primary Care Provider	Community-Hospital	Service Provider/Professional	NA	2	2	3	0.47
First Aid Worker	Primary Care Provider	Community-Hospital	Voluntary	Director Mgmt	2	1	3	0.47
Dietician/Nutritionist	Primary Care Provider	Hospital/Clinic	Service Provider/Professional	RCH	3	1	2	0.47
Medical Lab Assistants	Paramedics	Hospital, Lab	Service Provider/Professional	NHP	2	2	2	0.40
Hospital Workers in PH Dept	Paramedics	Hospital	Service Provider	NA	1	2	3	0.40
Dais	Primary Care Provider	Community	Voluntary	RCH	1	1	3	0.40
Sanitary Inspectors/Food Inspectors	Paramedics	FDA, PHD	Public Services	FDA	3	2	1	0.40
A/W	Primary Care Provider	Community	Part time worker	RCH	3	2	1	0.40
MMPW	Primary Care Provider	Community	Public Service	NHP	3	2	1	0.40
CHW -ASHA	Primary Care Provider	Community	Voluntary	NHP	3	1	2	0.40
Various Technicians	Paramedics	Hospital	Service Provider	NA	1	2	2	0.33
Dental Assistants	Paramedics	Dental Clinic	Service Provider	NA	1	1	1	0.20

⁵ National Blindness Control Programme
 NA = Not Applicable (No relevant NHP for their role)

Capacity Building for Public Health in the Asia Pacific Region

-Thelma Narayan¹

Evolving Definitions of Public Health and Primary HealthCare

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

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

3. The International Association of Epidemiologists also defines public health with a broad perspective "*Public health is one of the efforts organized by society to protect, promote and restore people's health. It is the combination of services, skills and beliefs that are directed to the maintenance and improvement of the health of all people through*

collective or social action. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same; to reduce the amount of disease, premature death and disease produced discomfort and disability in the population." (JM Last, 1995).

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

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

Strategies for Capacity Building in Public Health

6. Human resource development- Developing a pool of well-trained, competent, highly motivated professionals and workers in public health is a priority for all countries in the region. There is an urgent requirement for a range of public health skills and competencies – including specialist epidemiologists, policy analysts, health administrators, program managers, trainers, health economists demographers,

¹Extracts from a report of the same name written by the author for the UNESCAP (United Nations Economic and Social Commission for Asia and the Pacific) office in Bangkok in 2004. The UNESCAP had initiated measures to strengthen public health, including public health education in the 62 countries that come under the Asia Pacific region. Many parts of the report were incorporated into a strategy paper adopted later by UNESCAP. Email: <thelma@sochara.org>

statisticians, researchers, social and behavioral scientists, public health nurses, health promoters/educators, laboratory technicians, social workers, multipurpose workers, health assistants, community health workers, health animators and others. While specialization in sub-sections of public health will be inevitable, the key focus should be on training more multi purpose, integrated, socially relevant, public health generalists at different levels.

7. Planning and forecasting the numbers of trained staff in public health required at different levels of the health system is a task to be undertaken by each country. Based on a needs assessment, numbers retiring per year, and overall attrition rates, the numbers to be trained every year can be calculated, keeping in hand a reserve stock of personnel who can manage leave vacancies, respond to emergencies, undertake consultancies etc. Most important is the policy recognition that in order to achieve effectiveness, relevance and quality, some positions at specific levels in the health system will necessarily need professionals with competency and training in public health. The tendency to appoint clinicians to public health positions, and to be susceptible to political compulsions, needs to be avoided if public health objectives are to be met.

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

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

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

attending a certain number of courses and achieving competencies required for different levels.

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

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

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

Training Methodologies for Public Health Practitioners for the Asia-Pacific Region

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

15. It is important for countries in the region to consider the underlying philosophy, educational methods and processes of learning, adopted in the higher education of public health professionals. Two foundational premises that continue to have a major influence have been the biomedical scientific roots of public health and its proximity with state power. These developed historically within the then dominant social context often linked with the industrial revolution, capitalism and colonialism. At the interface with people in the Asia Pacific region, who have their won culture and knowledge base, there is often an alienation of philosophy, concept and praxis. Public health practice is often perceived to be an expert driven, top-down, centralized, prescriptive approach, implemented in a heavy handed manner by the government bureaucracy. This does not win the hearts and minds of people and

is often met with scpticism if not with resistance, non-action and non-adherence. Development of pedagogical methods, and the learning environment and process, will need careful thought in order for students of public health to identify and retain the core principles and elements of the discipline, to be sensitive to the cultural and social context of communities with whom they work and to best utilize the right knowledge base and traditional health and healing practices in the region. Since the 1970s much experience has been gained, particularly through community health and development projects in the voluntary sector, in the use of participatory, experiential, reflective and transformatory learning processes. While these methods initially evolved through working with communities, they have also been used in the education of professionals who find it a more liberating, meaningful and motivating process of learning and personal growth. Besides theoretical content and competencies, it includes experiential learning in community based programmes, self awareness and reflection, teamwork, social skills, understanding culture and community dynamics, spiritual and ethical dimensions of health and public ethics, among others. This qualitative change in the method of teaching-learning enhances social effectiveness and community support increases personal motivation, prevents burnout and helps the creation of a social network among public health workers.

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

Training Approaches

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

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

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

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

Training Content

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

protect public interest and human rights and to reduce social inequality, with resultant benefits to the health, and wellbeing of people.

22. Content areas to be covered in the training would include:

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

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

Developing Centres of Excellence for Teaching and Research

24. There is a need for a number of centres of excellence for teaching and research in public health and community health in the Asia Pacific region. While countries with large populations may have more than one centre, smaller countries could share a centre or send their professionals to recognized centres. Mechanisms for generation of financial and technical resources could be developed. Regular exchange and electronic networking between academic and research centres in the region, and close collaboration with WHO regional and country offices would be beneficial. Mapping of existing centres and resource groups in the region could be initiated by the secretariat. Scholarships could be established for least developed economies. Electronic methods of communication could be institutionalized so that whenever required

rapid mobilization of expertise and quick sharing of information is facilitated. These centres will be the nerve centers for knowledge generation and application, and will need to be very dynamic and alive. Countries are advised that the leadership, management systems, library and information centres and financial security of these centres are critical areas for development. Their purpose would be to be socially relevant to the public health related issues and concerns in their countries and neighboring areas. Interaction and alliance building with the local health services, NGOs and social movements would enable them as a group to impact on the determinants of health.

Community Capacity Building for Public Health

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

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

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

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

50. Self-help groups of persons living with particular illnesses who also become advocates for preventive and promotive action play an important role.

Involvement of persons living with HIV/AIDS at all levels of health decision making has significantly altered the public health discourse. Shifting the balance between experts, health providers and patients from one of dependency to one of greater autonomy and equality has been an important step forward.

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

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

53. Experience across the region has shown the great value addition of involving communities with health institutions through a variety of institutional mechanisms that include:

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

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

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

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

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

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

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“Accreditation Guidelines for Educational/Training Institutions and Programmes in Public Health”¹

4.2 Recommendations on Public Health Training and Education

Public health training takes place at different levels. Unless the training of health professionals working in all these areas was addressed simultaneously, it was considered that the desired effect would not be achieved.

The public health training needs of three levels were identified: “Sub-centre”, or “community level”, the “primary health centre” level or “district level” and the “provincial or regional level.” Since these terminologies are used with different meanings, the three levels were re-defined by the size of the population to make comparisons easier.

(1) The “community level” or “sub-centre” level provides health service to a population of 5000 or less.

(2) The “primary health centre” provides health services to a population between 30,000 to 50,000.

(3) The “district level” provides health services for more than 100,000. This level can be applied to provincial or regional level in some countries.

(1) Sub-Centre level

Generic Skills and Competencies

At the sub-centre level, health workers were considered to be the first level functionaries. These functionaries were expected to have essential attitudes such as empathy, ability to listen and communicate and develop specific technical skills.

Using each country’s experience, the group could show that there were similarities in the skills required by workers in different countries. Technical skills in the following areas were considered essential:

- Community needs assessment including high risk identification;
- Data collection and interpretation, facilitating the surveillance system;
- Record-keeping and timely reporting;
- Basic planning and management;
- Health promotion;
- Providing specific protection;
- Diagnostic and treatment skills with timely referrals;
- Community-based rehabilitation;

¹Taken from the Report of the Regional Consultation, Chennai, India, 30 January-1 February 2002 (WHO Project: ICP OSD 002)

- Disease control of local importance and
- Women’s issues and gender concerns

Eligibility Criteria

The group recommended that workers at the sub-centre level be recruited locally from districts, after completion of secondary schooling and put through training lasting for 1 ½ to 2 years. For those in service, a bridge course be established.

Curriculum: Nature and Design

The following guiding principles were recommended for the design and teaching of the curriculum. It should be

- problem/practice oriented;
- job/tasks oriented;
- focussed on hands-on training;
- balanced combination of theory and practice with appropriate apportionment of time;
- an integrated curriculum with emphasis on attitudinal skills and nurturing and supportive supervision, and » strengthen supervisory and managerial skills.

Faculty/Teachers

- A trainee-tutor ratio of 10-15:1 was suggested.
- Teachers should have received training to be teachers, with experience/exposure in field situation and experience in carrying field studies.
- Teachers should have received training to at least one level above the course they have to impart training to. There should be core faculty and extended faculty.

Teaching/Learning Resources

Besides adequacy of infrastructure (money, materials and manpower), the continued professional development for staff from the private and government sector and provision for National Teachers Training Centres for SEAR countries were discussed and recommended.

Teaching/Learning Methods and Processes

Besides lectures, emphasis should be laid on site visits to field, health facilities, and hospitals for demonstration and participatory observation, on-the-job practical training and focus on active learning, close to reality using simulation, and role-plays.

Monitoring and Assessment

A basic requirement was that a plan for monitoring and assessment should be in place with an emphasis on

improving quality.

Assessment was needed for students and teachers including, internal and external assessment.

Continuous assessment of skills and performance were considered necessary and to be given higher weightage rather than terminal assessment.

(2) PHC level

The categories of persons who would need training to work in a 30 to 50000 population would include: medical officer, public health nurse, district level public health officer and allied health supervisors. Some of the allied health personnel are country-specific in nomenclature, usually at a basic degree level of competence.

Generic Skills and Competencies

At the PHC level, (30 to 50000 population), the group identified skills needed under three main categories: (i) Technical skills; (ii) Administrative and management skill and (iii) Self-development skills.

Technical skills were needed in areas relating to:

Community diagnosis and health promotion; prevention and control diseases of public health importance; supervising and monitoring health programmes; investigation and management of outbreaks, and disease surveillance.

Administrative and management skills were needed

- to manage health promotion and disease prevention activity; to use of health information for management; implement health legislation; influence public health policy; provide cooperation between health and other sectors; design and implement IEC; implement ongoing continuing in-service training; manage human resources; address quality control issues and set up systems to monitor quality; mobilize the community to participate and use local resources for public health programmes effectively; initiate action to promote environmental health and report on circumstances that may be hazardous to the environment; take proactive steps towards women's issues, and initiate and participate in applied research.
- Self development skills such as accessing and utilizing information from different sources, particularly in using the Internet and a computer are also necessary.
- These guidelines were suggested for staff functioning at PHC level such as the medical officer, public health nurse and allied health supervisors.

Eligibility Criteria

Institutions involved in training public health categories such as medical officer, public health nurse must clearly state criteria for eligibility/admission to the course.

Curriculum Design

The curriculum to be designed should consist of all essential competencies; it should be community-oriented, flexible, dynamic and sensitive (culturally and gender-wise), and based on needs assessment.

Faculty

It was suggested that the faculty should be public health specialists, multidisciplinary, with a mix of field and academic experience.

Composition

- Public health specialist
- Multidisciplinary specialists
- Faculty with experience and skills in teaching
- Mix of faculty with academic and field-based experience

Number

Minimum number adequate to maintain teacher student ratio 1: 10 in all disciplines. The faculty recruitment should be transparent and there should be an ongoing assessment, which should include service output, educational achievement, research and faculty development activities.

Teaching/Learning resources

- Teaching methods should be learner-centred, self-directed, balanced between theory and practicals and mentoring should be available. Monitoring and assessment should be periodic, teaching processes should be assessed; results should be used to improve teaching.
- The basic infrastructure should include a library with current books and journals, facilities for use of the computer/Internet and an adequate supply of A.V. teaching aids/materials.
- Field practice area should be accessible, the institution should have a good rapport with community and the infrastructure should be adequate for field work. There should also be a good liaison/ partnership between the government and NGOs involved in public health. .

Teaching learning methods/process should have a/an:

- good balance between theory and practical sessions; approach which is learner centred, encouraging self-directed learning; system that encourages active learning; sequence of learning activity from simple to complex ideas; agreed proportion of time devoted to field based methods; mentoring - where trainee works with a practising public health person of same vocation, through empowerment approach.

Monitoring/Assessment

- Monitoring of students and faculty should be periodic and focus on knowledge/skills/attitudes of students with

periodic assessment of the course/programme.

- Faculty performance should be assessed by the administration, peers, self and students.
- Assessment should include methods/processes used in the course, outcome/relevance of each component of the course assessed, with a written system of monitoring, and assessment of skills
- Results/Outcomes of monitoring must be used to improve training. The environment should be conducive for the acceptance of results of monitoring/feedback in a constructive manner.

Courses Identified: MBBS, MD (basic degree), BN, BScN, BPH, etc.

(3) District/Provincial or Regional level

(Population 50000 – less than 200 000)

The group developed a comprehensive list of competencies for the higher category of health workers that could be used across different countries. They usually belong to the professional group with advanced educational qualifications and experiences. The lists of skills needed at the district level and above were categorized under the following competencies:

Public Health Competency

- Planning, implementation, supervision, and coordination of disease control activities;
- Organization of district-level surveillance programme including response to outbreaks and emergencies;
- Monitoring environmental safety, and
- Implementation of public health laws

Managerial Competency

- Conducting needs assessment
- Prioritizing health problems
- Setting up objectives and targets
- Organizing reporting systems
- Interpreting HMIS and critically evaluating data
- Evaluating programme quality and effectiveness
- Health manpower planning and human resource management
- Mobilizing community participation
- Targeting resources to make health care initiatives equitable
- Explaining scientific information to lay public
- Preparation of budget

Leadership Competency

- Carrying out district level programme planning
- Facilitating PHC level programme planning
- Facilitating inter-sectoral coordination
- Explaining scientific information to decision-makers and opinion leaders
- Organizing in-service training programmes
- Carrying out cost analysis of health care inputs

Teaching Competency

- Organizing teaching learning sessions for professorial students
- Identifying curriculum content and needs
- Identifying appropriate teaching methods
- Teaching how to learn
- Facilitating the learning process
- Training the trainers
- Training future teachers

Research Competency

- Expertise in epidemiology and biostatistics
- Critically evaluating data
- Identifying gaps in knowledge
- Enunciating Research questions
- Designing and implementing studies
- Carrying out health systems research and sensitivity analysis
- Understanding efficiency and carrying out cost effectiveness studies
- Preparing research papers
- Organizing dissemination of research results
- Carrying out meta-analysis

Under each competency, specific skills that were expected of the members of a district team were listed. The difficulty faced by individual countries to have such highly skilled personnel at the district level was deliberated and hence the group agreed that the individual country may vary the level/number of skills that could be managed in the different geographies of the Region.

The group identified the minimum competencies required at the district level and suggested that the course bridge the academic and service divide, with uniformity in achieving credit transfers. The courses identified at this level were MPH, MSc, MD, M.Phil and Ph.D. Core and optional units were identified (see Annex 3) the courses were left flexible so that part-time and distance learning

options were available. Teaching methods and processes required that the 50% of the study was field-based. Self-directed learning, and team training were some of the other methods suggested. Effort should be made to bridge the academic/service divide.

Internal and external assessments were suggested, including continuous self-monitoring and periodic evaluation of faculty by students. Externally conducted examinations would be a method of measuring the progress. There should be uniformity across countries, thus achieving credit transferability between accredited institutions nationally and internationally.

Courses Identified - MPH; M Sc; M D; M Phil; Ph D

Curriculum Content

Core units

- Epidemiology
- Biostatistics
- Research methods
- Environmental health
- Public health laws
- Health planning and management
- Population sciences (Sociology, social work, anthropology, demography)
- Health information management systems

Optional Units

- Maternal and child health
- Reproductive health
- Nutrition
- Occupational health
- Health economics
- Policy analysis
- Public health microbiology/Parasitology
- Medical entomology
- Health systems development
- Disaster preparedness/Response
- Advanced biostatistics

Curriculum Design

Could be a residential course or part time - credit-based programme or distance learning format.

Faculty and Teachers

Qualifications

PhD, MD (Community Medicine) or Masters' degree with three years' research/teaching experience and published papers

Experience

Experience in public health services may be equated in a proportion of one year of research to three years in public

health experience.

Teaching Methods and Processes

Field based study, Case studies and Didactic teaching, self directed learning, Integrated teaching, Adult learning methods, Team training, Portfolio learning

Resources

- Field practice Area: to consist of urban areas, semi-urban area, rural area, and urban slums.
- Material resources to include: Public health laboratory, computers and web access, library with adequate books and journals, and teaching aids. Institutional linkages may be considered for specific faculty.

Monitoring

Internal

Continuous self-monitoring, in class room/field and project monitoring were suggested. Periodic evaluation of faculty by students.

External

Monitoring should be considered using examinations and progress measurement.

Assessments

Methods: multiple assessment methods to be used such as MCQ, short answers (these may be optional, but should be kept to a minimum), projects and practicals.

Requirements

- Content validity of the method to be ensured
- Credit for internal assessment
- Every area of the competency grid should be assessed at some point in time.

(4) Continuing Professional Development

The group suggested that the goal would be to improve delivery of health services at all levels. The following objectives were identified to achieve this goal:

- The public health workers/professionals should be able to: maintain acquired knowledge and skill; upgrade knowledge and skill in response to changing needs of community at large; acquire new skills, and develop cadre/pool of resource people - e.g., trainers of trainees.
- Formal and informal methods to use innovative techniques wherever possible in order to make training community-based, participatory and problem-solving, innovative methods to be used with greater use of information technology. CPO should be introduced as a policy in public health using innovation.
- In the discussion that followed, the group felt that in the current context, continuing education be used for updating the knowledge and skills to serve the community better, and not for recertification or re-registration.

Redefining Public Health?

- C. Sathyamala*

The setting up of the Public Health Foundation of India marks the coming together of interests that are inimical to public health. The PHFI and its institutes – albeit located in India and with the blessings of the Indian government – will in effect function as an extension of American interests. It is to be governed by technocrats/bureaucrats and nominated NGOs and will be subjected to little or no accountability/scrutiny by the Indian polity.

The Public Health Foundation of India (PHFI), said to be modelled on the National Academy of Sciences in the US, was launched by the prime minister, Manmohan Singh, on March 28 this year, in the presence of representatives of the Indian government, the Association of Schools of Public Health (ASPH), US, the corporate sector, donors, and select NGOs.¹ Set to supersede all existing public health institutions in the country, whether in research or training, this “public-private partnership” is structured to function as an autonomous institution that will not come under the purview of the government. All that is expected of the Indian government is that it will provide clearance through Parliament, a subsidy in the form of land and some token funding² as a “symbol of support” [PHFI 2006].

The foundation plans to set up five “world class” institutes – Indian Institutes of Public Health (IIPH) – in carefully chosen locations to provide training and conduct research in prioritised, “high impact” areas of public health. Standardisation of public health education in India, another role envisaged for the foundation, will be achieved by establishing an independent accreditation agency along the lines of the ASPH, bypassing the Medical Council of India, the body set up by an act of the Parliament to oversee medical education in the country. Although no joint degrees will be awarded, the ASPH will help design the course. Senior and middle level faculty will be sourced from overseas and the next generation of faculty will be groomed by sending about 100 candidates, over the next three years, for higher studies in public health in the US, with all expenses met. These candidates will be aided by the “pull to return” by creating an attractive career path as leading future faculty of IIPHS, as well as other attractive packages.

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Amartya Sen, a PHFI board member,³ described the launch as a “great moment” while observing, rather enigmatically, “India was important to public health, as public health was important to India” [Express News Service 2006a]. For Srinath Reddy (2006), slotted to become the first president of the foundation, the 350 public health professionals that India produces every year are “woefully” inadequate for India’s needs. The IIPH intends to fill this need by training more than 10,000 persons annually, thereby raising “an army” of public health professionals [Rashid 2006]. For McKinsey, the consultancy firm which has worked on a pro bono capacity (!) to set up the foundation, it is to “stimulate a demand for public health professionals”, by creating a “mandate for public health qualification in government machinery... unlock demand in emerging private sector”, and make public health education an “attractive stand alone profession” [PHFI 2006].

The demand for this specialist course has, however, already been “unlocked” in the public sector, by the Commission on Macroeconomics and Health [GoI 2005]. In its report published last year, the commission recommended that there is a need to “(e)stablish an All India Cadre of Public Health... earmark posts that must be manned by people who have basic public health qualifications; and establish six schools of public health to serve as centres of excellence for training in public health in addition to strengthening PSM departments of medical colleges and existing public health institutions” (p 10).

The rationale for this recommendation comes from a study undertaken in 2000 by the Indian Council for Research on International Economic Relations (ICRIER), to provide inputs into the Commission on Macroeconomics and Health [Misra et al 2003]. Besides the existing public sector research infrastructure, and a pharmaceutical industry, the following were identified as some of the special advantages for health research in India:

(a) huge and diverse clinical material (sic) for research giving the country a unique opportunity to turn an acknowledged disadvantage into a research advantage.

...a strong claim to being an appropriate site for clinical trials and that as companies seek to conduct global trials contract research organisations in India are ideally placed to take advantage of this opportunity.

A large and diverse population steeped in tradition has

ensured that many rarer genetic disorders have survived in India, and this can become the subject matter of valuable research.

The future belongs to bio-informatics. The sequencing of the human genome would hardly have been possible without the strong inputs from information technology. India with its strong IT base, can take a lead in research areas which require strong software inputs (p 192).

Apart from providing special incentives and improving compensation to attract professionals, the group underlined the urgency for capacity building to undertake clinical trials for new molecules likely to be introduced for various communicable diseases.

Fulfilling US Demands

The “demand” for an increased production of human resources in public health coincides with that of the American government – some years ago the latter had identified an urgent need for a vast number of public health specialists of all categories. These were for employment not only in the US, but more specifically for the developing countries to handle the emerging threats to health.

In 2001, a Committee on Emerging Microbial Threats to Health in the 21st Century was set up by the Institute of Medicine of the National Academies, US and was charged to review the current state of knowledge regarding factors in the emergence of infectious diseases; to assess the capacity of the US to respond to emerging microbial threats to health; and to identify potential challenges and opportunities for domestic and international public health actions; and respond to microbial threats and human health [Smolinski et al 2003].⁴ Noting that “infectious diseases are a global threat which requires a global response” the committee recommended that the US should seek to enhance the global capacity to respond to infectious disease threats, focusing in particular on threats in the developing world which should include a significant investment in the capacity of developing countries to monitor and address microbial threats as they arise.

To this end, the committee recommended that the Centers for Disease Control and Prevention (CDCs) in the US should enhance their regional infectious diseases surveillance; the US department of defence (DoD) should expand and increase in number its global emerging infections surveillance (GEIS) overseas programme sites; and the US National Institutes of Health (NIH) should increase their global surveillance research and the overseas disease surveillance activities concerning relevant US agencies (CDC, DoD, NIH, US Agency for International Development (USAID) and US department of agriculture) should be

coordinated by a single federal agency such as the CDC⁵ (pp 8-12).

The committee stated that the US capacity to respond to microbial threats was contingent upon a public health infrastructure, which had suffered years of neglect and that there was a need to rebuild domestic public health capacity. It also felt that upgrading current public health capacities would require considerably increased investments as the number of qualified individuals required in the workforce for microbial threat preparedness was considered to be dangerously low. In 2001, for instance, the need for at least 600 new epidemiologists in public health departments across the US was identified to meet the requirements for bio-terrorism preparedness alone. Yet, only 1,076 students had graduated with a degree in epidemiology in the previous year, and the largest percentages were trained in chronic disease, not infectious disease epidemiology. Between 1999 and 2000, the most needed occupations identified in the US were public health nurses, environmental scientists and specialists, epidemiologists, health educators and administrative staff.

Setting up schools of public health in India helps solve the human resource problem of the US in two ways. First, and the obvious one is that it would supply lowcost qualified professionals trained in public health according to the ASPH standards. Supplying qualified human resources to the west at low cost is what the country’s several training “institutes of excellence” in medicine, set up since independence in accordance with Bhore Committee’s recommendations (1946) have been doing. Developing countries “donate” a full 56 per cent of all migrating physicians and receive less than 11 per cent, the principal donating countries for physicians being India and the Philippines [World Bank 1993]. But the more important and the not so obvious advantage is that the future IIPHS are intended to produce a cadre of public health personnel (Indian made, but with a foreign *chhap*) who will be the extension of American vigilance on Indian soil without evoking distrust.⁶ This strategy in any case has been the *modus operandi* for the last several years.

For more than 20 years, CDC has collaborated with ministries of health around the world to establish field epidemiology training programmes (FETPs) and have trained more than 900 international public health leaders in epidemiology and outbreak investigation [Smolinski et al 2003]. The Committee on Emerging Microbial Threats recommended the enhancement of the FETPs by providing all with laboratory support in the diagnosis of infectious diseases as was being done in the case of Thailand. In addition to this, the recommendation was that “CDC, DoD and NIH should

develop new and expand upon current intramural and extramural programmes that train health professionals in applied epidemiology and field-based research and training in the United States and abroad” (p 183).

The American government’s desire to influence policies and programmes of other countries has never been in doubt and one of their most important and successful strategy has been through financing educational support and providing research inputs. The political coup in Indonesia, spearheaded by the Ford Foundation (FF) in the late 1950s/early 1960s is a specific example of how such influence works [George 1978]. The first step was to create a “modernising elite” by training Indonesian students in several top American universities, notably Berkeley,⁷ MIT, and Harvard. After the extermination of the core of the communist party in the CIA staged coup, the American trained Indonesian elites moved in to restructure the Indonesian economy to suit American interests.

In India too, the FF has come to exercise considerable influence through philanthropy [Sathyamala and D’Mello 2003]. Apart from supporting educational and fellowship programmes, the FF and other such donors, operate through funding NGOs for both research and other programmatic purposes. Till the 1980s, activist groups did not consider foreign funding, particularly FF money, an appropriate source to finance their activities and those who did, were scathingly attacked [James 1995].⁸ But in the last 15 years, this position has changed drastically with many institutions in the country (even those with left leanings), working in the areas of gender, reproductive health, and human rights, accepting funding from FF for their activities. In a short period, FF has attained acceptance and respectability which is a consequence of the FF’s close association with individuals and groups, many of whom are persons of integrity and social commitment, at the forefront of several progressive movements.⁹ With such advocates, FF has no need to defend its past or its present. Moreover, since groups and individuals in opposing camps are supported, the funding policy appears non-discriminatory and non-directive and as stated by several autonomous women’s groups, in India it is more a question of co-option than suppression of progressive movements [Saheli et al 1991]. The experience of the last two decades in the country has also demonstrated that FF and other such private donor agencies from the US do aim at deliberately influencing policy-making in the country through “evidence” generated by their funded partners [Population Council 2005].

Interests Inimical to Public Health

All this may seem little to do with PHFI, as the major player here is not FF but the Bill and Melinda Gates

Foundation (GF), which having come into existence only since 2000, is not sullied by history of the kind FF has in furthering imperialism. In contrast, in the short period of its existence, it has become the world’s largest charitable foundation by disbursing more than US \$ 3.2 billion for health programmes aimed at AIDS prevention and neglected diseases of the third world (http://en.wikipedia.org/wiki/Bill_%26_Melinda_Gates_Foundation, accessed on April 24, 2006).¹⁰ One reason for such largesse appears to be rather prosaic, as the foundation, whose annual income is that of a small country, needs to donate at least 5 per cent of its assets, amounting to over \$ 1 billion at a minimum each year to maintain its status as a charitable organisation.

However, this is not the compelling reason and to understand Bill Gates’ interest in matters of health, one needs to understand his business needs and practices. Bill Gates’ interest in philanthropy is said to have coincided with Microsoft’s battle with the American government over its Windows monopoly during which he lost out on a lot of public good will.¹¹ In 1999, the ruling in the antitrust case against Microsoft was that its dominance of the PC operating systems market constituted a monopoly and that Microsoft had taken actions to crush threats to the monopoly, including Apple, Java, Netscape, Lotus notes, Real networks, Linux and others (<http://www.usdoj.gov/atr/cases/f3800/msjudge.pdf> accessed on June 19, 2006). The judge remarked: “Microsoft was a company with an institutional disdain for both the truth and for rules of law lesser entities must respect” [Thurrott 2001].

What does the GF, built on the fortunes of a company that has thrived by ruthlessly destroying all competition, bring to the understanding of public health?¹² As legend has it, it was an interest in family planning that brought the Bill and Melinda Gates to a Seattle-based organisation, Programme for Appropriate Technology in Health (PATH) [Paulson 2001]. By breaking the cycle of disease and poverty that contributes to the high birth rate, Gates hopes to “get at the problem that originally motivated his philanthropic impulses – overpopulation”.

On October 17, 2003, the Foundation for the National Institutes of Health and the GF announced the first 14 challenges that were to be the focus of the “grand challenges” in health that the GF considers as “roadblocks” standing in the way of its medical objectives. According to *The Economist*:

The challenges in question... range from the mundane (“Prepare vaccines that do not require refrigeration”) to the esoteric (“develop a genetic strategy to deplete or incapacitate a disease-transmitting insect population”). The latter will require both serious genetic engineering

and a public relations campaign designed to persuade people that it is safe and sensible to unleash engineered insects into the wild. Nor are basic matters neglected... half of childhood deaths in a poor world have malnutrition as an underlying cause. So one of the challenges is “to create a full range of optimal, bio-available nutrients in a single staple plant species”. More genetic engineering there, in all probability, or a revolution in plant breeding techniques. So, if a new, healthy crop called *Billgatesia* graces your table one day, you will know who to thank (italics in the original) [Anon 2005a].

The Economist further remarks:

...Gate's speciality is software... And he seems to have realised what biologists themselves are only starting to come to grips with – that biology is basically a software problem in which biochemical pathways stand in for computer algorithms. From this perspective, disease is the result of software failure or inappropriate data input – a fact that is very evident when listening to a conversation between Mr Gates and his scientists about the weak points of, say, the malaria parasite [Anon 2005b].

The GF has also reportedly purchased shares in nine big pharmaceutical companies, 13 valued at \$ 250 million which are a new type of investment for the foundation [Bank and Buckman 2002] with obvious conflicts of interests. A GF representative is one of the 18-member board of the Global Fund to fight AIDS, tuberculosis and malaria, and the chief executive of Merck is one of the board members of Microsoft. Importantly, the GF was a major sponsor of the Commission on Macroeconomics and Health, which had made a strong recommendation that intellectual property protection was critical for the continued investment in drug research and development.¹⁴

The GF is said to be worth \$ 25 billion, ten times the size of Rockefeller Foundation and three times the size of Ford Foundation (http://www.iicd-volunteer.org/newsite/tce/tce_news_000.html, accessed and therefore its influence is probably greater.

In conclusion, the setting up of the PHFI is the coming together of interests that are inimical to public health. The PHFI and its institutes, albeit located in India with the blessings of the Indian government, will in effect function as an extension of American interests, to be governed by technocrats/bureaucrats and nominated NGOs,¹⁵ and as an “autonomous” body will be subjected to little or no accountability/scrutiny by the Indian polity, termed “political interference” in newspeak. Since the 1990s, this kind of institutional arrangement is becoming increasingly the norm as can be seen from the example of the “autonomous” body, the National AIDS Control Organisation (NACO)

[Saxena 2006].

Lack of accountability and transparency in such institutional arrangements has meant that technocrats with the support of bureaucrats have a free run in implementing programmes that may not be in the best interests of those who are at the receiving end. The HIV vaccine trial on healthy volunteers is a case in point which has been viewed with serious misgivings relating to the absence of compensation to the volunteers in case of vaccine failure, and more importantly, the proof of efficacy in this trial being based on the implicit need for the volunteer to practise unsafe sex [Kumar 2002]. The lack of transparency about the contents of the MoU signed by the GoI and International AIDS Vaccine Initiative (IAVI) is equally disturbing, as despite repeated requests, the document has not been made available in the public domain.

Shaping Public Policy through Funding

One of the “key charters of the PHFI is to be policy shaping think tank” [PHFI 2005], which plans to advise both government and the private sector on critical policy issues on matters related to public health policy [Express News Service 2006b]. Zafrullah Chowdhury (1981), writing about research as a method of colonisation, gives the example of the proposal to set up an International Institute for Health, Population and Nutrition Research in Bangladesh in the late 1970s which, according to him, was primarily planned for the benefit of US researchers. He concluded that Bangladesh will end up serving as a laboratory whose population may or may not benefit from the experiments and all will be done in collaboration with, under the management of and through funds and personnel in the control of the US.¹⁶

Funding is known to influence policies in critical aspects of health, be it the WHO formulating guidelines for hypertension, stifling debate on infant feeding [Ollila 2004], revision of the *Diagnostic and Statistical Manual*, the official manual for psychiatric diagnosis in mental illness in the US [Cosgrove et al 2006], or in voting patterns at the Food and Drug Administration, US [Lurie et al 2006]. Shaping policies through funding is true not only in the case of direct funding from the drug industry but with foundations too, even those calling themselves philanthropic, that have financial interests or are involved in developing healthcare products.¹⁷

The teaching and the practice of public health in the country have very little to recommend itself and health groups such as the Medico Friend Circle have grappled with these issues for the last three decades.¹⁸ But at no point in time was the need for public health as a “stand-alone” profession articulated as the strategy for

overcoming the lack of a public health perspective in medical education. It is therefore surprising to see individuals who had vigorously championed for a reform in medical education now championing for a “stand-alone” public health perspective. Given that public health (the better known term is Preventive and Social Medicine) is not considered a worthwhile career (not only in India), the “compensation” being envisaged for the IIPH graduates as a “pull” factor can only mean that the need for such specialists has become critical to the development of the healthcare industry. The National Polio Surveillance Project (NPSP) is a good example of the kind of highly paid job opportunities possible in the future for the PHFI type of “public health” graduates. It is also more than likely that there will be more and more new threats, both real and generated (as witnessed in the case of the “terror” unleashed by the bird flu), that will require medical policing. Hence the need for an “army” that will function as a modern day medical police that will “educate” the “masses” that it is for their own good that they should follow expert advice.

Notes

1 Institutions providing postgraduate training in public health in India, such as the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, had not been invited for the launch.

2 Of the initial capital of US \$ 50 million, eight Indian “philanthropists” are to pool more than US \$ 20 million, with the Indian government and the Bill and Melinda Gates Foundation donating US \$ 15 million each [Chen 2006].

3 The other members of the board include Rajat Gupta (McKinsey), Montek Singh Ahluwalia (vice-chairman, Planning Commission), R A Mashlekar (director-general, Council of Scientific and Industrial Research), T K A Nair (principal secretary to the prime minister), Prasada Rao (former health secretary), Sujatha Rao (head of the National AIDS Control Organisation), Srinath Reddy (head of department, cardiology, All-India Institute of Medical Sciences), Shiv Nadar (HCL), Gurudas Dasgupta (CPI leader), Lincoln Chen (director, Global Equity Center, US), and Jim Curran (chair of board of directors, ASPH, US), and Ravi Narayan (community health cell, SOCHARA) [*Indian Express*, March 28, 2006; Rashid 2006; Narayan, personal communication].

4 The committee’s co-chair M A Hamburg is the vice-president for biological programmes, Nuclear Threat Initiative. Although, the Committee was set up earlier to the attack on the World Trade Center in 2001 this event as well as the anthrax scare that followed it, made the committee particularly sensitised to the threat of bio-terrorism as an imminent possibility.

5 The CDC mentioned here is the CDC Foundation, a federal agency of the US, established by the US Congress to “connect outside partners and resources with CDC scientists to build programmes that can substantially enhance CDC’s impact”. CDC foundation began operating in 1995. CDC Foundation is provided programmatic support by corporations, businesses and corporate foundations (among other sources). The list of such providers virtually reads like a “who’s who” in the pharmaceutical industry, agribusiness and oil companies

(www.cdcfoundation.org/ accessed on April 22, 2006).

6 The Global Polio Eradication Initiative (GPEI) is a recent example in which CDC, a US institution, was accepted on par with the WHO and UNICEF, both UN institutions. Being a part of this triumvirate, CDC has access to surveillance data and to the virology laboratories of the entire world.

7 These Indonesian students came to be known as the “Berkeley” boys.

8 Writing in *The Marxist*, Prakash Karat viewed foreign funding as a “sophisticated and comprehensive strategy worked out in imperialist quarters to harness the forces of voluntary agencies/ action groups to their strategic design to penetrate the Indian society and influence its course of development... to counter and disrupt the potential of the left movement” [James 1995].

9 It was during the World Social Forum (WSF) in Mumbai in 2004 that a clear opposition to such funding emerged in recent times (Research Unit for Political Economy 2003). After much soul-searching, the organisers of the WSF meet in Mumbai decided to decline funds from the FF.

10 The leaders of the foundation’s global health programme are those who have been closely associated with CDC and McKinsey ([http:// www.gatesfoundation.org/GlobalHealth/RelatedInfo/GHTeam.htm?version](http://www.gatesfoundation.org/GlobalHealth/RelatedInfo/GHTeam.htm?version), accessed on April 15, 2006).

11 Rockefeller too is reported to have begun his philanthropy after he was convicted several times in antitrust cases [Vanheuerswyn 2005].

12 With a net worth of \$ 46.5 billion, cynics comment that while Gates gave 100 million to fight HIV, he spent 421 million to fight Linux, Microsoft rival, making Linux a more serious threat than HIV/AIDS (Green 2002)

13 Merck and Co, Pfizer Inc, Johnson and Johnson, Wyeth, Abbott Labs and others.

14 The GF had sponsored the report of the ICRIER, which laid the foundation for the recommendation that world-class institutes in public health be set up in India.

15 Although individuals from several NGOs in the country attended the launch of the PHFI and are closely involved as members of governing board and advisory committee, they cannot be said to represent the NGO sector or the health movement, as they are nominees of the founders of the idea.

16 The district of Matlab in Bangladesh has functioned as the research laboratory for the schools of public health in the US for decades, as much as the African country Gambia has for the Medical Research Center UK.

17 Often the direct relationship with the industry is obfuscated by organisations such as the WHO, acting as “middle men” in the “private-public partnership”. For instance, Norplant, a hazardous long-term invasive contraceptive was developed and registered by the Population Council, manufactured under licence from population Council by Huhtamaki Oy Leiras Pharmaceutical, Finland, and the clinical trials were conducted by the WHO and ICMR.

18 See Medico Friend Circle Bulletins Nos 97-98, 99, 264-265. Writing about the state of medical education in the country since 1833 (Bentinck’s Committee), it was pointed out the “Even though nearly four decades have passed since we achieved independence, the colonial mentality of the medical profession, the elite bureaucracy and the political leadership have not disappeared. The “brown sahibs” who rule India have very deep roots in their background and education which makes them see the dictates of western society as more important than the basic needs and aspirations of our own people [Narayan 1984].

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Unmet National Health Needs Visions of Public Health Foundation of India

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Following the launch of the Public Health Foundation of India (PHFI) in late March 2006, reputed academics and practitioners of public health have raised concerns and doubts regarding the rationale for such an institution.¹ They have questioned the relevance of PHFI in serving India's unmet health needs and constructed visions of its mandate and activities that are somewhat misplaced. They have also expressed concerns that the PHFI, through its partner institutions and proposed collaborations, might represent a health agenda in teaching, research and policy advocacy that is likely to be antithetical and inimical to national interests and needs of development.

This article would argue that the formation of PHFI is in response to a widely articulated demand, by several expert committees constituted by the government and academia, to infuse greater public health expertise into the health services as well as for making policy development and research more responsive to India's public health needs. The construction that the PHFI is driven by a foreign designed agenda, therefore, does grave injustice to such long-lasting Indian advocacy for strengthening public health education.

There is a huge need for qualified public health professionals and well-trained public health functionaries in India, which cannot be met by the limited available institutional capacity for training in public health. The Indian Institutes Economic and Political Weekly September 16, 2006 3928 of Public Health (IPH) to be established by the PHFI would aim to make their education and research activities relevant to India in content and context, while attaining standards which are qualitatively comparable with the best in the world. Each IPH would provide multidisciplinary education which will impart a broad appreciation of the multiple determinants of health (especially the social determinants) and the skill sets needed for designing and implementing a broad range of multi-sectoral actions required to advance public health – there is, therefore, no attempt to propagate a restricted biomedical or technology intensive model of healthcare.

Apart from establishing new institutes, the PHFI would also assist the growth of existing and other emerging public health training institutions as per their stated

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need, and facilitate the creation of a nationwide network of public health capacity-building institutions – therefore, there is no aim or scope in PHFI's charter to subsume existing institutions.

The PHFI would like to benefit from a wide range of international partnerships, with public health training and research institutions from all parts of the world. While early partnerships have been established with such institutions/networks in US and UK, efforts are under way to develop similar partnerships with other regions, especially with public health institutions in other developing countries.

On the issue of autonomy and transparency in the working of the PHFI, it needs to be asserted that the representative nature of the public-private partnership that governs PHFI permits an "autonomy", in terms of operational freedom, while providing for governmental guidance and civil society scrutiny. The PHFI's commitment to transparency (in purpose, process and products) will enable monitoring and constructive inputs by other Indian votaries of public health who may not be included in the board which has, of necessity, be of a limited number. The soon to be constituted Academic Advisory Committee, Research Advisory Committee and policy-related ad hoc expert committees will provide an ample opportunity for the engagement of a broad range of public health professionals and advocates in guiding the work of PHFI.

The interest expressed by several states so far² to partner PHFI in the establishment or strengthening of public health institutes, as well as their readiness to infuse public health expertise into their health services, is also an evidence of the wide endorsement of PHFI's agenda by the principal providers of healthcare in India.

The private, corporate organisations that are a part of the PHFI partnership have also attracted distrust and criticism as they are perceived as being inimical to an equitable public health agenda. Alternately, the interest of corporate donors in supporting public health education should be interpreted as an indicative of the growing, albeit delayed, recognition by several segments of the Indian private sector that health of the people is an essential requirement for accelerated economic growth and that development can be derailed by public health catastrophes. The PHFI is also

committed to ensure that conflicts of interest would be avoided and that public interest would always prevail over any sectoral interest. As the programmes of PHFI would be visible in the public domain, any deviations from this commitment should be easy to detect by all champions and defenders of public interest.

Acceptance of financial support from international foundations does not mean that PHFI is contracted to pursue an agenda that is alien to India's interests. While some of these donors may have emphasised technological solutions to public health problems, their willingness to provide support to multidisciplinary public health education should be seen as a welcome attempt to broaden their engagement. It would be inappropriate to suspect a hidden agenda, when no proof exists, at such an early stage of PHFI's life. It would be even more unfortunate to condemn PHFI as "guilty" by association, by superimposing the past activities of other organisations on the PHFI's yet to be undertaken activities.

The PHFI, which has commenced its operations very recently, would attempt to engage with as many organisations, agencies and individuals relevant to public health in India as possible over the next year, to invite their inputs to help shape its evolving initiatives in education, training, research and policy advocacy – it would seek to erect a broad and inclusive platform for the participation by multiple stakeholders, many of whom would be welcome to play the role of objective critics, whose evaluation of PHFI would be based on its performance and not conditioned by preconceived prejudice.

Unresolved Health Challenges: Public Health Response

Notwithstanding the substantial progress in health indicators since independence (e.g., doubling of life expectancy to 63 years, halving of infant mortality to 67 deaths per 1,000 live births), India faces serious health challenges in the form of multiple disease burdens and an inadequate response to this health crisis. Apart from childhood undernutrition and unsafe pregnancies, there is evidence of the resurgence of communicable diseases, rise in non-communicable diseases (e.g., cardiovascular disorders, cancer, diabetes), and emergence of other health burdens (e.g., accidental injuries). However, the government responses to these needs have been characterised by inadequate government spending on health (only 0.9 per cent of GDP compared to 1.8 per cent by China), poor allocation of the amount that is spent (wide urban/rural disparity, most needy states spend less) and inefficient, utilisation of the allocated resources (e.g.,

10-25 per cent of funds are actually spent on programme delivery).

It is increasingly evident that this composite threat to India's health and development needs a concerted public health response to ensure efficient delivery of cost-effective interventions for health promotion, disease prevention and affordable diagnostic and therapeutic healthcare. Since the determinants of health are multisectoral, it is essential to develop a supportive policy framework that addresses and influences all of these determinants. Healthcare too needs to be addressed not only from the scientific perspective of what works, but also from the social perspective of who needs it the most. Equity issues and a human rights perspective, therefore, become important considerations in exercising choices in healthcare.

Public health should emphasise prevention through collective actions to address the underlying causes of disease and foster conditions in which communities or population groups may lead healthy lives. In this way, it extends the ambit of healthcare to the areas beyond medical care. At the same time, the broad domain of public health also embraces essential medical care and seeks to define its optimal utilisation levels. This multi-pronged effort requires capacity-building for health research, policy development and analysis, programme development and evaluation, health systems organisation and for developing sustainable models of healthcare financing. Scientific research too has to span the spectrum of basic, clinical, social, economic, policy and programme research to be fully informative. Public health practitioners are needed, therefore, with not only technical skills, but also training in meaningfully involving communities in public health, the ability to work in multidisciplinary teams and communicate with government and community leaders.

Public Health Education

The need for relevant public health education and the deployment of public health cadres with adequate analytical skills and in specialised roles in public health administration has been frequently voiced by health policy documents and expert reviews. Much before the PHFI was established in March 2006, there was a growing consensus, even in the mid-1990s at many levels, about the need for many more public health institutions, the need for increasing public health training and the expansion of activities for public health human resource development³ at various levels of health and allied services.

To understand the true significance of the crisis and challenges of public health education one must recall the main recommendations of the Bhole Committee (1946) and Mudaliar Committee (1961) reports, that tried

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

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

However, the first two decades of national health planning saw a series of policy trends that impeded the public health system, with many of the Bhore and Mudaliar committee recommendations not being operationalised.⁴ While academics, researchers and activists had been highlighting the crisis and challenge of public health education from the 1980s, national policy documents gradually began to identify these trends and problems and suggested strategies to strengthen public health education in various ways. For instance, the National Health Policy document of 1982, recommended many strategies of action – foremost of which were the need to formulate a national medical and health education policy and the establishment of comprehensive primary healthcare and public health services within an integrated referral system.

The most recent and comprehensive analysis and required response, was by the Expert Committee on Public Health System 1996, constituted by the government of India.⁵ After 50 years of national planning and policy evaluation, it stated that public health services do not have requisite number of senior level public health professionals, and stated that this was compounded by many programme managers at national and state level who lack any public health orientation or public health qualification. It suggested many strategies for action to strengthen both the public health system in the country and the public health education. The recommendations on the latter were:

- Need to open new schools of public health – so that more public health and para professionals can be trained.
- Existing public health schools to be strengthened (AIIPH in the eastern region) and four other regional schools to be set up – central, northern, western and southern.
- Existing medical colleges with significant expertise in PSM/community medicine should be upgraded as advance centres for teaching public health and producing professionals (at least 25 per cent of existing departments to be upgraded).⁶

Six years later, the National Health Policy 2002 reiterated these concerns and reaffirmed the urgency to strengthen the capacity for public health education.

The unmet need for public health oriented personnel is, therefore, far from a post facto justification to create “an army” of public health professionals.⁷ Clearly the gap in supply and demand has only widened in recent years since the needs for public health training and practice have now expanded, not only to address the unmet needs of the government sector, but also to ensure that sustainable public health practices are adopted in the increasingly prominent private sector as well provide public health expertise to the voluntary sector which is becoming an increasingly important provider of health services to disadvantaged populations and vulnerable groups.⁸

Emergence of the PHFI

The framework of the PHFI was evolved through a situation analysis study initiated by the ministry of health and family welfare and conducted by McKinsey in 2003-04. The results of the study were then presented at the National Consultation on Public Health Education in India convened by the ministry of health and family welfare in 2004.⁹

This report appraised the current situation in public health education, to identify the need for a supportive foundation to strengthen the architecture of public health in India. Researchers, policy-makers, teachers

and health practitioners in the government and NGO sectors who were interviewed articulated a lack of sufficient public health expertise in policy development across sectors and stakeholder groups, noted the absence of skills in programme design, delivery and evaluation as well as health system management and public health research.

An important lacunae identified was that the MD – community medicine was open only to medical graduates, lacked a multidisciplinary content and in-depth training in several core public health relevant subjects, such as health economics and social sciences, while even the curricular content of epidemiology is also suboptimal. The MPH and MSc courses were limited in the number of students that they catered to and they were challenged by the small size of faculty and deficiencies in course content. The PhD programmes were inadequate in number and there was insufficient impact on public health. And finally, even the shortterm training programmes were limited in coverage of present public health functionaries and lacked an integrated approach. While some of the existing institutions offered fairly high quality public health education, their limited capacity fell far short of the latent and increasingly articulated demand for public health professionals in the state health services.

The study also indicated that there were two key deficiencies in the public health response in India. On the human resource side, there is a dearth of public health professionals in the government health machinery – around 10,000 public health professionals, of various categories, would be required on an annual basis at different levels of the health services from the primary healthcare officer to the central level public health functionaries, to equip the government machinery with a qualified public health workforce. Even the best institutions are small in scale, suffer from a serious faculty crunch and run programmes with limited curricular content or restricted trainee profile. Moreover, there is a wide difference in the quality of existing public health professionals due to lack of set academic standards.

Finally, the study also noted the absence of employment opportunities for public health professionals in government services, as there is neither a mandate for public health qualifications nor a meaningful career track for those who qualify themselves in public health. With regard to support structures, it identified three key limitations: absence of a surveillance system to collect and disseminate timely and accurate data; limited applied research that can utilise available data to shape policy; and the absence of a credible entity that utilises even the scarce available research to help shape policy. There is a need

to address the problem in an integrated manner, simultaneously working on both supply and demand sides of the problem.

The national consultation reviewed the results of the study and the following recommendations were made: (1) establish new institutes of public health; (2) assist existing institutes to enhance their capacity and output; (3) promote research in prioritised areas of public health to inform policy and empower programmes; (4) facilitate policy development, programme evaluation and advocacy on public health related issues; and (5) enable the development of standards and adoption of a credible accreditation system for public health courses.

The PHFI Mandate

The PHFI was therefore constituted on the model of a public-private partnership and was formally launched on March 28, 2006. The launch itself included workshop discussions on the PHFI mandate, which sought to draw upon the advice of public health trainers, administrators, researchers and academia.¹⁰

The PHFI will undertake the role of establishing new IPH, to enhance existing institutions and network them to form a closely integrated group which will pursue the mission of strengthening public health-related research, training, policy development, programme development and evaluation.¹¹ Each IPH would, therefore, form part of a broader effort to be undertaken by the PHFI to strengthen various activities needed to advance the public health agenda in the country, in collaboration with a broad array of partner institutions and agencies.

Apart from the broad-based MPH programmes that would form the core of the IPH academic programme, each IPH would also provide short- and medium-training to facilitate implementation of prioritised health programmes by enhancing capacity among health system functionaries, across all levels of healthcare, to design and deliver the various strategic programme components. It would also strengthen public health relevant research by promoting transdisciplinary collaboration in the creation of knowledge relevant to public health and facilitate multisectoral coordination of implementation pathways. It would help in critical appraisal of available research and ensure its better utilisation through appropriate advocacy.

Towards this end, the PHFI would establish new schools, assist existing institutions in their growth and network them to form a closely integrated group which will pursue this common mission. In this context, it needs to be clarified that the “autonomous” status of the PHFI includes accountability to its board where representatives of the government and others who

represent public interest are present. In partnerships that would involve state governments, the PHFI would aim to preserve autonomy in its administration while accepting the responsibility to closely align with state and regional health priorities and programmes and to develop networks with existing state-run institutions to share and enhance competencies in teaching, research and practice.

Education and Research at the IPH

With the needs of an interdisciplinary approach in mind, the curriculum for the MPH degree, the core course at the IPH would be based on a range of core courses along with the specialisation in subjects such as epidemiology, statistics, demography, health economics, health administration and healthcare financing. Social science disciplines would form an important part of the curriculum for the MPH and a vital component of the research agenda since the context of the social determinants of health is essential to understand and address critical health challenges in India today.

At the same time, it must be recognised that training in public health need not and should not be confined only to longterm postgraduate courses for a few students, but should also address the need to upscale the public health knowledge and skills of diverse groups of health professionals, health system managers and health NGOs who play a vital role as public health functionaries. This can be done through suitably structured short-term and medium-term training programmes. The IPH will, therefore, develop courses to train health and allied professionals in the principles and practice of public health, through structured, multidisciplinary and target-specific educational programmes.

Each IPH would also be reliant on developing networks and symbiotic tie-ups with existing schools and universities. This would by itself ensure an anchoring in existing "India" based education systems, by sourcing an existing pool of academic programmes in the established professional schools and research bodies.

The IPH would therefore be characterised by: A "Hub and Spokes" model in which it would link with multiple institutions and agencies with convergent interests. Training as well as research would be conducted at several sites, with the PHFI playing the role of a catalyst and a coordinator.

(1) The IPH would need strong linkages with academic medical and nursing institutions of excellence located in its vicinity. These would provide a broad platform for public health training and research, extending from

the community to the clinic.

(2) The IPH would interface with the national law schools in developing the disciplines such as public health law and health and human rights. It would also seek collaboration with schools of business, management and administration for developing disciplines such as healthcare financing, health administration, health economics and health policy. It would link with schools of social sciences to develop training and research programmes in the areas such as social determinants of health and disease, behaviour change and community interventions.

(3) The IPH would need to link with a community/population field unit which will serve as a demonstration site (for research and training). Collaboration with health NGOs who run field-based programmes would be very helpful in this regard.

(4) The IPH would need strong laboratory support for conducting multidisciplinary research relevant to public health interventions, in the prioritised areas of communicable diseases, nutritional disorders, maternal and reproductive health and noncommunicable diseases. Some of these laboratories may be identified in partner institutions and linkages established.

(5) The IPH would be treated as part of the university system. It would seek and obtain a deemed university status.

To execute this agenda, the creation of a pool of competent faculty and research staff has therefore been a priority in planning the role and function of the PHFI. As one of its first initiatives, a faculty development programme has been initiated. This involves the sourcing of a first batch of faculty from all over India, with a preference particularly towards potential faculty with broad-based field experience in health programmes and projects in rural areas. Some of these faculties are in the process of leaving for training abroad, while others will pursue distance learning courses with established public health schools. Potential faculty already trained and based in India are also in the process of being identified to initiate the training programmes that PHFI will initiate in the first half of 2007. The PHFI also plans to assist existing public health departments and centres to develop their teaching strengths, by supporting programmes for training of that faculty in deficient areas, with a view to their enriching the resource of existing institutions.

Conclusion

The crisis in the teaching and practice of public health has been widely acknowledged by all the stakeholders in the health sector and beyond. Indeed, health activist groups such as the Medico Friends Circle have made a

pioneering contribution in the past few decades by advocating the need to locate health concerns, including the crisis in medical education, in an understanding of community needs and rights. While there may be differences in approach to filling the gaps in public health capacity, there is no debate on the pressing need to strengthen public health education, research and practice to appropriately and adequately address India's critical health challenges and meet its most felt public health needs. Finally, it would be a grave error to tolerate an unacceptable "status quo", solely due to misplaced apprehensions that new initiatives for change may have suspect motives.

The PHFI and a large number of other institutions and courses that have emerged in the past few years are testimony to new and innovative models to address the challenges in public health education. We believe that it is possible to effectively address the urgent and immediate need for relevant and composite public health education through appropriate training in the precept and practice of public health education, by enhancing the capacity of public health functionaries and by fostering linkages and partnerships with existing academic institutions in India and abroad.

As we navigate the early challenges of setting up the new institutes of public health, it is the learnings and experience from academic and activist players in the area that will be invaluable in anchoring us firmly in national needs. Indeed, it is this dialogue and collaboration amongst institutions, individuals and networks in this critical area that will move us nearer to what are common aims and commitments of social equity and sustainability amongst all who are interested in promoting public health.

Notes

1 The most recent publication is C Sathyamala's article titled 'Public Health Foundation of India: Redefining Public Health?' *Economic and Political Weekly*, July 29-August 4, 2006, Vol XLI, No 30, pp 3280-84.

2 These states include West Bengal, Andhra Pradesh, Delhi, Gujarat, Punjab, Kerala, Haryana, Maharashtra, Uttar Pradesh, Jharkand, Karnataka and Tripura. Some of these state representatives, mostly health secretaries of respective state governments, were also present and participated in the discussions in the board meeting of the PHFI held on August 4, 2006.

3 This review of early recommendations regarding public health education is based on the following sources, in particular to Ravi Narayan's recent review of the history of medical education: Bhole Committee (1946), health survey and development committee, compendium of recommendations of various committees on health development, 1943-1975, Central Bureau of Health Intelligence, DGHS, ministry of health and family welfare, GoI; Mudaliar Committee (1961), Health Survey and Planning Committee, Narayan, Ravi (1984): '150 years of Medical Education: Rhetoric and Relevance', *Medico*

Friend Circle Bulletin, Nos 97-98, Pune, pp 1-9; Narayan, Ravi (2006): 'Public Health and Community Health Education in India – A Historical Overview', CHC Workshop on 'Community Health and Public Health Education: Towards a New Social Paradigm, Community Health Cell, Bangalore; Banerji, Debabar (1985): 'Health and Family Planning Services in India – An Epidemiological', Socio-Cultural and Political Analysis and a Perspective', *Lok Paksh*; Banerji, Debabar (1986): 'Social Sciences and Health Service Development in India – Sociology of Formation of an Alternative Paradigm', *Lok Paksh*; Banerji, Debabar (1988): 'Trends in Public Health Practice in India – A Plea for a New Public Health', B C Dasgupta Oration, 32nd Annual Conference of the IPHA, Hyderabad, February 5-7, 1988; Deodhar, N S (2004): 'Public Health System in India with Special Reference to School of Public Health', National Consultation on Schools of Public Health, New Delhi, September 2004.

4 Banerji (1985 and 1986) and Narayan (1984 and 1991) and Deodhar (2004) have written extensively, on what happened and why – highlighting the reasons and reviewing policy trends and policy distortions as well. They focused on many aspects of health system including medical education and human resource development in public health education.

5 This Committee included public health stalwarts like Harcharan Singh (Planning Commission), Jayaprakash Muliyil (CMC, Vellore), N S Deodhar (MOHFW), K J Nath (AIIPH Kolkata) and K K Datta (NICD). This report unfortunately did not receive the attention that it merited though its findings and recommendations were significant.

6 This report also emphasised the eight policy constituents that were necessary for these systems to become more relevant to Indian community realities and public health challenges. These included: decentralised health planning; more allocation to health sector; strengthening health information and early warning systems; inter-sectoral coordination; community participation; continuing education of all categories of health personnel; health services research; involvement of Indian Systems of Medicine Practitioners.

7 Quoted in C Sathyamala (op cit), p 3280.

8 The number of public health professionals produced from various existing degree programmes annually is estimated at 350.

9 The papers presented at this national consultation were from different sectors – government, NGO and private and from most of the institutions in the country that were contributing to ongoing renewal of public health education and capacity building. These papers in turn were utilised to refine and detail the broad agenda that was finalised for the PHFI.

10 Contrary to Sathyamala's assertion, in her recent article on the Public Health Foundation of India, two senior faculty members of the Centre of Social Medicine and Community Health, JNU were invited and one attended the PHFI launch. Sathyamala, op cit, p 3283.

11 In the past few years there have been a growing number of public health institutions that have been established to strengthen public health education. Some of these institutes of Health and Family Welfare were developed with funding from multilaterals and bilaterals and others are in the process of setting up a Masters in Public Health Programme, the latest being the Centre for Interdisciplinary Studies, Pune University. PHFI would aim to assist these new initiatives in overcoming the challenge of limited capacity and would form mutually supportive networks and platforms to synergise and facilitate the sharing of resources and to optimise performance.

Whither Public Health*

A letter doing the rounds in US universities is revealing. It says that the Association of Schools of Public Health (ASPH) of the US has been asked to facilitate the Public Health Foundation of India (PHFI) – which was launched by the prime minister on March 28 – in identifying faculty with expertise and passion, to assist in the development of new and independent schools of public health, design curricula, build departments/disciplines, mentor Indian faculty, and teach courses, all within four weeks to a year. The letter implies that it is child's play to draw a suitable curriculum for public health in India. But, obviously, the Indian medical bureaucracy has not taken its own professionals into confidence, and they will now have to wait for the building of their capacity to manage public health.

Curiously, the union health secretary (now a member of PHFI's board) – after placing the socially irrelevant reproductive and child health II (RCH II) at the core of the national rural health mission (NRHM) – is reported to have pontificated, “public health practitioners need to understand the social, economic and environmental determinants of health” (*The Indian Express*, March 20, 2006). He does not appear to know that India was the first country to use social science studies in its national programmes: successfully in the national tuberculosis programme, and unsuccessfully when American demography shaped the family welfare programme. *The Indian Express* also reported that finances for the “autonomous” PHFI are to come from US financial donors and Indian industrial houses. The working draft, marked confidential but circulated to US institutions, proposes a chain of institutions to raise an army of public health experts, led by the head of the US ASPH, to train doctors, managers, analysts, demographers, epidemiologists, and community health workers. AIDS and dengue fever are the “challenge of public health”, and the root causes are “shortage of professionals, small-scale and questionable quality of current schools of public health, and absence of high quality public health research agency”.

The empowered financing committee has passed the proposal and the Foundation proposes to pay scales higher than the government institutes! Thus, while primary health centres are being curtailed to “save” money under NRHM, the Bill Gates Foundation has the freedom to push resources where it wants in the

name of collaboration among selected “stakeholders”.

The idea of new AIIMS-like institutes is not new. What is new is the thought that the country cannot either mobilise its own intellectual resources to define public health needs and develop the required curricula, or rejuvenate the over 200 medical colleges and their preventive and social medicine (PSM) departments. It is difficult to see humour in a situation that evokes only sadness. It is even more disconcerting to believe that those trained by India's premier institutions will have no hesitation in joining consultancy firms to serve private capital for professed enrichment of Indian public health, and be willing to forgo what is vital for the country's intellectual independence. In the 21st century, when linking up with the rest of the world with confidence and on our own terms is possible, a public-private partnership is quietly smuggled in to accommodate a political mentor.

Why is India unable to define its public health needs and invite the best minds and proven practices from all over the world? Why are consultancy firms with no experience of public health, like McKinsey, given contracts to run public health projects and learn on the job when it collaterally damages the services by focusing on AIDS alone? Are we under the illusion that this is an altruistic step on the part of the donors?

The PHFI seems to be important to both the American and the Indian governments, one needing the markets, the other more resources to increase middle class consumption patterns. In the process, what is being neatly avoided is that public health is not just the amalgamation of social sciences, health management, and epidemiology, but the integration of their perspectives.

Consequently, the vision of a public health that is inclusive as well as comprehensive may get further postponed. Unless the islands of excellence deal with the new epidemics (farmer suicides, hunger, violence against the poor, their shattered homes and livelihoods, falling food availability, and disappearing little girls), and reach out to the existing medical colleges and their PSM departments that train important components of human resources in public health, there can be no revival of the same.

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New Delhi

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Public Health Foundation of India - will the Public be placed at the centre?

- *Abhay Shukla**

This short note seeks to outline some issues for discussion, concerning the Public Health Foundation of India being currently launched. Overall, given the unsatisfactory state of Public health research and training in India today, any initiative towards its strengthening should be considered welcome. We do need to understand all aspects of the initiative, and wait for it to further unfold before coming to any definitive conclusions about it. However, there are certain areas of concern which need to be addressed and if possible remedied, if the Foundation and its associated institutes are to live up to expectations of their genuinely strengthening Public health in India.

Privatisation of Public health?

As stated in the PHFI Agenda document, the majority (85%) of funding for this initiative is to come from private sources: out of the \$100 -110 million projected to be required, 30% from Private health foundations (e.g. Bill Gates Foundation); 30% from corporations, 25% from individuals and 15% from the government. As we understand it, supporting Public health is a core function of the welfare state, and Public health research and training in India have till now been largely the responsibility of Public institutes and mostly publicly funded Medical colleges, which of course have had their own limitations.

Now if private (essentially corporations, corporate foundations and individuals) funding is to be the main basis of the entire Foundation, how will this influence the prioritisation, decision making, choices of technical inputs, staffing at apex positions and other aspects of the Foundation? Why are donors with a direct potential of conflict of interest such as Ranbaxy Healthcare represented on the Governing board?

What would happen if say, a Vaccine manufacturing multinational or Health Insurance company were to make a large donation and join the Governing board - would this not have the potential to influence the research and policy decisions being made by the Foundation? How would industry representatives view major public health issues like hazardous and polluting industries where the industry itself is largely responsible? What would be the decision making status of the GOI representatives on the board, and what would happen if they were outvoted by the (numerically larger) private representatives on an issue

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involving national public health interest?

The Institutes are supposed to become 'self sustaining from year 3 onwards' and the revenue model mentions that 45% of revenue would come from tuitions. The resulting tuition fees are likely to be quite high - each school would need to earn an estimated approx. Rs. 8 crores annually from tuition based on the figures in the Agenda document - according to a rough estimate based on the numerical student load expected, this could come to a fee of upto Rs. 20,000 per month per trainee. Which kind of students would most likely be able to avail of such training courses? Would these institutions be able to look at the public health problems of the rural and urban poor of the country, or would they become 'Centres of excellence' facing towards a global market?

These and other questions need to be addressed in considerable detail, to make it clear how such heavy reliance on Private funding and high tuition fees based education will not lead to 'Privatisation of public health' in terms of both structures and work content of the Foundation, notwithstanding the genuine intentions of certain of the public health-minded founders. One way of putting this question could be to ask how it will be ensured that 'those who pay the piper do not influence the tune' - which should be guided solely by public interest. Given the importance of this initiative, and the renewed emphasis on Public health, why is it not possible for the Union government to invest a larger amount (say about Rs. 225 crores over a couple of years, which would be 50% of the projected total of 450 crores), and allocate some funds for ongoing costs, which would endow a strong and unequivocal Public character to the Public Health Foundation?

Influence of US Public health institutions - what are the benefits?

Certain US based public health schools (Harvard School of public health, John Hopkins School) and the US Association of Schools of Public Health are involved in the foundation; they appear to have a significant role in developing this initiative.

Of course, positive academic contributions from various sources should be welcome, and we should be in favour of exchange of knowledge with various other institutions; however to the extent that such collaboration is necessary, we need to see whether the sources involved are most appropriate for the Indian setting.

Here two issues of concern may be pointed out: firstly, the US Health care system model based on large scale

private insurance and HMOs, which despite being practically the most expensive health care system in the world leaves 45 million US citizens uninsured, is definitely not the kind of Health care model we need to develop in India. While seeking expertise on Health system development in India, rather than keeping the US type Health system as a model, we may be better off looking at experiences of countries like Sri Lanka, Costa Rica, Cuba, Brazil and among developed countries, perhaps Canada, UK and some of the Scandinavian countries. Even concerning communicable disease control and larger public health measures, a predominantly bio-medical model as adopted by many mainstream Public health institutions in the US is unlikely to be relevant for Indian conditions.

Secondly, collaboration in the Public health field between institutions in developed countries and their Indian counterparts has prominently included trials of vaccines and new bio-medical measures. The Indo-US Vaccine Action Plan conceived in the late 1980s, where a number of new vaccines that were not approved for use in developed countries were to undergo trials in India, had come under significant criticism and was subsequently shelved. With the major involvement of private foundations, the trend of 'outsourcing' medical trials, and the participation of pharmaceutical companies not ruled out, it will need to be clarified how the Foundation would treat the issue of such trials and studies in India.

Relationship with existing Public health institutions and PSM departments

The PHFI is of course not entering the Public health scenario in India in a vacuum; there are a large number of Preventive and Social Medicine departments in various medical colleges, along with established national Public health institutions.

Due to a variety of factors, including limited mandate and often low priority given by policy makers, the contribution of these bodies concerning Public health training and policy formulation in India has on the whole not been upto the requirements of the situation. Given this larger context, it is positive that the PHFI institutes would seek to build upon and strengthen selected existing institutions. However, a wider national engagement with the existing public health profession and interaction with existing departments and institutions, with a view to both learning from their contributions (which should not be ignored) and strengthening their expertise, should also be centrally on the agenda of the Foundation.

Need for an integrated Social Medicine approach, not a narrow Bio-medical approach

It is too early to comment on the approach to Public

Health, which would be adopted by the Foundation. However, the documents available so far do not give any indications of departure from the mainstream, bio-medical / behavioural modification focused approach to Public health. It need not be reiterated here that the spectrum of Public health issues in India today - such as communicable disease resurgence due to social-ecological imbalances, large-scale undernutrition due to poverty and food insecurity, occupational and environmental hazards to health, addictions and mental health problems, conflict and its health impacts - are unlikely to respond to a narrow bio-medical or behavioural modification approach. A distinct break from current thinking would be the pre-requisite for effective integrated public health action, which would require addressing the full spectrum of determinants in the complex Indian context. Whether such a positive departure is made by the Foundation remains to be seen.

Need for Community Health Orientation

A number of prominent Health activists from various NGOs active in Community health and public health had been invited for the PHFI launch function; this is in itself a positive feature. However, it remains to be seen whether the PHFI adopts a definitive Community-empowerment approach to public health, which would entail not only engagement with some NGOs but also people's organisations and movements, health movement platforms such as Jan Swasthya Abhiyan, and an appreciation of processes such as the Decentralised health planning experience in Kerala. If genuine activation of communities is accepted as a prerequisite for strengthening community health, then such movements would need to be consulted and interacted with while deciding on priorities and plans for the Foundation. When strategies for strengthening Public health are being devised, concrete experiments and alternatives developed in collaboration with community groups would need to be studied and supported; the role of the Foundation at its best would be to support such wider social health initiatives, rather than its expertise appearing as a 'prescription from above' for improving Public health in the country.

Whether regarding its financial means, its trainee clientele, its collaborative framework or its orientation to community health efforts, it would be fitting for the Public Health Foundation to keep a 'Public' perspective at the centre of all its endeavours.

... palliatives will no longer do. If we wish to take remedial action, we must be radical. Palliatives in such cases are more costly than radical action ...

- Rudolf Virchow, *Report on the Typhus Epidemic In Upper Silesia, 1848.*

Will the public be placed at the centre?

Public Health in Private Hands?

- A Note on the Public Health Foundation of India

- Mohan Rao, K.R.Nayar*

I

We live in a world of profound, and growing, inequalities. Changes in the global economy over the last three decades have been accompanied by dramatic reversals of health gains made in the post-Second World War period. While some countries have witnessed stagnation in health indices, others have seen dramatic declines. At the same time, what is termed the health divide - between rich nations and poor nations, and between the rich and poor within countries - is increasing remarkably. Thus for example, the gap in the under-five death rate, considered a sensitive indicator of social and economic development, has widened between the rich countries and the poor. The under-five death rate gap increased from a ratio of 7.8 in 1978 to 12.5 in 1998. Similarly, the death rate ratio in the age group five to fourteen has also increased from 3.8 in 1950 to 7 in 1990.

It is widely accepted that these widening health inequalities are the consequence of the imposition of the World Bank and IMF-led policies of structural adjustment, and the accompanying health sector reforms, around the globe. Over the same period the role of the WHO has shrunk with the World Bank increasingly setting the agenda for health. World Bank loans for one disease alone, malaria, exceeds the entire budget of the WHO.

In addition to reducing state commitment to health, typically, these health prescriptions of the Bank are committed to methodological individualism and to behaviourism; they do not recognize the structural factors that govern and contour health or the ecology of disease. As a result, interventions tend to be disjointed (ORS for diarrhea rather than emphasising water supply and sanitation; focusing on anaemia in pregnancy, but not anaemia in the general population), and of a technical nature - what is referred to as the bio-medical approach in public health. This has led to the growth of disease-centric vertical programmes. Globally - and indeed reflecting this, even in India's National Health Policy 2002 - it is recognized that one of the failures of health sector development in the past have been due to such vertical programme development approaches. Assuming there is a grave fiscal crisis - which still seems to allow for the subsidies given to the rich in a variety of areas - these prescriptions typically include fee for services. Again the global experience has been that this excludes the

*Centre of Social Medicine and Community Health, JNU, New Delhi. Reproduced with permission from *National Medical Journal of India*, Vol. 19, No.4, 2006, pp.221-224.

poor from access to health services. Indeed it is this explicit recognition that has led countries like Zambia to do away with this policy prescription. What the package of prescriptions tends to do is to wrench apart comprehensive public health care, entrust profitable sectors of it to the private sector and enjoin the State to subsidise a minimum clinical package, which typically involves family planning.

The global experience with this approach to health sector development has been dismal, and in not just poor countries. In Russia, following the neo-liberal changes in the economy and the accompanying health sector reforms, between 1991 and 1994, life expectancy among men decreased by close to seven years, from 63.6 to 57.5 years; among women the decline was close to three years from 74.4 to 71.1 years. Such a decline in life expectations in populations not at war or suffering the onslaught of that other horse of the apocalypse, famine, is historically unprecedented. Accompanying the collapse of under-funded systems of health care, a booming private health system has emerged, along with a resurgence of old communicable diseases, and hunger. Indeed, even in the USA, data on life expectancy by race, a crude indicator of inequality, shows increasing divergence between whites and blacks beginning in the Reagan years. The most telling data are from the U.K that reveal increasing mortality differentials by class. The Black Report showed a substantial increase in mortality differentials by social class: the mortality rates among the unskilled working class men in 1981 were higher than they had been ever in the twentieth century, deteriorating after 1971.

This is despite the fact that the advanced countries spend much more on health than India does, not only in absolute per capita terms but also as shares of national income or public budgets. The UK spends 6% of its budget on health, India now less than 1 %. In contrast the USA spends 12% of its budget on health. The UK relies on universal coverage and a state supported and led National Health Service. It has better health indices than the USA despite less spending on health. In the USA, for instance, about 40 million people obtain no health coverage. Infant Mortality Rates (IMRs) and Under-Five Mortality Rates (U5MR) are significantly higher than in the UK. This calls for fundamentally re-thinking some neo-liberal shibboleths such as the supposed inefficiency of the public sector and the greater efficiency of market-driven private behaviour. Sri Lanka offers an excellent example of state-led quality health care provision. In Sri Lanka about 97 per cent of in-patient care and 83 per cent of out-patient care is in the public sector, where they have also integrated so-

called indigenous systems of medicine.

India is yet to achieve the National Health Policy 1983 target to reduce the IMR to less than 60 per 1000 live births. More serious is the fact that the rate of decline in the IMR, which was significant in the 1970s and 80s, has remarkably decelerated in the 1990s. The percentage decline in IMR between 1971 and 1981 was 14.7; between 1981 and 1991 it was even more marked at 27.3 per cent. However in the period 1991-99, there has been a marked stagnation with the rate of decline in the IMR at 10 per cent. Similarly, while there has been a decline in the U5MR, the pace of decline has come down and the U5MR is currently hovering around 95. During 1971-81, the percentage decline was 20.6. The decline was much sharper during the eighties, with a percentage decline of 35.7. However during the nineties, with the onset of policies of liberalisation, the rate of decline has reduced to 15.1 (Misra *et al* 2003).¹

Equally significant have been other changes. Inter-regional, rural-urban, gender and economic class differentials in access to health care in India are well documented. But since the onset of liberalization policies, these have considerably widened. The decline in public investments was matched with growing subsidies to the private sector in health care in a variety of ways (Baru 1998).² State support for private health care grew with the initiation of private-public partnerships that took a variety of forms. At the same time, there were far reaching changes in drug policies. Thus India – earlier characterised by relatively low costs of drugs and pharmaceuticals, along with a significant indigenous production of drugs – has witnessed a greater concentration of drug production, a larger role for multinationals, a higher proportion of imported drugs and unbelievably steep rises in the costs of drugs (Sengupta 1996).³ Concurrently, marked shifts have occurred in health care utilisation. Among people who sought out-patient services in 1995-96, more than 80 per cent did so in the private sector, a sharp increase in even the poorer states of the country (Sen, *et al* 2002).⁴ In 1995-96, 55 per cent and 57 per cent in rural and urban areas were hospitalised in the private sector compared to 40 per cent in 1986-87. NSS data indicates greater inequality in use of health facilities by economic class gradients. In rural areas the class gradient in in-patient use of public hospitals – which was insignificant in the mid-1980s – turned statistically significant in the mid-nineties. In urban areas, inequality in use of public facilities did not worsen significantly, but inequality in use of private facilities did. The steep fall in rural hospitalisation rates, along with increasing use by the better-off indicates that the poor are being squeezed out. Fee-for-services is undoubtedly one important mechanism that has succeeded in doing this. In other words, World Bank policies on health, contained in the influential *World Development Report*

1993 succeeded in doing exactly the opposite of what was ostensibly its *raison iêtre*: reduce the utilisation of public services by the better-off to increase access to the poor.

Costs of both out-patient and in-patient care increased sharply in both rural and urban areas, compared to the mid-eighties. Private out-patient costs increased by 142 per cent as against 77 per cent in the public sector in the rural areas. In urban areas, private out-patient costs increased by 150 per cent compared to 124 per cent in the public sector. The increase in costs in in-patient care is even more striking: average costs rose by 436 per cent in rural and 320 per cent in urban areas (Sen *et al* 2002).⁵ It is thus not surprising that, as the NHP 2002 notes, medical expenditure has emerged as one of the leading causes of indebtedness (GOI 2002).⁶ At the same time, the proportion of people not availing *any type* of medical care due to financial reasons increased between 1986-87 to 1995-96: from 10 to 21 per cent in urban areas, and from 15 to 24 per cent in rural areas (GOI 2000).⁷

Thus it is evident that what we need is state-led support to Primary Health Care in all its dimensions. Efforts to do so through the National Rural Health Mission appear diminished in vision, totally lacking a *systemic* perspective. It is also seriously under-funded. Thus the need is to concentrate on strengthening the entire primary health care system – which includes efficient referral systems to secondary and tertiary levels of care. State governments are facing huge financial problems in doing so. There are massive shortages of human resources like public health nurses, ANMs, male multi purpose workers etc, not to mention specialists. This is especially the case in states with poor health indices. Given low financial outlays, a large part of the health budget goes towards merely salaries. Without resources, time, support staff and drugs to do effective public health care, doctors lose motivation and seek alternative work. In this situation the PHC system offers little other than family planning and oral polio vaccination, driving people, the poor included, into the private sector. In this situation of state led-collapse of public health structure, community initiatives are both inadequate and regressive. The ASHA cannot function in a dysfunctional health care system. A further drain on public resources is through knee-jerk initiatives like increasing PPP or NGOisation.

II

It is against this backdrop that the effort to create a Public Health Foundation of India (PHFI) needs to be critically examined. This is an apparently autonomous institution with 15 per cent of funds from the government and the rest from other sources. State governments are expected to provide land and other infrastructure facilities. The PHFI will create five new institutions for training in public health, commencing

initially with two schools. We understand that recruitment of faculty has already commenced in schools of public health in the USA (the last date for applications was 9th March 2006, as per a circular to Deans and Assistant Deans of schools of public health in the USA; the PHFI was inaugurated on 28th March).

There are a number of issues with regard to the new-found love for world-class “India-centric, India-relevant and tailored to India” public health. It is apparent that dual systems of health care will now extend to dual systems of training in public health. This includes possibly dual salary structures, leading to internal brain drain.

The question that needs to be seriously considered is what system of public health is now being considered worthy of emulation. As we noted earlier, one model of health care that should not to be emulated is the US model. It is not only significantly more expensive, but also leaves out substantial sections of the population. Indeed it would not be exaggeration to state that the aim of the American system of public health is the creation of markets in health care. Under the influence of such a system, the global industry in health has increased from 396 billion dollars in 1976 to 786 billion dollars in 1990.

It is in this context that one should examine the role of Harvard School of Public Health, indeed the American system of public health schools, in shaping public health education and research in India and in many other developing countries, including China. Scholars like Hugh Leavell, Benjamin Paul, John Gordon, Carl Taylor, Theodore Ingalls, James Simmons and John Wyon, collectively known as the “Harvard group”, were instrumental in shaping the population control agenda with a neo-Malthusian bias in the early nineteen sixties. The damage this has caused to health sector development in the country is well known. Their ethnocentrism was quite evident when one of their influential studies concluded: “Westerners have strong feelings about the value of children not shared by Punjabi villagers” (Wyon and Gordon 1971).⁸

However, perhaps more important is the shaping of the curriculum of Preventive and Social Medicine by scholars like Carl Taylor who chaired the department of PSM of the Christian Medical College in Ludhiana. No doubt, at that time as well, the curriculum was India-relevant as it was based on the well-known “internship studies” undertaken by the Harvard group. The approach was strikingly similar to colonial anthropology, studying the “natives” (Qadeer and Nayar, 2005).⁹ A survey undertaken in 1959 of the teaching of PSM revealed that the rural internship programmes were in serious trouble. It was found that rural health centers for training interns had been evolved without proper planning. The major problems were inadequate staffing, equipment and

accommodation. There was widespread apathy among the interns regarding the purpose of the programme. Following this, a project on rural orientation of physicians was undertaken on a request from the Minister of Health, Government of India by the Department of Preventive and Social Medicine of the Ludhiana Medical College under the leadership of Carl Taylor. The project was funded through a PL-480 grant from the Bureau of Educational and Cultural Affairs of the United States Department of State. The study reinforced the internship approach by expanding the practical training over four levels of facilities: teaching hospitals, average district hospitals, teaching health centers and average health centers and suggested the philosophy of “medical colleges without walls”. Despite such heavy foreign funding and American “wheat” funding, the quality of public health teaching could not be salvaged.

The intervention of the Indian Medical Council and the recommendations of the Srivastava committee led to further shifts in the teaching of public health in the medical colleges. The significant shift was the introduction of Reorientation of Medical Education (ROME) scheme in 1977. The objectives of the ROME scheme were to involve the medical colleges in the direct delivery of health services to the rural population as well as to expose students to the rural environment. Some foreign governments even donated huge mobile clinics for the rural areas under the programme, which of course did not serve the purpose since these large vans could not traverse narrow unpaved rural roads. The ROME scheme was implemented initially in 25 medical colleges and was extended to all the medical colleges recognized by the Medical Council of India (MCI). It can now be safely asserted that the present poor state of PSM education in medical colleges in the country and the failure to produce a “managerial physician” could be attributed to the original sin committed in the fifties. Further cosmetic changes did not succeed due to the poorly envisioned curriculum that continued to remain unattractive.

It is quite evident that without strengthening the existing public health teaching in medical colleges – there are 120 of them throughout the country at present, it will be impossible to create a “managerial physician” who needs to provide effective leadership in the health services system. An elite oriented public health education on such a large scale and in a vertical fashion may not achieve such an objective.

It appears that planners in India seek to bring back this variety of U.S exported public health. Once famously described as a-theoretical, a-political and a-historical, this is now touted as a model for “high impact public health research”. It is also not accidental that many American and European schools of public health (based on the so-called “hygiene” and “tropical” medicine

models) that have been cornering international research funds for “sanitising” and intellectually “colonising” many African countries are looking for new markets for their knowledge.

The PHFI initiative also aims to create a capacity to train 10,000 people per year in public health by offering long and short-term programmes with multiple degrees such as certificates, DPH, MPH, Ph.D etc. Is this what our country actually needs? If we look at the manpower requirement in rural primary health care, it becomes evident that most shortages are at the level of low-level primary care staff such as nurses and male health workers (See Table 1). Can such high-profile institutes provide the personnel needed to manage the primary health care services? There is no doubt that the duality in public health education will breed elitism and produce an unfit and unwanted class of professionals. What it will also do is produce public health staff for the First World, at a cheaper price. Currently 4 to 5,000 doctors trained at public expense, emigrate every year, at an estimated cost of 160 million US dollars to the Indian exchequer (VHAI 1997).¹⁰

It is also necessary to mention the role of private foundation funding in this whole process. For instance, the Bill and Melinda Gates Foundation is a major partner in PHFI. The “grand challenges” proposed by the Gates Foundation have turned critical challenges in public health into a narrowly conceived

understanding of health as the product of technical interventions divorced from economic, social, and indeed epidemiological contexts (Birn 2005).¹¹ Six of the fourteen grand challenges in public health relate to vaccine development. It is possible that such a narrow technology-driven vision of public health is going to be the paradigmatic basis of the grand new public health in future. Should such a public health orientation set standards and determine accreditation of public health education in this country as has been proposed through PHFI? When the market starts dominating the discourse of public health, it will only undermine academic autonomy as is already the case in management education (EPW, 2006).¹² Indeed, it will create a discipline based on the rules and games of the market including profits and student- customers who can buy such an education.

A further substantial part of the PHFI’s budget is to come from unspecified private sector contributions. This is even more undesirable as it will distort public health priorities even further towards profitable interventions alone. Examples are legion of private sector funding skewing research agendas, and indeed findings. Thus for instance, the ban on routine inclusion of antibiotics in animal feed in order to reduce antibiotic resistance in the general human population, effected in England after the outbreak of Bovine Spongiform Encephalitis (mad cow disease), has been bitterly

Table 1. Manpower Requirement in Rural Primary Health Care Institutions:

Category	Requirement 1991	In Position 30.6.96	Number sanctioned 1995	Post Needed
Specialists at CHC	22348	2751	4763	17585
Doctors at PHC	22349	26930	32074	-0-
BEE/Health Educator	22349	9621	6287	16062
Pharmacist	27936	20022	21790	6146
Lab. Tech.	27936	9711	12371	15565
X-ray Tech./Radiographer	5587	1288	1596	3991
Nurse/Midwife	61548	12683	16754	44704
Health Asst. (M)	22349	15745	18323	4026
Health Asst. (F)	22349	18904	21638	691
Health Worker (M)	134108	62229	71165	62943
Health Worker (F)	156457	133773	140751	15706

Source: Government of India (1996), Ministry of Health and Family Welfare, *RHS Bulletin*, New Delhi, June.

contested by public health scientists in the U.S., on the basis of research funded by the animal foods industry (Walters 2004).¹³

It is not our argument that public health training does not need strengthening or that institutionalized education in this matter is not necessary. Both are indeed very important. However, before we set up new institutions at great cost – whatever the source of funds – we must examine what ails the existing system. India already has institutions such as the NIHF, the National Tuberculosis Institute, the All India Institute of Hygiene and so forth – some of which did remarkable public health work in the past. There are however problems with many of these institutions, with lack of funds, lack of autonomy, and so on that need to be dealt with. Without doing so, to start new institutions is not only undesirable, but in a situation of fund constraint, also hugely wasteful economically.

Acknowledgements

Grateful thanks to Jayati Ghosh for her comments. She is, however, not to be besmirched by the weaknesses of our arguments – or infelicities in them.

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²Baru, Rama (1998), *Private Health in India: Social Characteristics and Trends*, Sage, New Delhi.

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maceuticals”, *Economic and Political Weekly*, Vol.XXXI, No 48.

⁴Sen, Gita, Iyer, Aditi and George, Asha (2002), “Class, Gender and Health Equity: Lessons from Liberalising India” in Gita Sen, Asha George and Pirooska Ostlin (Ed), *Engendering International Health*, MIT Press, Massachusetts.

⁵*Ibid.*

⁶Government of India, Ministry of Health and Family Welfare (2002), *National Health Policy*, New Delhi.

⁷Government of India, Ministry of Statistics and Programme Implementation (2000), “Note on Morbidity and Treatment of Ailments: NSS 52nd Round (July 1995-June 1996)”, *Sarvekshana*, Vol.XXIII, No.3, Jan-March.

⁸Wyon, John B and John E.Gordan (1971), *The Khanna Study: Population Problems in Rural Punjab*, Harvard University Press, Cambridge, Mass.

⁹Qadeer I and Nayar KR (2005), “Politics of Pedagogy in Public Health”, *Social Scientist*, Vol.33, No. 1-2.

¹⁰Voluntary Health Association of India (1997), *Report of the Independent Commission on Health in India*, New Delhi.

¹¹Birn, Anne-Emanuelle (2005), “Gates’s Grandest Challenge: Transcending Technology as Public Health Ideology”, *Lancet*, Vol.366, No.9484, 6th August.

¹²Editorial (2006), “Higher Education: From Politics to Market”, *Economic and Political Weekly*, Vol.XLI, No.8, February 25th.

¹³Walters, Mark Jerome (2004), *Six Modern Plagues: And How We Are Causing Them*, Island Press, Washington.

Applying Yesterday’s Standards Today

Cristina Odone, Sunday December 10, 2006, *The Observer*

How easy it is to apply today’s standards to yesterday’s heroes. We have now learnt that Richard Doll, the world’s greatest pioneer of cancer research, and the man who down-played the cancer risks posed by Agent Orange and vinyl chloride, was in the pay of big companies that produced these chemicals. Immediately, Doll’s expert witness work was condemned as worthless and Doll deemed a fraud. Today, his retainer from the chemical industry would be seen as a serious conflict of interest. Either he would have to declare it or shun any work that might give rise to question. Scientists know to steer well clear of Big Pharma because we see it as the worst of Big Business: a multi-billion pound industry that colludes to keep us in the dark in the one area we feel most vulnerable - our health. We have become such pharma-phobes that John le Carre’s recent bestseller, *The Constant Gardener*, has a character claiming that in terms of hate-figures: ‘Big pharmaceuticals are up there with arms dealers.’ But back in the 1970s, things were different. Pharmacology was seen as the great hope that could save us from polio, TB, mumps and cancer. Doll felt no desire to conceal his links with this industry (indeed, had he done so, it’s hardly likely that he would have kept his contracts among the papers he bequeathed to the Wellcome Trust). In those days, professional ethics, not written codes of practice, were what guarded us against fraud and fiddles. The conventions did not ban a link between science and industry; honourable practice was expected to be the norm and scientists were expected to live by this. Anyone who came across Doll would have recognised this. In the late 1970s, my husband earned pocket money by being a Christmas postman in his university holidays. He remembers Doll’s impressive daily postbag and the modest house in north Oxford to which he delivered it. This was a man no one could accuse of being venal. Indeed, Doll gave all his fees to Green College, the Oxford postgraduate institution he founded. Doll was following standard practice at the time and to criticise him for not sharing our own code of conduct (and our suspicions about the pharmaceutical industry and big business in general) is as pointless as condemning Marx for his disparaging comments about the Irish and ‘Negros’ or criticising the spelling in Magna Carta. Each age has its mores: we cannot expect the giants of the past to live by ours.

Public Health Needs a Boost-Not Bickering

-K.S.Reddy¹

It is difficult to disagree with a passionate champion of public health like Mohan Rao. There is also no cause to disagree when he argues, in the initial part of his viewpoint exposition, that the social determinants of health and disease need to be identified and addressed through fundamental social changes that promote equity, access and affordability as essential characteristics of the health system. There is no dispute also when he argues for the strengthening of primary health care and affirms that it is the governments that bear the major responsibility for ensuring the availability of health care to all sections of the people, through appropriately structured and adequately financed public health services.

There could some minor differences, however, when he posits ORS and provision of safe water and sanitation as mutually exclusive public health programmes. While it is undoubtedly important to advocate, aim for and accomplish sustainable social promoters of health like universal supply of safe drinking water, interventions like ORS could still save thousands of young children who may fall victim to diarrhea, till that salutary social objective is achieved. Obsession with technology should never drive public health polices or programmes, which need to address the determinants of health rather than merely attempt quick fix solutions for disease. At the same time, public health should never shun appropriate use of suitable technologies to advance towards its goals.

Similarly, prevention and amelioration of anemia is the general population, through policies for improvement of mass nutrition and creation of hygienic conditions where parasitic diseases are avoided, is a laudable and necessary objective. Till that goal is achieved, would not special attention to the detection and correction of anemia in an especially vulnerable group of pregnant women, who run a high risk of pregnancy related complications and death, serve a useful public health purpose? Public health needs a broad array of interventions which can make complementary contributions to create a comprehensive response to complex health challenges. An 'either-or' approach can be self defeating and may freeze the status quo till major social changes can successfully influence all of the social determinants.

However, my major area of discord with Mohan Rao's writing arises only when it strays from being a sound social critique, which it is in the initial section, to become a string of speculative comments on the role of the Public Health Foundation of India (PHFI) in the latter part of the article. The criticism of PHFI is based on assumptions that the PHFI Institutes would (a) follow an American model of education, (b) produce public health professionals for an export market, create a cadre of elitist 'managerial physicians' distanced from primary health care, (d) promote a technology driven biomedical model of public health and (e) result in neglect of existing public health training institutions.

None of the above assumptions are valid. The PHFI will mainly draw upon Indian experience and Indian expertise, while drawing up its curriculum and developing its learning resources. Future faculty would be drawn from available expertise in India and others trained abroad, in multiple reputed centers across the world. PHFI would establish academic partnerships with public health institutions from all regions of the world and access global learnings which are robust in academic content and also relevant to the Indian context. Connectivity with public health institutions in other developing countries would be accorded a high priority. No exclusive relationship has been established with any American School of Public Health and each PHFI Institute will connect with a number of Indian and international partners. In the overall context of public health education, it is useful to draw upon the strengths of international partners, including American Schools where appropriate, in core disciplines like epidemiology, health economics, biostatistics and behavioural sciences. We should remember that American Universities are also home to persons like Amartya Sen, Noam Chomsky and Joseph Stiglitz, who are respected for their independent thinking and contributions to public discourse. Similarly, they also house many public health teachers and researchers who are not inimical to the interests of developing countries like India. It is for us to evolve the models of education most relevant to us and engage with those who can help us in areas of our identified need. Countries like Thailand, Iran and Bangladesh have much to teach us and we will learn from them, as we learn also from institutions in the Europe, North America and Australia.

Initially, the majority of the persons trained in the PHFI Institutes would be persons already employed in State health services or health NGOs. The aim would be to add value to their role as serving functionaries in the

¹ Reproduced with author's permission from: Reddy, K S (2006). "Public Health needs a Boost, not Bickering, Speaking in spite of Myself." *NMJI*, Vol.19, No. 4, 2006, pp. 224-226. Email: <ksreddy@ccdcindia.org>

health system. Simultaneously, efforts would be made to persuade States to create definitive positions for persons with public health expertise, so that even fresh graduates can be absorbed. The creation of a public health cadre has been recommended by several expert committees (Bhore Committee, 1946; Mudaliar Committee 1961; the Expert Committee on Public Health System 1996, constituted by Government of India.). PHFI would advocate for the creation of such a cadre, even while training existing physician and non-physician public health functionaries who are presently positioned in the health system. There would also be efforts to increase the absorption of public health professionals into the voluntary and private sectors in India. The purpose is to invigorate all components of the Indian health system with infusion of public health expertise.

Far from creating 'elitist physician managers', PHFI aims to provide multi-disciplinary education and training to a wide range of public health resource persons. In a situation where neither nurses or nutritionists have a major programme for training in public health and where public health law and public health engineering are rudimentary disciplines, PHFI hopes to evolve innovative models of education. Health management too would be an important educational stream, but only as one among several that PHFI would nurture.

In the present scenario, where are the programmes that can inform and influence sectors such as agriculture and urban planning to address public health needs? How many health economists are available in India to conduct policy relevant studies and document the effects of distorted development on health of the people, leave aside teach courses in this much needed but almost non-existent discipline? At the grassroots, how many trained personnel are available for nationwide disease surveillance? Why are cause-specific mortality data not available for many common diseases? Training programmes are obviously needed at many levels and PHFI would try to facilitate them, along with other institutions.

The fact that PHFI derives a part of its initial funding from the Gates Foundation cannot be construed as evidence that its public health education programmes would have a tubular technovision. The broad based education that PHFI envisages will encompass a clear understanding of the multiple determinants of health and provide the skill sets for undertaking multi-sectoral actions to advance public health. The Gates grant is an unrestricted grant and does not bind PHFI to any particular pattern of education or research.

PHFI is also committed to assist the growth of existing and other emerging public health training institutions in India. It would help to create a network of such

institutions which can strengthen each other through sharing of technical expertise and conduct conjoint programmes in teaching and research. It must be recognized that the existing institutional strength in public health education and training is very inadequate for developing human resources on a scale needed to transform the health services. If the present institutions were fully capable of delivering all that is required, why would the prevailing scene be so dismal both in terms of the available public health workforce and public health advocacy? Whether for advocating policy change or for implementing programmes, many more public health professionals are needed to generate and apply knowledge as relevant to public health goals.

Finally, it is misleading to suggest that PHFI has been created to place public health in private hands. The primary objective of PHFI is to strengthen public health services. The partnership with the Central and State Governments and their participation in the governance of PHFI and its institutes will ensure that the activities of PHFI are closely aligned to the priorities identified by the government and will readily respond to the needs of public health services. A number of State governments have already communicated their interest in establishing such a close partnership. The voice of the civil society would also be heard and heeded when it provides its inputs through various advisory bodies which would soon be established. It is only when public health continues to be neglected that the health of the people will be mostly transferred to private hands, by default. The PHFI's mandate is to protect public health, not to undermine it.

To let the 'status quo' continue, because of false insecurity about new institutions or misplaced fears about hidden agendas, would be a grave disservice to the Indian people. To deliver an advance verdict of 'guilt by suspicion' on PHFI, even before it has started functioning, reflects neither natural justice nor scientific objectivity. A new initiative should not be judged either by the best hopes of its friends or the worst fears of its critics but by the reality of its activities as they unfold. It would be better for skeptics to closely monitor the activities of the PHFI, which is just born, and reserve their judgment till it opens its first Institute in 2008. It would be best, of course, if all well-meaning advocates of public health join hands and promote a sound framework for addressing India's many health challenges.

***“Because things are the way they are,
they will not stay the
way they are”
- Bertolt Brecht***

The EPA Closes Its Libraries, Destroys Documents

The Environmental Protection Agency (EPA) maintains a nationwide network of 27 libraries that provide critical scientific information on human health and environmental protection, not only to EPA scientists, but also to other researchers and the general public. The EPA libraries are located in each of 10 regions of the country, at EPA headquarters in Washington, D.C. and at various EPA laboratories specializing in certain aspects of environmental protection.

In order to fulfill its mission to protect human health and the environment, the EPA must rely on accurate, up-to-date scientific information as well as the findings of earlier studies. To make the best scientific determinations, scientists need access to information regarding the health effects of toxic substances, records of environmental change over time, impacts on specific regions or communities and other issues. To this end, the libraries represent a unique and invaluable source of scientific knowledge on issues from hazardous waste to toxicology to pollution control. Additional benefit to scientific researchers is gained from the expertise of a dedicated library staff, who field more than 140,000 database and reference questions per year from EPA scientists and the public.

In February 2006 under the guise of cutting costs, the Bush Administration proposed cutting \$2 million out of the \$2.5 million library services budget for fiscal year 2007. Such a drastic cut would ensure the closing of most of the library network, but would hardly register as a cost savings against the \$8 billion EPA budget.

Despite the fact that Congress has not yet passed the 2007 budget or approved these funding cuts, the EPA has already moved with astonishing speed to close down several of its libraries to both the public and EPA staff. Three regional libraries, the Headquarters Library and a specialized library for research on the effects and properties of chemicals have already been closed, and four additional regional libraries have been subjected to reduced hours and limited access. Some books, reports and other resources formerly housed at these libraries have been sent to three repositories where they remain uncatalogued and inaccessible to the scientists and others who depend upon them. Other materials have already been recycled or thrown away.

While administration officials claim the changes are prompted by budgetary pressures, the existence of a dedicated library system has been shown to actually save money. A 2004 internal EPA report found that the library network saved over 214,000 hours a year in staff time, amounting to cost-savings of \$7.5 million—considerably more than the savings gained from cutting the program.

Officials claim the closings are part of a modernization plan, and that all materials will eventually be available online. However, no comprehensive assessment of information

needs has been undertaken—making it likely that some unique information will be lost—and no funding exists to carry out the time-consuming and expensive process of making documents available electronically. The end result is that the library resources are already unavailable and the promised electronic access could be years away.

Many scientists and lawmakers have spoken out in protest of these library closures. Four unions representing 10,000 EPA scientists sent a letter asking Congress to stop the destruction of the library network. A letter from Representatives Henry Waxman (D-CA), Bart Gordon (D-TN) and John Dingell (D-MI) has prompted an investigation of the library system by the General Accountability Office, the investigative arm of Congress. And members of both the House and Senate have called upon Administrator Johnson to cease and desist with the closures until the investigation is complete and Congress has authorized action; the House letter calls for a response from the administrator by Monday, December 4, 2006.

The closure of these libraries and the warehousing of their resources represents an additional barrier to the free flow of scientific information. The EPA will not have the best information readily available when it makes regulatory decisions, negatively impacting the agency's ability to carry out its mission of protecting human health and the environment.

These are large agencies; it is not uncommon for an agency to go into complete denial when confronted with questions such as the ones we are asking. However, this only underscores the importance of putting the administrator's office on notice that we are watching and will hold them accountable.

Are the Libraries Really Closing?

When UCS supporters began calling, the EPA Administrator's office was denying that libraries had been closed. In addition to the congressional letters cited above, UCS has ample evidence that this is indeed the case.

On the EPA's own library website, the five libraries that have been closed to date have been removed from the list and had their websites partially or completely shut down: the Headquarters Library, Region 5, Region 6, Region 7, and the Office of Prevention, Pollution, and Toxic Substances (OPPTS). The EPA libraries website links to a plan of action for closing many libraries and dispersing or disposing of materials. We also have first-hand accounts from EPA employees that the libraries have been closed.

Also, several newspapers have reported or editorialized about the library closures, including:

Christian Science Monitor, 11/30/06: "As EPA Libraries go Digital, Public Access Suffers" *Boston Globe* editorial, 11/20/06: "Save the Earth's Libraries" *Arizona Star*, 11/05/06: "EPA Libraries Taking Big Hits: They're closed or curtailed

to cut costs, agency says; critics skeptical”

Is Material Being Destroyed?

Ample evidence exists that the EPA has already destroyed documents. *The Christian Science Monitor* reports that “scientific journals worth hundreds of thousands of taxpayer dollars were thrown in dumpsters in October.” An EPA chemist told the *Kansas City Star* that one library was told to throw away journals. Public Employees for Environmental Responsibility uncovered documents ordering one library to recycle materials “as many as possible.” And the House and Senate letters described above also reference the destruction of documents.

Is Contacting Administrator Johnson More Effective than Congress?

Yes. Congress is already aware of this problem and has asked the EPA to cease and desist; the decision to stop the closing of libraries and the destruction of documents lies now with Administrator Johnson. Your message can still be clear: The EPA should stop closing its libraries and disposing of material until implementation of a plan to ensure that material continues to be accessible to the public and scientists.

Additional information is provided by the American Library Association and Public Employees for Environmental Responsibility.

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Views and opinions expressed in the bulletin are those of the authors and not necessarily of the MFC. Manuscripts may be sent by email or by post to the Editor at the Editorial Office address.

MEDICO FRIEND CIRCLE BULLETIN PRINTED MATTER - PERIODICAL

Registration Number: R.N. 27565/76

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1st Floor, Premananda Sahitya Bhavan
Dandia Bazar, Vadodara 390 001

