

Pre-People's Health Assembly (PHA) mobilisation in India

Amit Sengupta, T. Sundararaman (JSA - PHM India)

The Objectives

The Peoples' Health Assembly aims to draw public attention to the adverse impact of the policies of globalization on the health of people worldwide, especially on the health of the poor.

The Peoples' Health Assembly aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 AD' pledge. This commitment needs to be renewed. Health and equitable development needs to be reestablished as priorities in local, national, international policy-making, with primary health care on the strategy for achieving these priorities.

In the Indian context, globalization's thrust to privatization and retreat of the state has exacerbated the trends to commercialize medical care. Irrational, unethical and exploitative medical practices are flourishing. The Peoples' Health Assembly expresses the need to confront such commercialization.

In the Indian context, top down, bureaucratic, fragmented techno-centric approaches to health care have created considerable wastage of scarce resources and failed to deliver health. The Peoples Health Assembly seeks to emphasize the urgent need to promote decentralization of health care and build up integrated, comprehensive and participatory approaches to health care that places Peoples Health in Peoples Hands.

The Peoples' Health Assembly seeks to network all those interested in promoting peoples' health. It seeks to unleash a wide variety of people's initiatives that would help the poor and the marginalized to organize and provide some relief to their immediate predicament as well as contribute to building long-term and sustainable solutions to health problems.

Inspiring the India Campaign

Among the countries participating at the Peoples' Health Assembly at Dhaka, India has seen one of the most extensive pre-conference campaign activities. This has a history. India has an excellent tradition of progressive academic scholarship. This scholarship has laid bare the class and gender bias of health policies. It has exposed the problems of a technocratic approach that sees health as being given by a benevolent state and a benevolent medical profession to people who are seen as passive beneficiaries. India has also seen a large number of innovative models of community health care. These models have provided rich insights into community health care they have established the fact that 'Health for All' is not only desirable - it is possible as well.

The challenge that the PHA process in India set itself was to extend this understanding beyond select intellectual and NGO circles and make it part of the public consciousness. Without such widespread public understanding of the reason for the crisis in health care as well as the nature of the alternatives needed and possible one cannot succeed in placing 'Health for All' in the political agenda of the nation.

The India campaign of the PHA also understands that the vast majority of the country who are poor and who bear the brunt of the crisis in health care, have also their perceptions of what is needed for their health. Moreover they have rich experience in daily coping with the crisis. Efforts by a growing health industry to shape peoples' wants to suit the market needs of capital cannot succeed beyond a point. People can articulate what they need better if they are provided the space and organisation for doing so. The challenge however is to synergize the efforts of voluntary organizations and health action groups with them and their organizations such that their voices are heard and their needs gain priority.

Organizational Approach

To achieve this organizational goal of 'taking health care issues to the streets', the PHA process in India adopted a number of strategies:

- *Involving New Networks and strengthening existing ones:* A number of organizations and national networks who share a common understanding on globalization and have a considerable presence in the villages, but who were hitherto not involved in health care issues joined in the campaign. For example, the BGVS networks has a large team of literacy workers, but their health work was confined to only 20 districts across the country and that too in a very limited way. By getting involved in the PHA process, they could build up an understanding on health issues and strengthen the forces working for alternative health care policies. The BGVS is by no means a new network but its large-scale involvement in health issues is certainly a new and welcome development. This could be said about other networks also. For example the NAPM, which has been active in livelihood issues and on peoples' control over natural resources, enters with this campaign into the national scene as an advocate for alternative health care policies. This strengthens the alliance building up against globalization and its adverse impact on the health of people. For networks like the FORCES, which have always been active on child health issues, this campaign has provided it an opportunity to strengthen and extend their existing structure and outreach.
- *Networking Networks:* The other major dimension of the PHA organization was the mutual support and reinforcement that bringing together of the networks provided. Thus some of the organizations like CEHAT or CHC acted as resource groups to strengthen and deepen the district and village level mobilization of field based groups. In other states, AIPSN or MFC activists or VHAI state units provided critical resource inputs.
- *Resource Sharing:* Other than in program content, financial and infrastructure resources were also extensively shared. Thus in most states and often in the districts, some organization which had a training infrastructure supported both boarding and lodging expenses for the entire training programme, or at least a considerable part of the expenses. Others contributed to publicity activities and still others provided the capital to print the booklets. In the Tamilnadu campaign for example, TASSOS (related to CHAI) provided training infrastructure, VHA of TN provided support for Dear Doctor letters and contributed to the state convention, FEDCOT printed the posters and TNSF undertook most of the block level enquiries.

Without such extensive sharing of financial resources, in almost all states and at the national level, the programme in such an extensive manner would have been inconceivable. The entire cost of the PHA process had it been done in a full-fledged project would have cost a minimum of Rs. 25 million. Even if peoples' mobilization met over 85 percent of the costs incurred, the critical 15 percent that goes into centralized expenses at state and national level was impossible but for this sharing of financial resources.

Beyond, knowledge, skills and finances there were other shared dimensions too. New partners brought new confidence and new optimism. Groups working in the field or in isolation experienced the warmth of peer recognition of their work from others working for the same cause. Public recognition of their work has also enhanced.

And most important Networking Networks also brought forth new ideas and possibilities for future action.

- *Combining advocacy with community action:* One major dimension of the PHA organizational process was the linkage between advocacy/agitation for policy changes and voluntary/NGO work amongst communities including work in health care delivery. Though some organizations like the VHAI, CEHAT or FORCES have always had a synergy, for many others it was a policy decision to build up one or other dimension of their work. Thus organizations like CHAI, CMAI and Ramakrishna Mission have been over 40 years active in provision of health care services though seldom involved in advocacy work on such a large scale. Others who had functioned as resource groups active in policy concerns forged alliances with large field-action based groups.

By providing space for such synergy, the number of networks involved and therefore the outreach and the credibility of the entire process could be enhanced.

- *Autonomy, Flexibility and Coordination:* One other key understanding of the PHA organization was to safeguard and guarantee autonomy of individual organizations even while ensuring coordination. Coordination committees (made of organizations) and working groups (made up of members sponsored by the organizations) were set up in national, state and the district levels. These coordination committees planned for some coordinated or joint activities at that level and whichever organizations joined in and were active at that level could identify themselves publicly as the organizer at that level. Thus in each state the set of organizations that made the state coordination committee was quite different from that which made the national committee or the district coordination committee. This allowed for over 1000 organizations (that we have information of) to be listed as participants at either block or district or state level! This approach allows for an organization which is making a more extensive contribution to be seen publicly at so many more places and it ensures the distinct identity of each organization, especially the smaller groups. Nor was coordination insisted on. All organizations were welcomed and encouraged to take independent activities.

The other dimension of autonomy was that all national coordination committee decisions were in effect viewed as guidelines by states. Even 'quotas' set for funds or coordinated events left room for individual states or organizations to opt out or do it differently if so desired. The result has been a wide panorama of activities and vastly different levels of

participation.

It is difficult in this short note to do justice to all these variations. Given below is only a brief overview of processes that were largely common – cutting across most states.

Activities - seen as processes

Building a common understanding

After Dr. Zafrullah Choudhury had approached a number of sections of the AIPSN & BGVS leaders about the PHA, a national consultation of all potential partners - largely those already in touch with the Dhaka process - was organized in Chennai. Subsequent to this, the National Coordination Committee and the National Working Group was formed and it met subsequently at Bangalore in March 4th & 5th, in Hyderabad on April 6th and 7th, at Delhi in August and at Kolkata on November 4th and the 5th.

To build a common understanding of the programme content, the Chennai meet authorized a team to collect resource inputs in the form of theme papers. By March end, 30 base-papers were collected from over 30 resource persons. Then a small group worked intensively to edit and transform these base-papers into four simple popular booklets. A hundred xerox copies of these booklets in draft form were brought to the national preparatory workshop at Hyderabad. Here over 100 delegates from at least 9 organizations went through all the four booklets, in small groups, while rapporteurs noted down their suggestions. The group then incorporated these suggestions, and the text, which was complex in places, was made readable by an illustrated, 'conversational' presentation. The four books were printed in last week of May. A fifth book on Confronting Commercialization was also finalized, albeit with a more limited discussion, and that too was printed by June end. In English 4000 sets of these five books were printed and sold. Many times this number have been printed and sold in the form of translations (and that proved to be an equally daunting task) in Hindi, Kannada, Tamil, Telugu, Oriya, Bengali and Malayalam and in adapted versions in other languages like Marathi and Gujarati.

The five books represent developed for the campaign represented a shared understanding of the critique of existing policies as also our recommendations for change and the possibilities for peoples' initiatives. It was published not in the names of individual authors or organizations but collectively by the entire group and thus became a binding force in itself.

Establishing the commonality of understanding in a more succinct way was also the people's health charter. First mooted in Hyderabad workshop then worked up by a sub-committee and circulated to the states, discussed in state conventions, and finally at the national convention, the charter helped a closer understanding emerge amongst the partners.

Together the five books and the charter have become the central instruments through which the public understanding of the crisis in health care is sought to be built up.

The District Level Process

The programme has reached out approximately to 250 districts of the country. Though there are wide differences in what happened in various districts, the most common process at the district level was as follows:

1. A district resource group and a block resource group in each block was built up through a district level preparatory workshop. The five-book set and a model questionnaire served as the training material.
2. The block resource group conducted a dialogue (or participatory, rapid appraisal) with people in about 30 villages. They also visited the local PHC and subcentres and talked to the personnel there. In conducting this dialogue, they were assisted by an interview schedule/questionnaire prepared by the district team, based on state level guidelines for the same.
3. Based on the enquiry/dialogue, a local health charter was prepared. This charter places immediate demands that the local administration can meet and also charts out the follow up actions that can be done by people themselves. The charter is placed before the block convention.
4. The block level conventions were followed by a district convention. The charter was given to the administration as well as adopted at the convention. In many districts, block and district conventions were held together. The district report was then used as an input to a public awareness campaign. It was also placed before the state convention.

Public Awareness Campaign

The public awareness campaign took different forms in each district. In all states, the number of people involved in workshops, seminars, peoples' dialogue, surveys and conventions was the main form of building up public awareness.

The sale of the five books was in itself a campaign and nearly 25,000 sets, all languages included, have been sold. (That is worth about Rs. 250,000 !)

Poster campaigns also played a major role. The kalajathas – traveling street theatre – took the message to 23 districts in TN, 5 in AP, 14 in Karnataka and almost all districts of West Bengal, Kerala and Tripura. Kalajathas were also planned in some other states.

Rallies and Processions also contributed – especially the rallies in Delhi (1200 people) and Chennai (3000 people) and of course at Calcutta (over 30,000 people being mobilized).

Media coverage received was weak, partly because of our inexperience in handling media and also because of media's own preferences for news. Of course in almost all states, the news was given prominent and repeated space in local papers and in the regional pages of the national newspapers.

One interesting aspect of the campaign in many states was to reach out to the medical profession. Dear Doctor letters were sent on the PHA and these letters called for some immediate reforms within the profession. The campaign also involved few respected and concerned health professionals in most district and state levels. Though their numbers were few they played very important roles as resource persons and in lending a wider credibility to the proceedings.

The Peoples' Health Trains are another unique highlight of this process. Not only are they media events, they are an occasion for the over 2000 delegates to interact informally over 2 days of traveling together to the national convention.

The culmination of the public awareness campaign is in the National Health Assembly.

The National Health Assembly

This is a unique event and was a challenge to draw up a programme for such an assembly.

To do justice to the mobilization that had taken place and to catch the public imagination it had to be massive - over 2000 delegates are participating. But it also had to be participatory and allow for sharing a wide variety of experiences and concerns - from village level health workers to senior medical professionals and sociologists. The assembly needs to review work done as well as plan for the future. It had to be educative (what did we learn new is one question participants ask) and as a conference productive (what was the outcome?). And most importantly, the conference had to be designed by consensus amongst the 18 NCC organizations and itself was to become a consensus building process.

Beyond the Calcutta & Dhaka Assemblies

Understanding the PHA process is essential to plan for our future actions. We also need to take stock of what have been the limitations. Was there adequate dialogue between all the 18 organizations or were some not enabled to contribute optimally? Was the quality of the district level processes adequate? Has adequate understanding been built amongst many new sections, which have joined in? Could we have involved more health professionals in this process and so on?

Learning from the experience of working for the PHA process a consensus is emerging around the Post-Dhaka programme. The three essential processes that would go into a successful post Dhaka programme are:

1. An organizational form, which retains this mix of coordination and autonomy and allows for frequent consultation and mutual support.
2. Advocacy for policy changes (immediate as well as long term) based on a set of well defined objectives.
3. A few well-chosen coordinated programmes that would catalyze a wide number of peoples' initiatives, that would extend the outreach of the PHA network and thereby enlarge the forces working for alternatives. If our programmes also help people cope with the health crisis that would lends credibility to our efforts for policy changes.

In the final analysis, we will have to concede that the entire PHA process, massive as it has been, has only helped us to come together and engage with the problem. Unless we are able to sustain these processes for a few more years at least, we cannot hope to make an adequate impact! Placing health care on the political agenda requires far more than a year's campaign!

State Activities

In Kerala, Tamilnadu, Andhra, Karnataka, Maharashtra, Madhya Pradesh, Chattisgarh, Orissa, West Bengal, Assam, Tripura, Bihar, Uttar Pradesh, Himachal, Haryana, Rajasthan, Delhi and Gujarat, the PHA campaign at the state level has been led by a broad based coalition of 15 to 40 NGOs and People's Organizations.

The 5 PHA books have been translated/transcreated by the respective states into Malayalam, Tamil, Telugu, Kannada, Oriya, Bengali and Hindi. 2000-5000 copies of these books have been printed and sold by these states. The Karnataka Directorate of Health Services have asked for the 1 set of English books to be given to all Medical officers in all the PHCs and the a possibility of getting the Kannada books to all the ANMs is being worked out. Maharashtra has prepared a set of 5 books (though not a translation) based on the 5 NCC PHA books. Based on these books, all these 18 states conducted their State Preparatory Workshops. In most of the states, this was followed by the formation of broad based District Coordination Committee in 15-30 districts and then district and block level workshops.

Most of these states have also organized Block, Village and PHC Level Enquiries followed by Block/District Conventions. Apart from these common activities, most states have also independently organized a number of state level campaigns. The highlights of these special activities are given below:

Kerala: A series of lecture classes in all the 1000 panchayats (local self government units comprising village clusters) were organized. Arogyakootams - Meetings with activists, people, medical professions and administrators organized at the district and block level. A round of Kalajathas (moving caravan of cultural activists) covering the entire state has been organized. State convention held on November 15th. 124 delegates will travel by Ernakulam Patna Express to the NHA.

Tamilnadu: The SCC has 32 State Level Organizations. The campaign covered about 160 blocks in 23 districts. Based on the enquiries and the overall perspectives of the PHA, District Health Charters have been prepared and adopted in several district conventions.

15,000 Dear Doctor Letters were printed and sent to doctors across the state – apart from explaining the PHA process, the letters urge doctors to fight against feticide, commissions system and to follow rational prescription procedures. Five Kala Jatha teams were trained which then covered 23 districts between November 12th and 25th. Nov 14th was celebrated as Girl Child Day (with emphasis on preventing Feticide). 3 posters – on Female Feticide, on Impact of Globalization on Health and on the Commercialization of Health Care – were designed and 2500 copies of each was printed. They were released all over the state on Nov. 14th. The State Convention was held on November 26th with about 1000 delegates. This was followed by a rally and a public meeting with about 3000 people. A Policy Dialogue has been planned after Dhaka. 160 delegates will travel by Ernakulam Patna Express to the NHA.

Andhra Pradesh: 30 posters have been designed and 1000 sets printed. The campaign covers 500 villages in 18 districts. Of these in 12 districts the campaign has been more intensive covering all the mandals. Two districts have organized Kala Jatha programmes. The State Convention was organized on Nov 12th. About 140 delegates will travel to the NHA by the Ernakulam Patna Express.

Karnataka: The SCC has 19 Organizations. The campaign reached out to about 50 blocks in 15 districts. A preliminary Kala Jatha was organized followed by a training workshop and Kala Jatha programmes in 10 districts. A Policy Dialogue was organized on Nov 11th. The State Convention was held at Davangire on the 26th and 27th of November with about 500 delegates participating. 5 Kalajatha teams performed at the convention. 156 delegates will travel to the NHA on Coromandel Express.

Maharashtra: Health Dialogues organized in 50 Talukas. A 15 point criteria was used to evaluate the government health system in 16 districts and in Urban slums in Mumbai and Pune. Nov 1st to 14th was celebrated as People's Health Fortnight. 6 posters were designed and printed. Dear Doctor letters have been sent to doctors asking them not to give injections and saline. In one case, 3000 adivasis put their thumb impressions after the letter was read out and explained. A PHA Jatha was organized in 15 villages in Nashik District. On August 1st, a 6 km long Arogya Dindi (Health Procession) was taken out in Pune. The State Convention was held on the 18th and 19th of Nov. 78 tickets have been booked on Ahmedabad-Hohrah Express. Important magazines/weeklies related to various movements have started publishing articles on PHA. Starting August, a series of fortnightly articles in District and Regional Marathi Newspapers have been published.

An interesting experience of the campaign in Maharashtra was a rally on 18th September in Kolhapur district. 400 people shouting slogans took out a procession and met the Medical officers and the BDO. They raised a number of issues about malpractices in local Rural Hospital. After a stormy debate, the officials agreed that all doctors in the Rural Hospital would henceforth reside there, be available 8 hours every day besides their weekly 24-hour emergency duty, and that no illegal charging of patients would take place in the future. A proposal for people's monitoring of health services was also accepted - it was agreed that, people would maintain a publicly displayed calendar in some villages with the dates of the ANM/MPW's advance programmes. If the health functionary did not report, s/he would be marked absent by the people and this issue would be raised with the PHC. It was also agreed that a meeting would take place every two months between the health authorities and the people's representatives. This would form a mechanism for ongoing feedback and 'people's supervision'.

Gujarat: Campaign reached out to almost all the districts. The state convention held on the 11th and 12th of Nov at Baroda with more than 500 people attending. Along with the convention, a policy dialogue was also held. 84 delegates have booked their tickets to the NHA.

Madhya Pradesh: Block enquiries completed in about 20-25 blocks. 3 posters have been printed. A Kala Jatha team has been trained and is touring the state. On 23rd Nov, a Health dialogue was organized in Badwani. The State convention was organized on 25th Nov in Bhopal. 70 delegates will travel by Shipra Express to Calcutta for the NHA.

Chattisgarh: The campaign has reached out to 8 districts. A Chattisgarh Health Status Report has been planned. 24 delegates will attend the NHA by the Ahmedabad Howrah Express.

Orissa: SCC has 22 organizations. Campaign reach - 125 blocks in 15 districts. District Conventions held in 12 districts. The State Convention and the district conventions in the remaining districts will be held after the NHA. 50,000 posters on the PHA have been published. Lyrics for an Audio Cassette on the PHA has been composed and the recording has been planned. 2 Rallies have been organized in Cuttack and Bhubaneswar and a document outlining case studies and work done by NGOs is being published. Reception to the People's Health Trains is being organized all along the way - at Behrampur, Cuttack, Bhubaneswar, etc. The Local and National Press has been invited for this. A policy dialogue on Disaster Management is being organized. 100 delegates will come to the NHA.

Tripura: The SCC has more than 18 organizations. All blocks in all the districts have been covered. The State workshop had 300 people from all the sub-divisions. The Tripura committee also hosted the Indo Bangladesh Kala Jatha which covered all the blocks in Tripura and now has moved to Bangladesh. After 7 days performance in Tripura, the teams moved to Bangladesh. There they are performing for 7 days before finally coming to the International Assembly on 3rd Dec. The State convention has been planned for the 26th and 27th of November. 70 Delegates are coming for the NHA.

Assam: 2 state workshops have been held. There are about 15 organizations in the SCC. They have planned intensive programme in 5 districts and in others are holding a meeting. 70 delegates are coming on Kanchenjunga express to the NHA. The planned state convention on Nov 12th has been delayed.

West Bengal: SCC has 75 organizations! The entire state team has been very active in organizing the NHA and the Public Meeting and Rally. A total of 100 blocks are being covered as part of the campaign. Block and district level enquiries and conventions have been completed. In South Bengal due to floods, this process has been affected. Kalajathas programmes are being held in various districts. The State Convention has not been planned separately – it is possible to organize it along with the NHA. 300 delegates will be attending the NHA.

Bihar: SCC has 18 organizations. The programme is on in about 140 blocks in 35 districts. District

conventions have been conducted in 20 districts and Block conventions in 100 blocks. In each block 5 villages have been covered. 4 posters have been printed. 12th September celebrated as Health for All-Now! Day. (On this day in 1978, the Alma Ata Declaration was passed). As part of the celebrations, 7 districts had seminars and 2 districts organized cycle rallies. A State Level Seminar was also organized on this day, in which prominent doctors and media persons participated. The State convention was held on 19th Nov at Patna and a policy dialogue on 18th Nov. Kala Jathas and Cycle Rallies have been planned in 9 districts. 190 delegates will come to the NHA.

Uttar Pradesh: 22 Districts covered. 6 zonal workshops and block enquiries completed. State convention has been planned for 26th and 27th Nov. They have booked 50 seats and 100 delegates are coming for the NHA on the Kalka Howrah boarding at Kanpur.

Delhi: SCC has about 50 organizations. An intensive signature campaign mobilized people on a set of local demands linked to larger demands of the Health Charter. With each signature, Re. 1 was collected. Six Health Melas were organized on the Health Policy, Population Policy and Reproductive Health, Violence of Women, Food Security, Economic and Health Security, and Child Health. A Phad (Street Drama) team was trained and scripts prepared. A rally was organized on 15th Nov in which 1200 people from various bastis participated. The procession was planned as a carnival ending in a public meeting. DD Metro is covering the rally. 67 people have been confirmed for the NHA and 9 for Dhaka. A big send off is being organized at the time of boarding of the train to Calcutta.

Haryana: SCC has 9 organizations. State Convention was held on 1st Nov. The campaign has covered 9 districts. In 5 districts, workshops and block enquiries in 3-5 villages (large ones) each have been conducted. Special seminars on Health for All organized in 5 districts. Policy Dialogue on Feticide will be held after Dhaka. 56 Delegates for NHA booked.

Rajasthan: SCC has 10 Organizations. In 8 districts out of the 14 planned, the district conventions have been held. The State Convention is on the 27th Nov. 72 tickets have been booked on the Jodhpur Howrah.

Himachal Pradesh: SCC has 11 Organizations. The campaign was organized in 51 blocks in 9 districts. Kalajatha teams covered all the districts. 4 pamphlets on the PHA Process, Continuing Education, Status of Health Services and on the RCH programme were printed. The sale of the PHA books (both English and Hindi) has been very brisk. The state convention is on 26th and 27th Nov. 72 tickets have been booked on the Kalka Howrah for the NHA.