Project Proposal for a
Community Health Fellowship Programme in Madhya Pradesh (MP-CHFP),
by the Centre for Public Health and Equity (CPHE),
Society for Community Health Awareness, Research, and Action, (SOCHARA)
Bangalore

2. Introduction - A Community Health Fellowship Program for Madhya Pradesh, India

The Centre for Public Health and Equity (CPHE), a new unit established by the Society for Community Health Awareness, Research & Action (SOCHARA) in 2008, after discussions within the team and at the SOCHARA EC meeting and AGBM, decided to initiate a Community Health Fellowship Program (CHFP) in the state of Madhya Pradesh (MP) in central India in 2009. Existing funding from the Sarathy Foundation, a small grant from the Sir Dorabji Tata Trust, and support from EZE, Germany were used for an initial preparatory phase in the second half of 2008. This phase included discussions at the SDTT office with staff from the National Health System Resource Centre (NHSRC) and others; field visits to Bhopal and different districts in MP to identify NGOs and academic institutions that can support the initiative; appointment of an additional team member; data gathering from secondary sources; a workshop in Bhopal for detailed discussions and subsequently development of the project proposal.

The Community Health Fellowship Program in MP (MP-CHFP) will take a batch of 20-30 young professionals from multi-disciplinary backgrounds, for a two year period, to learn and work at a sub-district and district level, in order to strengthen the public health system from below by building community capacity for health and for effective participation in the health system utilizing mechanisms available under the National Rural Health Mission and other schemes. The fellows will be based in civil society with NGOs working with communities and with field staff from the health system. A support system with a small office in Bhopal, and a network of field NGOs working in health and development, field mentors, supportive academic and resource institutions will be established

Team members in CPHE have considerable expertise and experience in community health and public health. They also have knowledge and experience in Madhya Pradesh over the years. The senior CPHE staff have worked in the Community Health Cell for twenty five years and earlier in a medical college and bring with them considerable organizational experience. They will also bring to MP linkages with national and global partners in public health and community health.

What is Unique about the MP-Community Health Fellowship Program
1. It is an ‘alternative learning through work, study and reflection program’ in community health and public health, based on a societal understanding or paradigm, using community based approaches that strengthen comprehensive primary health care systems, with a focus on the National Rural Health Mission at district and sub-district level.
2. It focuses on ‘practitioner’ oriented public health & community health training using innovative methodologies.
3. It offers a person-centred, experiential learning opportunity for young professionals in community health
4. It believes that persons and the public are central to public health. Transformation of the public health system can happen through transformed persons and community involvement at different levels.
5. It is rooted in the experience of the voluntary sector /civil society/ peoples movements and will build on this collective base.
6. It focuses on central India, specifically Madhya Pradesh.
3. Background to the MP Community Health Fellowship Program

3.1 The National Rural Health Mission (NRHM) established by the Government of India in 2005 provides an important policy, programmatic and financial framework to strengthen the public health system in India in an integrated and time bound manner. Among its goals is the adoption of a comprehensive primary health care approach to achieve equity in health and in access to health care. Respect for health human rights is foundational in the NRHM.

The ‘communitisation’ or community health components of the NRHM includes the training of ASHAs (accredited social health activists); the setting up of Village Health and Sanitation Committees (VHSCs); involvement of PRIs (Panchayati Raj Institutions); community action for health inclusive of village health planning and community monitoring of health services; and civil society involvement in PHC committees, Rogi Kalyan Samitis/arogya rakshak samitis (Patient Welfare Societies). These elements when introduced in the right spirit will help to operationalise the key Primary Health Care principle of community involvement and participation in health action and decision making (see http://mohfw.nic.in/NRHM.htm).

Implementation of these components on a state or national scale however is a large task requiring committed and competent support and mentoring. It reflects a major paradigm shift in approach requiring collaborative and systematic work from the health departmental staff; professionals with multi-disciplinary backgrounds such as community health, social sciences, management and allied disciplines; educational institutions; non-governmental organisations; community based organisations; people’s movements; donor agencies and all public spirited groups / individuals.

Support systems at community and sub-district level would form the critical base from which community driven change, and realization of NRHM goals could be made possible and sustainable. The proposed fellowship program is being designed as an input to the support system for the communitisation component of the NRHM. It will build community capacities for health and for effective participation using available mechanisms, and will help to strengthen the health system.

The National Health Systems Resource Centre (NHSRC) was established by the Ministry of Health & FW in mid-2007 in Delhi to provide technical assistance to states in their efforts to implement the NRHM. A CPHE-SOCHARA member is one of the founding Governing Body members of the NHSRC. The Union Principal Secretary Health & FW chairs the Governing Body.

The NHSRC has picked up the idea of the fellowship scheme from CHC and other initiatives and proposed an ASHA fellowship program in an agenda note to the NHSRC governing body in January 2008. This proposal was approved in principle by the GB and the NHSRC is encouraging organisations to develop these programs particularly for the Empowered Action Group states.

Health is constitutionally a State subject and states evolve their own policies, programs, and traditions in health work that are relevant to their specific context within the broad framework of national policy guidelines. A state specific two year community health fellowship program with a clear health system focus is therefore a further innovation in praxis oriented public health/ community health education.

3.2 The Community Health Cell, functional unit of SOCHARA initiated a successful community health internship and fellowship scheme (CHFS) for young professionals from 2003 to 2007 with financial support from the Sir Ratan Tata Trust, Mumbai (SRTT). This was initiated and led by the present CPHE Coordinator when she was coordinating CHC. Altogether over the first four years forty young professionals went through a 6–12 month program and are working in community health. A concurrent and later external evaluation both recommended scaling up of the initiative to offer different learning
programs including a longer program at post-graduate degree level, but maintaining the values and perspectives developed by CHC over the years.

The second three year phase called the Community Health Learning Program (CHLP) commenced in January 2008 and is managed by a competent team at CHC supported whenever necessary by senior staff from CPHE. Mr. Premdas is the present Coordinator of CHC and Dr. R Sukanya a public health professional is the Project Officer managing the CHLP. A multi-disciplinary team provides teaching, mentoring and administrative support. Besides the Bangalore office and team, CHC has a small unit in Chennai, Tamil Nadu with Dr. Rakhal Gaitonde a public health professional and Mr. Ameer Khan with a social work background. CHC has developed a very well equipped CHC Library and Information Centre (CLIC) to support teaching and research. CPHE has developed a Hindi collection of material and also a collection of reports on MP. CHC also has a wide network of organizations and individuals in different parts of India to support teaching and mentoring of community health practitioners and activists. They include SOCHARA members, CHC associates, and field partners/mentors of the CHFS. CHC is also closely linked to the People’s Health Movement (PHM) at global, national (Jan Swasthya Abhiyan) and state levels. CHC hosted the global PHM secretariat from 2003 till 2006-7. CHC members have been national joint convenors of the JSA over the past eight years. Details about SOCHARA – CHC & CPHE objectives and activities are available at www.sochara.org.

3.3 The Centre for Public Health and Equity: This is a new unit of SOCHARA which has been growing out of the Health Policy Research, Action and Advocacy sub-unit of CHC from mid 2006 was formally launched by SOCHARA in 2008 on the silver jubilee of CHC (see Annexure1). The MP-CHFP is one of its key initiatives to be operationalised in 2009. Other work undertaken by the CPHE team includes taking responsibility in an international research program titled ‘Revitalising Health for All - Learning from Comprehensive Primary Health Care’ in collaboration with the University of Ottawa and the University of Western Cape. The team is very actively involved in NRHM related activities at the national level. The CPHE Coordinator is a member of the national ASHA mentoring group; the Advisory Group on Community Action which is a standing committee of the NRHM; a member of the first Common Review Mission and a member of other Task Groups. As part of the national ASHA mentoring group she supports Madhya Pradesh. Another senior CPHE member contributed actively to the Task Group on Medical Education and the National Knowledge Commission based on years of experience and research on community oriented medical education. The CHC teams are actively involved in community action for health in districts of Karnataka and Tamil Nadu. Mr. Juned Kamal a medico social worker from MP who has done a community health internship program with CHC joined CPHE in October 2008 to support the MP-CHFP. Dr. Deepak Kumaraswamy is helping with research assistance for the MP-CHFP. One of the important initiatives of the CPHE will be to develop and run the Community Health Fellowship Program (CHFP) for and in Madhya Pradesh, central India. The CPHE Coordinator Dr. Theelma Narayan, MBBS, MSc (Epid.), PhD. Public Health Policy, London University, will be the person with principal responsibility for developing the MP initiative supported by a small team and larger networks that have been established over the years. Initial thoughts about an MP initiative began in early 2008. The Sir Dorabji Tata Trust, Mumbai was interested in this initiative based on an idea draft and preliminary discussions, and provided a Small Grant in the later half of 2008 to develop a more detailed project proposal. Field visits to places in several districts of MP (Bhopal, Raisen, Chindwara, Indore, Barwani, Alirajpur, Jhabua, Sidhi, Jabalpur, Gwalior and more recently in Bhind, Morena & Shivpuri ); collection of secondary sources of information on MP; and a stakeholder workshop in Bhopal in November 2008 were organized through this 3 month Grant. Links have been made with NGOs, federations/associations, academic institutions, public sector staff and individuals through the field visits. The Sarathy Foundation, USA also provides core support to the Bangalore team for the preparatory phase. A national workshop held in Bangalore in April 2008 as part of the Community Health Learning Program supported by the Sir Ratan Tata Trust to disseminate the learning’s from the Community Health fellowship scheme run by CHC from 2003-2007, helped to bring a national group to work on the draft.
framework, perspectives, goals and objectives, curriculum etc of the proposed MP initiative. The National Health Systems Resource Centre, Delhi is supportive of this and similar initiatives in other states. Thus considerable ground work has been done during the preparatory phase with several individuals and institutions in MP, other parts of India and elsewhere, who are interested and willing to get involved.

**The Madhya Pradesh Initiative is being undertaken in the context of recent developments in public health and public health education in India.** Increased policy interest with larger institutional and financial support is occurring through the NRHM; the Public Health Foundation of India (PHFI) which is setting up 6 – 7 new schools of Public Health; and several other public health education initiatives by the ICMR, & other medical colleges and universities. This is a very positive environment. **One of the gaps is that none of the new public health education initiatives is in Central India.** The other concern is that most of them may develop elitist professional courses not necessarily rooted in grassroots public health practice.

The health status of populations in the EAG states including Madhya Pradesh is poor as evident from all recent, reliable sources of health information (see Annexure 2). The public health system and health institutions in these states are relatively weak and function sub-optimally in recent years with little public health expertise. Madhya Pradesh has however introduced several innovative community oriented health programs over the past decade providing a base for further work.

**Given the experience of SOCHARA/ CHC in the field of community health over several decades it is felt that this is the right time to initiate strategic work in Madhya Pradesh that could support human resource development and help strengthen the public health system through a community based approach.**

### 3.4 The rationale for the Madhya Pradesh initiative is as follows:

- **a)** The need in MP in terms of poor health status and health system functioning is evidence based (see Annexure 2).
- **b)** There is a large gap in public health training (*ibid.*) in central India with huge deficiencies in availability of trained public health personnel in relation to the population. The MP public health system, other than the medical colleges, reportedly has only one person with a post graduate training in public health.
- **c)** Among over thirty recent initiatives towards evolving India relevant MPH courses, including new Schools of Public Health, this is the only initiative which is specifically focused on the NRHM paradigm, and links public health education to the primary health care system and to communities. It is also practitioner and practice oriented rather than being only theoretical and focusing on higher level specialist orientation.
- **d)** Recently the National Knowledge Commission – report of the working group on Medical Education have recommended that appropriate Community Health education programs should be initiated that respond to people’s needs in order to improve public health in India (see Annexure 5). This is one such innovative approach that is being undertaken by a credible organization.
- **e)** The present CPHE team have been involved in Madhya Pradesh, both with the government and with NGOs, during their work in CHC over several years. This has included support to the Rajiv Gandhi Mission on Diarrhoea; the Swasthya Jeevan Guarantee Yojana: two evaluations of the Jan Swasthya Rakshak Scheme (JSR) in 1997 and 2001; and the Madhya Pradesh Human Development Reports.

During the 1980s CHC hosted and ran the MFC national office and participated in the post-Bhopal disaster work undertaken by the Medico Friend Circle for several years. Active support was provided to the MP organizing committee for the Second National Health Assembly organized by the *Jan Swasthya Abhiyan* in March 2007 in Bhopal with around 3000 participants from different parts of India. Global steering committee members of the Peoples Health Movement were also present. CHC also supported the short IPHU course held in Bhopal at the same time.
4. Community Health Fellowship Program for MP (MP-CHFP)

4.1 Vision, Mission, Goals, Objectives

The vision of the alternative Community Health Fellowship Program in Madhya Pradesh is to develop a critical mass of vibrant, optimistic community health professionals who:

- are people and person centric,
- are well grounded in the public health realities of MP and India and in the principles and practice of public health & community health through experiential learning,
- engage with and strengthen the public health system,
- strengthen community processes and capacities, and
- become community health practitioners.

The mission for the Madhya Pradesh CHFP initiative is to create and establish a system for training such practitioners in community health and public health through establishing -

1. An Academic Framework — to develop the selection criteria, curriculum, educational and training design, assessment/evaluation processes, certification and accreditation in the course of the first three year phase;
2. Mentoring — to create a group and a network of mentors through identification and capacity building of field mentors; to develop a framework of collaboration with field mentors and resource groups/academic institutions; and to link them to national and other groups.
3. Organisational Systems and Processes — to set in place an advisory group; field office with financial, management, administrative and communication systems; core faculty and field staff; and processes of partnership with the health system.

This vision and mission will help to attain the Goal of creating a group or critical mass of community health and public health practitioners, who work towards ‘better health and access to health care for the people and by the people’, as part of a transformation towards an inclusive society with peace, justice, health and well-being.

The objectives of the proposed Fellowship program include

1. To establish a person centered Community Health Fellowship Program in Madhya Pradesh in 2009 with an intake of 20-30 young professionals per batch who become committed to community based health initiatives and processes over the period of their two year course. To support them later in getting placements and providing opportunities for networking (20 with one funding partner, 30 with two or more funding partners).
2. To enable participants gain skills to build community capacity for health; to strengthen the public health system from below; and help develop strategies to reduce inequalities in health and access to health care, and
3. To develop and support practitioners, researchers and advocates in community health in Madhya Pradesh.
4. To develop a network of NGOs, academics and public health system staff keenly involved in community health action in Madhya Pradesh to undertake 3 & support 2.
5. To develop the necessary organizational systems in Bhopal and Bangalore to support this, including a library and information unit focusing on health and health system issues relevant to central India, including developing a collection of resource material in Hindi.

In order to establish such an initiative specific activities that need focus during the preparatory period and throughout the first three year phase include:

- Sensitizing the health system to this initiative.
• Preparing mentors – mapping of potential mentors and organizations and creating a forum for them to share their work experience and grow.
• Developing mechanisms and capacities for mentoring within the organizations.
• Identifying and engaging with resource persons in the public health system and in civil society.
• Preparing district profiles with health care services available and a detailed first person account of the working of the health system, the various functioning units of the NRHM, public-private partnerships and the community inter-phase with the public, private and traditional medicine/AYUSH health system.

**Perspectives – Participants will be encouraged to understand:**
♦ Community based and led approaches – understand community dynamics, perceptions, community mobilisation, community capacity building and societal analysis;
♦ People’s perspectives of health systems;
♦ Social, economic, political and cultural analysis;
♦ Gender perspectives;
♦ Political economy of health and the forces of liberalization, privatization and globalization and their impact on health and equity;
♦ Secularism and pluralism;
♦ Socio-Epidemiological perspectives-understand data, analyse data/situation and respond;
♦ Anthropological approaches;
♦ Perspective on self-awareness and transformation while engaging in social action.

**Principles**
♦ Health equity (understand the differences based on factors such as caste, class, urban/rural location, region, culture, gender and religion)
♦ Health rights/entitlements (health as a fundamental human right, universal access to health care and comparison with other country models)
♦ Governance
♦ State responsibility and role for health, including universal access to health care
♦ Leadership and activism in health that is enabling
♦ Respect for Indigenous practices and systems of healing and medicine

**Values and Ethics**
Respect and trust in persons and communities will underpin all work.
Integrity and quality in work
Respect for and inclusion of Indian systems of Medicine/AYUSH
Spirit of collaboration in work
Respect for diversity of beliefs, views and opinions

**4.2 CH Fellows - selection criteria, number, selection process**

**Selection of Community Health Fellows**
The selection criteria and process used in the CHC community health fellowship and learning programs over the past five years have been found to be robust. Retention in community health work among selected participants has been very high. The Fellowship is unique as its mission is to develop a cadre of young professionals sensitive to community health issues and to community health action and therefore would require suitably motivated candidates willing and able to work with communities, with the health system and with civil society.
The **selection criteria** including qualifications required are based on the objectives of the MP-CHFP of a) building community capacity for participation in health using existing mechanisms available and b) strengthening the health system from below by creating a critical mass of field based community health and public health professionals who become life-long learners.

- Given the potential for this Fellowship program to lead into an alternative MPH program in the future, it is imperative to select post graduates or graduates with two years work experience.
- The intake/selection will be multi-disciplinary, with weightage given to candidates with field experience and those sponsored by NGOs. Sponsorship by government of PHC medical officers will also be explored.
- Applicants may be doctors (any system of medicine), dentists, nurses, allied health professionals, medico social workers, person’s with social science, management and law backgrounds. Doctors and dentists are eligible with undergraduate degrees (ie five and a half years training) while for social science candidates a post-graduation is required with an interest to work long term in health. Undergraduates in social sciences with 3 years experience in the field in health work may be considered.
- Weightage will be given to candidates who are women, *adivasi*, from minority groups and from remote disadvantaged populations.
- Candidates will need to speak, read and write both Hindi and English as both languages will be used. Hindi will be the preferred language as it is critical for community work. Those not very fluent in English will be encouraged to gain greater proficiency in the language to enable them to access the vast literature in public health, community health and related disciplines available.

**Number of community health fellows in the first batch**

Twenty persons will be taken for the first batch. However if additional funding is available covering stipends for fellows, other related costs and additional staff at CPHE then thirty persons can be taken as a maximum intake. Initial budgeting will be done for twenty. After discussions with potential donors this can be revised.

The number and timing of the second batch will also be discussed. The first batch will by necessity be experimental, building on the earlier experience of CHC, and learning from similar experiences from other states.

**Advertisement and Selection Process**

This process is based on the practical principles evolved and operationalised already by the CHFS scheme of CHC supported by the Sir Ratan Tata Trust since 2003. Their feasibility and viability are now well established.

- The program will be advertised in selected health journals such as Health for the Millions, Health Action, Medico Friend Circle Bulletin, National Medical Journal of India and selected publications in MP; through e-groups such as the PHA-NCC and MFC e-groups, devnet, invites etc; and through correspondence and personal contact with NGOs and educational institutions in MP. This brings in a pre-selected and manageable number of applicants.
- The selection process is an integral and important part of the overall process of the MP-CHFP program. It will build relationships with local NGOs, help with continuity and sustainability, and with support to participants in the field. Given the fairly close and intense mentoring process required during the program, selection is a critical step and warrants the extra time and attention at this stage. It may reduce dropouts and wastage and could be applied to the first few batches. Selection processes can be expanded/modified later after review.
- Prospective candidates will apply to the MP-CHFP course coordinator with their CV; contact details of two referees; a write-up or statement of purpose of why they are interested in this program; their long term interest/work-career plan; and a brief background of their experience.
- Candidates will be short listed after screening the applications and contacting referees, and a date for interviews fixed and intimated to them in advance. Candidates will be paid a one way fare to attend the interview. Accommodation arrangements will be made for outstation participants when they come for the interview.
• In the initial batches suitable candidates who meet the requirements from participating NGOs/community based organizations/ campaign groups or practitioners working close to communities even from the public sector will be given preference in the selection process as part of community based/oriented system development.
• A panel/selection committee of 3 members will interview the candidates and mark them on criteria given below. (See next page)

**MP-COMMUNITY HEALTH FELLOWSHIP PROGRAMME**

**Name of the Candidate :**

### SELECTION CRITERIA

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<th>S.No</th>
<th>Criteria</th>
<th>Max. Score</th>
<th>Actual Score</th>
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<tr>
<td>1</td>
<td>Interest in and long term commitment to Community Health</td>
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<td>2</td>
<td>Social commitment / skills / experience</td>
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<td>3</td>
<td>Decision making / self-confidence/self-reflection</td>
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<td>4</td>
<td>Language / communication facility</td>
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<td>5</td>
<td>Intellectual ability / creativity</td>
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<td>6</td>
<td>Academic performance / additional qualifications</td>
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<td>7</td>
<td>Broader interests / values</td>
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<td>8</td>
<td>Family/socioeconomic background / belonging to disadvantaged groups</td>
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<td>9</td>
<td>Overall assessment</td>
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<td><strong>Total</strong></td>
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90+ = A+

80-89 = A

70-79 = B+

60-69 = B

<60 = C

*Name of the Assessor

Weightage will be given to candidates sponsored by organizations. This will be determined by the selection committee.

Date: 

Signature of Assessor/s:

5. **Overall Framework of the Teaching- Learning Processes**

This framework was developed at an intensive, participatory two day National Workshop bringing together community health & public health teachers and trainers from several organizations in different parts of the country (see ‘Learning Programmes for Community Health and Public Health’ Report from a National Workshop – April 2008 by CHC and CPHE, Published by CHC, Bangalore, December 2008).
An important challenge in planning this field-based program is structuring the two years with a residential induction period; field component working with community organizations and with the health system guided by field mentors; small action research projects; faculty visits and monthly meetings in clusters; contact sessions every three months; continuing education in the field; mentoring and assessments. It thus differs from the community health fellowship programs being developed in other northern states in that it has strong support system with mentors and an important component of learning the core principles and practice of key components of community health and public health. It will also maintain working links with the public health system at state and district levels and with staff in health and health related institutions.

The Fellows will be located or based within civil society, interacting and working with the health system. The interaction with the health system will be facilitated locally, and at district and state level. The National Health Systems Resource Centre (NHSRC) is willing to draw up a tripartite letter of understanding with the state government to legitimize and provide an identity to the Community Health Fellows.

Dual language Hindi – English learning will be used as the CPHE team is fluent in both languages. Being a postgraduate level program with several technical issues English will be encouraged as there is a lot of teaching material (books, manuals, articles) from the mainstream and voluntary sector in English. At a practical level many aspects of the sharing and learning would be in Hindi. The difficulties faced by students who have studied in school and college in Hindi to switch to English are recognised. Therefore there will be inputs and support by resource persons to help participants with English.

Efforts will be made by the organising team to identify and minimize risks and resistance that the program may face.

Aspects of accreditation, standards, course curriculum, quality of the program, and affiliation with academic councils are necessary for post-graduate level programs even in the voluntary sector. The first three years of the Fellowship would be an experimental phase for establishing the Fellowship Program. A post-graduate level program requires solid grounding in Community Health concepts and practice and not merely developing perspectives. This three year period would also help CHC-CPHE to create and strengthen its institutional base and backing in Madhya Pradesh. In due course, accreditation for the program by a University in Madhya Pradesh or elsewhere could be explored. Another possibility is to keep it as an ‘alternative’ socially relevant, good quality learning program that retains its independence and offers its own certification.

**Key components to be covered in the training**

- Health Systems – history and evolution of the health system in M.P and India, public and private health systems, indigenous health practices and systems and their current status.
- Understanding health status and disparities in health in MP and how the public health system and public health programs can improve health status and equity in health.
- Issues of access to health care: with quality, integrity, acceptability, affordability, availability, inclusiveness,
- History and relevance of comprehensive primary health care as an approach or strategy towards achieving Health for All or equity in health.
- Learning from people’s health initiatives and local health traditions.
- People’s struggles/movements and people’s health initiatives.

Competing perspectives and interests in health and health care, and their methods of interaction, negotiation, gaining of dominance by one or the other approach, and consequences for different sections of communities will be discussed. Efforts will be made to present various perspectives and develop the
analytical capacity of participants to think through, dialogue, discuss and debate issues based on different types of evidence with different sections of communities in focus, especially deprived social groups and regions, and to grow through a process of praxis and reflection.

5.1 Contents of the teaching component
The contents of this Fellowship Program will be comprehensive and organized into modules, which will be developed further with background material. The modules include:

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<tr>
<th>I</th>
<th>Health and Society</th>
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<tr>
<td>➢</td>
<td>An understanding of health, development, and equity;</td>
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<td>What is community health and public health</td>
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<td>Values, social justice, health human rights and public health ethics.</td>
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<tr>
<th>II</th>
<th>Determinants of Health &amp; Situation Analysis</th>
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<tr>
<td>➢</td>
<td>Understanding the underlying socio-political, economic and cultural determinants of health, and their inter-relationships and dynamics</td>
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<td>Situation analysis of health and health determinants in India and specifically in MP; distribution and trends; critical analysis of data and data sources; socially disaggregated analysis; social exclusion and health in India.</td>
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<td>Culture and health – further details;</td>
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<td>Environment and health and worker’s health in agriculture (pesticides), industry and mining, social security and social protection of these worker’s.</td>
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<td>Social determinants of health and social movements for health;</td>
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<tr>
<th>III</th>
<th>Health Systems and Alternatives</th>
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<td>3.1</td>
<td>Health Systems</td>
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<td>Historical understanding of health policies and programs in India and MP;</td>
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<td>➢</td>
<td>Understanding the entire health sector (public, private, voluntary, Indian systems, peoples sector); role, contribution of different components. Pharmaceutical policy and all health related policies.</td>
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<td>Health system issues- at different levels-institutional, taluk, district, state and national levels; equity and quality issues in access to health care and access to essential medicines</td>
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<td>Health for All and comprehensive Primary Health Care- with a focus on experiences from India and Asia in training of community health workers and community participation in small projects and scaled up to state level; inter-sectoral action for health.</td>
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<td>Health planning, administration and management;</td>
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<td>Basics of health financing, health budget analysis, health insurance</td>
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<td>National Rural Health Mission; implementation and organizational issues; understanding all its components; tracking the website, review reports; studying innovations; skills required to realize the communitisation components, training Village Health &amp; Sanitation Committees, strengthening the ASHA program and its support system at district level, community planning and monitoring and community action for health.</td>
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<td>Urbanization, health and health care for the urban poor, National Urban Health Mission analysis and action</td>
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<tr>
<th>3.2</th>
<th>Alternatives</th>
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<td>➢</td>
<td>The voluntary sector in health in India; different perspectives and approaches; NGOs and their federations; the role of civil society in health; peoples’ organizations; health empowerment strategies</td>
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The global Peoples Health Movement (PHM), Peoples’ Charter for Health, country circles, campaigns, WHO advocacy circle, Global HealthWatch, PH exchange, International Peoples’ Health University, website

The Jan Swasthya Abhiyan (PHM India) and state units; Peoples Rural Health Watch; community mobilization and campaigns on various issues, booklets produced for two Jan Swasthya Sabha’s.

**IVa Major public health problems, with public health approaches and community action to address them.**

- priority public health problems in India – nutrition/food issues; communicable diseases including TB, Malaria and other vector borne diseases, water borne and water related diseases; HIV – AIDS; reproductive tract infections; leprosy; disability; mental health; cardiovascular diseases; diabetes; cancer
- women’s health, gender and health, children’s health
- urbanization, health and health care for the urban poor, National Urban Health Mission analysis and action

**IVb Special groups and situations**

- Mental health; Disability;
- Environment and health; worker’s health in agriculture (pesticides), industry and mining; social security and social protection of worker’s.
- Disasters; Displacement; Health of IDPs, migrants and vulnerable groups
- Social Exclusion; Marginalisation

**IVc Inter-sectoral Challenges**

- Nutrition, food security
- Water supply, Sanitation

**V Community processes, dynamics, stratification and institutions**

- *Panchayati Raj* Institutions and health; perspective and capacity building of PRI members.
- Gender and Dalit empowerment
- Community institutions and bodies at village level

**VI Right to Health and Health Care**

- Constitutional and legal aspects of health and health care
- Public Health Acts and introduction to public health law

**VII Research**

- Health enquiries and research,
- Analytical reading & interpretation of reports and data

Course participants will be encouraged and helped to develop an adequate knowledge base, perspectives, skills (networking, advocacy, CH skills) and attitudes that are sensitive to diverse communities and to field implementers. They will become familiar with the public health system, and be able to collect, analyse, present and interpret data. CHC-SOCHARA publications and essential reading lists already prepared for the Bangalore based community health fellowship program will be used and updated regularly. Books from the NRHM, the Public Health Resource Network and other organizations will be utilised.

### 5.2 Structure of the Program

- **Full Fellows with PG Certification**: The total duration of the fellowship is two years, each year divided into time periods of 3 months with periods of residential training once in 3 months and cluster level meetings more frequently. The first year would be a foundation course where most of the learning is in Madhya Pradesh. Visits to other states and community health projects may be
facilitated in the 2nd year for cross-learning. Given the multi-disciplinary intake efforts will be made to respond to the learning needs of different types of participants. Those who complete the second year would be awarded a post-graduate certificate.

- **Fellows with Diplomas:** Some would be given the option or encouraged to move on to jobs after the first year.
- **Flexi-Fellows:** Short modules during the teaching period could be offered to additional participants. Such short-term courses can be used to train a larger group of people in MP more frequently.

The traditional approach of structuring a course is often to complete theory and follow up with field work. In this instance, a framework of orientation program for 6 weeks, field placement of 2 months and coming back to the organisation for residential training and reflection for 2 weeks is planned. The sequencing of theory and field work or the converse sequencing (i.e. field-work followed by theory) would be both necessary for the kind of inputs that are given. For example, field visits to nearby communities/organizations and public health institutions will also be organised during the 6 week orientation cum induction phase. A broad outline of the process is given below.

**Process:** Orientation → Field → Residential / institution based

**Duration:** 6 Weeks → 2 Months → 2 Weeks

**Methodology:** Theory Materials, Data, Experiences Analysis & interpretation of field data of experiences at personal and community level
### Teaching Calendar (Provisional)
Numbers indicate weeks

<table>
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<th>First Year</th>
<th>Second Year</th>
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<td>1</td>
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<tr>
<td>Initial residential orientation training in Bhopal involving CPHE - MP resource network including TN, RN, Manoj Kar, Anil Cherian, Sunil Nandeshwar, Yash Saraf, Biraj Swain, Savita Jain, Pragya, Anjali Noronha, Anil Sadgopal, Sathyu, Ajay Khare, officials from the public health dept etc (see annexure)</td>
<td>Cluster meeting</td>
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<td>13 Training in Bhopal</td>
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<td>19 Cluster meeting</td>
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<td>Collective teaching in Indore</td>
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<td>23</td>
<td>23 Cluster meeting</td>
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<tr>
<td>Six-monthly feedback from participants</td>
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<td>26</td>
<td>26 Cluster meeting</td>
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<td>27</td>
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<tr>
<td>Collective teaching in Gwalior</td>
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<td>33 Cluster meeting</td>
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<td>Collective teaching in Jabalpur</td>
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<td>Collective teaching in Rewa</td>
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<tr>
<td>Collective teaching in Bhopal; Presentation of reports; Mid-term assessment; Feedback on year one</td>
<td>Final collective teaching in Bhopal, final presentations, assessment, completion of reports; Vacation</td>
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<td>51</td>
<td>51 Vacation</td>
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A total of 12 weeks or 3 months intensive residential teaching will be done in year one; Six meetings of two days will be held at cluster level in five clusters (Bhopal, Indore, Jabalpur, Gwalior, Rewa) facilitated by a local resource person and a CPHE team member where possible; 8 months in the field; field support through field visits will be provided by the CPHE team. 1 month vacation spread over the year; Year two will have eight weeks of residential teaching in four two week sessions; six cluster meetings of two days each

5.3. Field Component

Participants would work in different districts either singly or in pairs with mentors from NGOs/ academics from the district. Their work in the districts will be linked to the Dept. of Health, but they will function with considerable autonomy. The ‘fellows’ will support the “communitisation” component of the NRHM with a focus on the functioning of ASHAs including their ongoing education and training and the ASHA support systems/mechanisms at district and block level; the functioning of village health and sanitation committees and their capacity building; support to the development of village and district health plans and the community monitoring of health services/ the NRHM. They will select specific villages and taluks for their work guided by their mentors. Wherever possible they will be also linked to NGOs/ federations/ peoples’ movements in the field

The term ‘field’ is interpreted in its broadest sense. Field placements will be facilitated and Fellows will be based in NGOs working with communities (rural, adivasi, a few with urban poor). Several of these have already been identified. Working links will be facilitated primarily with the public health care system and other health related public sector institutions and local bodies. Additionally they will network with the voluntary sector; practitioners of indigenous systems of medicine; individuals and organisations with specific expertise; and those working in the broader development sector. Participants will also be linked to resource persons from academic, research and resource institutions.

The broad learning components during the field placements are:

a. Perspective building with context and region specific understandings.

b. Working with the community -with key persons, vulnerable groups, local organisations and institutions; elected representatives/local bodies and with practitioners of the indigenous systems and informal sector.

c. Working with field implementers from the public health system, other health related departments,

d. Accessing and sharing information–about local communities/realities; computer & e-skills.

e. Learning skills – reading, writing and analytical thinking; listening to communities and team members; learning from praxis.

f. Reviewing concepts of health and disease in specific cultural settings.

g. Self-transformation and personal growth of individual participants– this component would be integrated throughout the course through regular personal and group reflections.

Many learning components would occur concurrently and would be supported through mentoring, suggested reading, learning from the field, group and individual reflection. An outline of the course in blocks for years one and two is given in the table below. The conceptual and experiential components are closely inter-related and will be drawn upon both by mentors and participants in developing insights and action plans.
### Three month Blocks

<table>
<thead>
<tr>
<th>Blocks</th>
<th>Conceptual</th>
<th>Experiential</th>
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| 1<sup>st</sup> block | • Health & Society  
• Determinants of Health  
• Community Dynamics  
• Introduction to Health Systems | Introduction to community organisations, institutions and the health system |
| 2<sup>nd</sup> block | • Situation Analysis of Health  
• Health Systems-Programmes, policies, NRHM  
• Community dynamics…  
• Health system – Alternatives | • Understanding Village-Population, dynamics, community perceptions of health problems  
• Developing relationships with community  
• First hand experience of Health system  
• Understanding NGO’s work |
| 3<sup>rd</sup> block | Situation Analysis of MP  
• Health system  
• Health research (state, district-secondary data sources)  
• Introduction to Health rights | • Community Based Survey of people’s perceptions of health services  
• Functioning of the Health system  
• Understand the barriers in Health services  
• Community Diagnosis  
• Health system- collect information from SC-PHC-CHC-Taluk-District |
| 4<sup>th</sup> Block | • Health Rights  
• Alternative Health systems  
• Community Mobilisation (Social audit, Public Hearing, Community Monitoring, Community Action) | • Preparing Village Health plan with community  
• Dialogue with community and Health care providers |

Core dimensions of public health and community health would be essential learning. Some modules could be taken up in the second year depending on individual and group progress and learning needs.

### 5.4. Mentoring

There would be a *mentoring process* for participants during the orientation/induction and ongoing training periods, as well as in the field. This would be person centred and supportive of learning as well as of personal growth and professional development with a focus on capacity development to undertake responsibilities in community health/public health systems.

There will be two types of mentors taking from the model followed in the learning programs conducted by CHC.

- The CPHE/institution based mentor would be the chief mentor for the long term mentoring process for a fellow. S/he will be the person with whom Fellow’s chart their learning cum working pathway. The Mentor- Fellow ratio is important to enable mentors to provide the necessary attention and guidance to the participants.
- A field mentor or a panel of mentors during the field/community placements. This could be combination of a person from the NGO and resource persons in the districts who will be available...
for discussions. Field mentorship will be established with necessary letters and agreements. The core CPHE team will keep track of the mentorship process and arrange for meetings in case of difficulties.

- Regular communication and meetings with mentors to strengthen participation and ownership will be operationalised through the cluster meetings and 3 monthly group training sessions.

Mentoring will be supportive and reasonably intensive in the initial phase with adequate planning and allocation of time for this both by mentors and participants. A system for follow-up with fellows through email, telephone will be established. Access to communication technology will be explored and used where possible. Notes by the faculty and mentors will help during the reflections with the Fellows. The mentorship process will be reviewed by the core team every six months. Meetings of mentors will be arranged annually. Mentors will be informed of opportunities to attend workshops, meetings, conferences etc conducted by other organizations in the country for ongoing professional development.

**Placement of Fellows - A Cluster Based Approach**

The Fellows (20-30) will be based with known and recognized NGOs working in health and development for a sufficient period of time. Selected NGOs would have a good community link, with a team/staff member who is able to play a mentorship role, a team of workers, with accommodation where the Fellow/s could stay. Field visits during the preparatory phase have helped the identification of such NGOs in different regions of the state.

For the first batch the placements would be made in districts/sub-districts around five clusters identified during the preparatory phase, based also on the availability of support groups and academic/resource institutions (see Annexure 4). This will enable cluster based meetings once a month for learning and solidarity between the Fellows. While it will also make it more manageable for the CPHE team, the process will enhance inter-personal, group and team work skills of participants through working in smaller groups, learning through dialogue, discussion and sharing, appreciating diverse views and plurality, enhancing self confidence and respect for each other. The clusters will be around Bhopal (central MP), Indore (western MP), Jabalpur (south eastern MP), Rewa (north eastern MP), Gwalior (northern MP). Links have been established with NGOs, medical colleges, Schools of Social Work, other resource institutions and universities. Further linkages will continue to be explored and developed during implementation.

The possibility of placing of Fellows singly or in pairs will be kept open, with the latter option for projects in remote areas. They may work in different villages/taluks but be based in the same organization. A feeling of isolation and loneliness has occurred in earlier fellowship programs and needs to be addressed.

### 5.5 Mechanisms of supervision and support to Fellow’s in the field

The CPHE team in Bhopal and Bangalore will provide the Fellow’s with ongoing supportive supervision and guidance for their work in the field. Besides field visits, email and telephonic communication will be used. Field mentors will be identified for each Fellow in the NGO where they will be based. A Letter of Agreement will be signed between CPHE and the field mentor. The network of CPHE contacts and friend’s circle in the region will be available to discuss issues with the Fellow’s. Our experience so far has been that the entire NGO team provides a learning and support environment for young person’s/fellows/interns. Similarly staff from the public health system can also provide inputs. However the CPHE organizational mentor and the field mentor are the two key persons for supervision and support. The others provide general or specific inputs.

### 5.6. Linking with the State and District Public health system

Discussions have already been held with the NHSRC for a Memorandum between the State Health Services, the NHSRC and CPHE-SOCHARA to ensure the identity and legitimacy of the Fellows. Links
will also be established with the District Health Authorities and staff at public health institutions by the CPHE team.

5.7. Assessment of the Fellows
Assessment to ensure quality of the training will be inbuilt and is crucial for standards to be maintained. Writing a journal or diary would be encouraged to develop self reflection and writing skills. Writing assignments and small projects will be given. Student/ participant feedback on the program will also be built in. Formats already developed in the CHFS will be utilized. These will be thought out and developed in a more detailed manner.

6. Organisational arrangements by CPHE-SOCHARA in Bhopal & Bangalore

See next page

Review of organizational arrangements in the field – with NGO’s, Mentors, Government and CPHE etc will be done every six months, using external reviewers if necessary.
6.1 Establishing a team and office in Bhopal and support from CPHE Bangalore

- Support systems including management cum teaching team, supportive administrative staff, office space with basic furniture, equipment and communication facilities will be developed. A core team of five members, viz. a program manager/team leader; two associates/assistants; an accounts cum administrative assistant; and a helper/office assistant will be required to be based in Bhopal.

- Besides the Project Coordinator/Director in Bangalore, a Bhopal based program manager for the MP-CHFP, two associates/assistants and an administrative cum accounts manager are being budgeted for the Bhopal office. The designations will be harmonized according to the SOCHARA Rules and Regulations which will apply.

- Dr. Thelma Narayan, Coordinator CPHE is also the Project Coordinator for the MP-CHFP and is based in Bangalore. She has been developing this initiative since July 2008 along with other responsibilities and regular visits to MP. Dr. Deepak Kumaraswamy, an ayurvedic physician with CPHE who has done the community health internship with CHC in 2007 is supporting the desk research and documentation from Bangalore. He will also travel to MP later during his tenure with CPHE after which he will go for further studies in Public Health. Dr. Ravi Narayan, a senior public
health physician with CPHE is the senior consultant to the project. Mr. Victor Fernandes, the Administrative Officer of CHC and CPHE provides overall administrative support. Mr. Mathew Alex is the Secretary to the Coordinator. Mr. Amarnath Scindia, CHC Accountant provides accounting support. Mr. HR Mahadevaswamy, librarian CHC Library and Information Centre (CLIC) provides library support. Mr. Joseph is the Office Assistant in CPHE.

- The first CPHE team member Mr. Juned Kamal functioning from Bhopal was appointed from 1st October 2008 after which he went through an induction period, and participated in a research training program and a CHLP alumni workshop in Bangalore.
- Initiatives have been taken to identify a small office space in Bhopal. The AO is visiting Bhopal in end January 2009.
- Arrangements for accommodation of participants during training periods in Bhopal and other places will be negotiated with existing NGOs/government facilities.

6.2 Communication links and support from Bangalore
Regular communication between the CPHE Bangalore and Bhopal teams is maintained through telephone, email, and visits between the units. This is being budgeted for.

Administrative and accounting support is provided by the Bangalore team. SOCHARA rules and regulations apply. SOCHARA is already experienced in setting up and running an extension unit in another state (in Tamil Nadu). Similar systems are being set up in Bhopal, MP. This will be taken forward once the main funding is secured. Ground work has already been initiated through the ongoing and small grants.

6.3 Developing a consortium of funding partners
It is important to develop a Consortium of funding partners for the MP-CHFP and its related community health work in districts of Madhya Pradesh. As mentioned earlier the ground work and some continuing support will be available from the Sarathy Foundation, USA and Misereor/EZE, Germany. The Sir Dorabji Tata Trust, Mumbai who readily provided a Small Grant to undertake field visits and develop the project proposal are being approached through this proposal for support for 20 Fellows and basic infrastructure for the Bhopal office and team. The Sir Ratan Tata Trust has also shown an interest in the initiative. They are interested to support some of the NGOs in Madhya Pradesh where the fellows will be placed for community health work. The SRTT could perhaps also consider supporting an additional 10 Fellows and two additional CPHE team members to be based in Bhopal. The Bhopal office of the UNFPA has also shown an interest and could be requested to provide support for provision of professional updates and meetings with mentors. Support for developing a CLIC (library and information unit) in the Bhopal unit is also required to meet the learning needs of Fellows, CPHE staff and others. The ICICI bank Child Nutrition unit team participated in the Bhopal workshop in November 2008.

6.4 Advisory Committee
An Advisory Committee for the MP Community Health Fellowship Program will be established. For a start it could include: a) Ms. Renu Khanna, Director, SAHAJ, Baroda; b) Dr. Narges Mistry, Director, Foundation for Research in Community Health, Mumbai and Pune; c) Dr. Ajay Khare, Secretary, Bhopal, Madhya Pradesh Vigyan Sabha, and Joint Convenor, Jan Swasthya Abhiyan (PHM India) d) Ms Anajali Noronha, Eklavaya, Bhopal; e) Dr. Shiv Chandra Mathur, Professor of Community Health, Medical College, Jaipur; f) Professor Mutatkar, Maharastra Association of Anthropological Sciences, Pune; g) Dr. Thelma Narayan, Coordinator, Centre for Public Health and Equity, Bangalore and Coordinator CHFP, MP; h) Dr. John Porter, Professor of International Health, London School of Hygiene and Tropical Medicine, London.

This is a tentative list. Once we receive their consent, the proposal will be sent to them for comments.

Annual meetings of the advisory committee will be held and will need to be budgeted for.
6.5 Linkages with NHSRC, and with Community Health Fellowship Programs in other states.
Linkages are already established with the NHSRC with Dr. T Sundararaman the Executive Director; Dr.
Manoj Kar the officer responsible for facilitating the ‘communitisation’ components of the NRHM with
the states; Mr. Arun Srivastava; and Dr. Savita Jain who helps to facilitate Community Participation for
the NRHM in MP, based in Bhopal. The NHSRC will sign a Memorandum of Agreement, the respective
state governments and the organizations running the fellowship programs as they have already done with
Rajasthan and other states.

Linkages have already been initiated with other groups/organizations involved with NHSRC facilitated
community health fellowship programs in other states. This includes SEARCH Gadchiroli, PRAYAS
Chittorgarh, CINI Jharkand, Public Health Resource Network (PHRN) with an office in Delhi and State
teams, SHRC Chhatisgarh, the Sir Ratan Tata Trust and the Child Nutrition unit of the social initiative
group of ICICI bank. Several representatives were invited to the April 2008 workshop organised in
Bangalore by CHC and CPHE. Some came for an informal meeting at the SDTT office in Mumbai in June
2008 and to the Bhopal workshop in November 2008. The formation of a network of these initiatives to
share learnings and methods would be useful. This would need to be anchored and budgeted by some

7. Reviews
Regular reviews of progress of the project will be undertaken with different stakeholders as this is the first
phase of the program.

- **Concurrent (mid-term) and terminal external reviews**
  This could be set up by the SDTT if so desired. This was done by the SRTT during the first phase of the
  community health fellowship scheme (2003-2006/7) and was found by us to be useful

- **Internal reviews**
  The CPHE will conduct internal reviews within the team every month and at the end of year one and two.
  It will report regularly to the SOCHARA – EC and AGBM.

- **Feedback from Fellows**
  Feedback from Fellows will be obtained after each block of teaching and of field placement.

8. Reporting mechanisms

- **Annual reports** will be produced by the CPHE team

- **Reporting systems from the field** will be established between Fellows in the field and the Bhopal
  office on a monthly basis and similarly between the Bhopal office and Bangalore. Visits between
  the Bangalore and Bhopal offices will also be regular.

9. **BUDGET**: (see ANNEXURE 1 for details)

The draft Budget covers the amount of money being requested for from the Sir Dorabji Tata Trust. It
covers (a) a Bhopal based extension unit of CPHE, (b) stipends and other costs for 20 Fellows, (c)
mentorship and training costs (d) support by the CPHE unit in Bangalore.

There are some items that are not covered such as meetings of the Advisory Committee, support to
resource persons, mentors meetings and support, reviews etc. these can be developed after further
discussion.
**ANNEXURE -2**

**Brief Organizational Background of CHC, SOCHARA & CPHE**

The Community Health Cell (CHC) established in January 1984 is a professional resource group in community health and public health, rooted in the voluntary sector. It has spearheaded community health action; innovative teaching of community health for different requirements; networking; and policy research and action in community health and public health. Seven years after its inception an external cum internal review led to the formation of the Society for Community Health Awareness, Research and Action (SOCHARA) which was registered in June 1990. CHC then became the functional unit of SOCHARA which plays a governing and support role.

In 1998 a health policy research and action unit was formed in CHC. Members participated actively in the formation and support of the national and global People’s Health Movement from 1999 onwards. They simultaneously supported the development of the Karnataka integrated state health policy which was adopted by the Cabinet in 2004; the Orissa health policy and the National Rural Health Mission. A community health fellowship scheme was launched in 2003 as an innovative teaching learning program.

In July 2006 the health policy research and action unit of CHC was named the Centre for Health and Equity (CHE). A transition of leadership and new initiatives took place at CHC at that time. The CHC team continues to function well in 2008, including the extension unit in Tamil Nadu which was set up in 2004 after the tsunami; the Community Health Learning Program through the Bangalore unit; and other new initiatives. CHE undertook several responsibilities at national and global levels and also supported the transition process in CHC. CHE further evolved into a more autonomous Centre for Public Health and Equity (CPHE) in 2008 during the silver jubilee of the Community Health Cell (CHC).

The two co-initiators of CHC and a small team presently comprise the CPHE. Close links are maintained between CHC and CPHE. The new initiative takes forward the twenty five year experience of innovative thinking, research and action undertaken by CHC into different parts of the country. CPHE is crafting processes and new teaching programs in public health and community health for strengthening health systems, building civil society and community capacities in health.

- The CPHE will also continue its other public health policy related work including the putting together and writing up of the CHC experience in community health. CD’s have been produced in November and December 2008 for the Annual Conference of the Karnataka Association of Community Health (KACH) and the CHC silver jubilee. The CDs include many CHC articles, publications and reports produced over the years classified into the following sections: 1 - Key Publications by Community Health Cell (16). II - Additional Technical Papers: a) Health Policy and Health Systems Development b) Health Human Resources; c) Communicable and Non Communicable Diseases(socio-epidemiology); d) Health Research; e) Rational Drug Policy f) Health as a Social Movement; g) Additional papers. This background material will be part of the reading material for the MP-CHFP.

- CPHE members continue to support the People’s Health Movement global steering council, its research circle and the International People’s Health University (IPHU). The national secretariat of the Jan Swasthya Abhiyan (PHM –India) has recently moved to Bhopal and CPHE links with the secretariat are well established. Dr. Ajay Khare coordinator, JSA national secretariat is involved in the preparatory phase of the MP-CHLP. As the Secretary of the MP Government Medical Officers Association and the Madhya Pradesh Vigyan Sabha, where he currently works on secondment, he brings in the participation of critical human resources and networks in the state for the MP-CHFP.
CPHE supports public health education at master’s and higher levels in different capacities with organizations such as the Public Health Foundation of India, Tata Institute of Social Sciences, Achutha Menon Centre for Health Science Studies and other institutions. CPHE along with other persons some of whom are JSA members is developing an informal Public Health Alliance to support the PHM and the public health system in the country in order to realize people’s right to health. In Madhya Pradesh linkages have been initiated with Departments of Community Health/Medicine in medical colleges; with colleges/departments of Social Work and Sociology to develop a network of academics who could support the MP-CHFP as guest faculty and perhaps as mentors.
Health and Access to Health Care in Madhya Pradesh – 2008
A Brief Summary

This summary provides a brief outline on the status of health and health care infrastructure and health indicators in Madhya Pradesh, which are particularly relevant to the evolving of MP- CHFP (Community Health Fellowship Programme) initiative of CPHE.

Information is based on data compiled from secondary sources, mainly the state data sheets of the National Rural Health Mission, Census 2001, Human Development Index of Madhya Pradesh, electronic citations, National Health and Family Survey 3, 2005-06, and district level data on infant and child mortality rates published by Population Council of India.

1. Introduction
Madhya Pradesh is located in the central part of India; the literal translation of Madhya Pradesh means the middle province. It was the largest state in India, until November 2000 when Chhattisgarh became an independent state carved out of MP. The states of Uttar Pradesh, Chhattisgarh, Maharashtra, Gujarat and Rajasthan border MP. While it has been part of the so-called disadvantaged “BIMAROU” region, and is one of the Empowered Action Group states, MP has shown a dynamic leadership in health, and worked over the last decade with a host of innovative development and health missions and initiatives responding to the major development challenges faced by the state.

2. A brief history of the State
Madhya Pradesh was created in 1950 from the former British Central Provinces (CP) and Berar and the princely states of Makrai and Chhattisgarh, with Nagpur as the capital of the state. The new states of Madhya Bharat, Vindhya Pradesh, and Bhopal were carved from the Central India Agency. In 1956, the states of Madhya Bharat, Vindhya Pradesh, and Bhopal were merged into Madhya Pradesh, and Bhopal became the new capital of the state. In November 2000 the state of Chhattisgarh was carved out of it, Bhopal remained the capital of the state. The project will keep this common history of MP and Chhattisgarh in mind and build synergies with the health and development resources of both states. (Source –Wikipedia MP)

3. Geography of the state
The geographical area of the state is 308,144 km² which constitutes 9.38% of the land area of India. Madhya Pradesh is located between 21°04’N Latitude and 74°02’ and 82°49’ E, longitude. The state include the Narmada River, which runs east and west between the Vindhya and Satpura ranges; these ranges and the Narmada are the traditional boundary between the north and south of India. Madhya Pradesh comprises several linguistically and culturally distinct regions, including:
   - Malwa;
   - Nimar (Nemar);
   - Bundelkhand;
   - Chambal;
4. The people and culture
Indigenous people termed in official documents as ‘tribals’ constitute a sizable proportion, 20.27% (122.33 of 603.85 lakh) of the population in Madhya Pradesh. There are 46 recognized Scheduled Tribes and three of them have been identified as “Special Primitive Tribal Groups” in the State. There are three distinct tribal groups that form the largest chunk. They are the Gonds, who once ruled most of the state and after whom Gondwana, the central portion of the state, is named. The Bhils inhabit western Madhya Pradesh, while the Oraons dominate eastern Madhya Pradesh. They influence the culture of Madhya Pradesh. The scenic beauty, fertile plains, flora and fauna, have nurtured the inhabitants, thus enabling them to develop their own creative acumen. This diversity and plurality will be reflected in the CPHE initiative and in its training and action programs, utilizing cultural resources to promote health communications.

(Source: Wikipedia, Tribes in MP and Culture of MP)

5. Language
The predominant language of the region is Hindi. Several regional variants are also spoken, which are considered by some to be dialects of Hindi, and by others to be distinct but related languages. Among these languages are Malvi in Malwa, Nimadi in Nimar, Bundeli in Bundelkhand, and Bagheli and Avadhi in Bagelkhand and the southeast. The dominant scheduled languages are Marathi (2.09%), Urdu (1.95%), Sindhi (0.42%), Guajarati (0.32%) and Punjabi (0.24%). Tribal’s use other languages like Bhilodi (4.92%), Gondi (1.53%) and Korku (0.61%). Hindi and English will be the languages for the project initiative. (Source; Census 2001)

6. Administration
Madhya Pradesh has a 230-seat state Legislative Assembly. The state has 29 Lok Sabha seats and 11 Rajya Sabha seats. Madhya Pradesh state is made up of 50 districts, which are grouped into ten divisions viz. - Bhopal, Chambal, Gwalior, Hoshangabad, Indore, Jabalpur, Rewa, Shahdol, Sagar, and Ujjain. The 50 districts are: Anuppur, Alirajpur, Ashoknagar, Balaghat, Barwani, Betul, Bhind, Bhopal, Burhanpur, Chhatarpur, Chhindwara, Damoh, Datia, Dewas, Dhar, Dindori, Guna, Gwalior, Harda, Hoshangabad, Indore, Jabalpur, Jhabua, Katni, Khandwa, Khargone, Mandla, Mandsaur, Morena, Narsinghpur, Neemuch, Panna, Raisen, Rajgarh, Ratlam, Rewa, Sagar, Satna, Sehore, Seoni, Shahdol, Shajapur, Sheopur, Shivpuri, Sidhi, Singrauli, Tikamgarh, Ujjain, Umaria and Vidisha. (source :Wikipedia MP) In the project we will not be able to focus on all the fifty districts, but will select a smaller number based on the number of fellows and the number of good field mentors identified in the state. A cluster approach with 5 to 6 clusters in different regions around Bhopal, Indore, Jabalpur, Gwalior and Rewa.

7. Demographic Profile
7.1 Population size: Madhya Pradesh has (60,348,023) 5.86% of Indian Population (1,028,737,436). The scheduled castes and scheduled tribes constitute a significant portion of the
population of the State. The scheduled castes are 20% while scheduled tribes 15%. M P also accounts for 5.49%, 14.50% of SC and ST population in India. Males constitute 52.10% of the population while females are 47.90%, the gender ratio being adverse to women. The gap between the male and female population seems to be slightly better in rural than in urban areas. 73.54% of population is rural while 26.46% are urban. The distribution of population in rural and urban areas is indicated below. (Source: Census 2001)

| Table 1.1 Population distribution in Madhya Pradesh (Census 2001) |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| MP              | Total           | Percentage      | Male            | Percentage      | Female          | Percentage      |
| Rural           | 44,380,878      | 73.54%          | 23,031,093      | 51.89%          | 21,349,785      | 48.11%          |
| Urban           | 15,967,145      | 26.46%          | 8,412,559       | 52.68%          | 7,554,586       | 47.32%          |

7.2. Population Growth: Madhya Pradesh stands along with Rajasthan, Bihar, and Uttar Pradesh, which account for a higher population growth than the rest of the country (MP Public Health and Family Welfare portal accessed on 28/12/2008).

7.3. Density: The Population Density (person/Square KM) is 196, varying from 200 to 2000 (Census 2001)

7.4. Crude Birth Rate (CBR) and Crude Death Rate (CDR): In 2000 the CBR was 31.4 while the CDR was 10.3 which have respectively come down to 29.1 and 8.9 over a period of 7 years. The CDR of rural Madhya Pradesh is 10.3 as compared with 6.8 percent in urban areas. The CBR also varies, being 32.2 in rural areas and 22.6 in urban areas (MP Public Health and Family Welfare portal accessed on 28/12/08)

7.5. Gender difference. 17.86% of population is between the age group of 0-6 years. Sex (gender) ratio is an important indicator of women’s status. According to 2001 census there were 919 females per 1000 males. Details are furnished below.

| Table 1.2. Gender distribution in Madhya Pradesh (Census 2001) |
|-----------------|-----------------|-----------------|
| Gender            | Sex ratio      | Sex ratio (0-6 years) |
| Total             | 919            | 932            |
| Rural             | 927            | 939            |
| Urban             | 898            | 907            |

7.6 Life expectancy: In 2001 the overall life expectancy was 56.4, in comparison with male (56.5) and female (56.2). The life expectancy has improved over a decade from 54 in 1991 to 56.4 in 2001. The latest estimate for longevity, measured as life expectancy at birth was 59 years for males and 58 years for females(Source: Census 2001, MP-HDR 2007)

8. Socio-cultural profile

8.1. Literacy: The male literacy rate is 76.1% while female literacy rates stands at 50.3%, with a 25.8 % difference. There is also a considerable disparity between rural (57.8%) and urban areas (79.4%) Male literacy rates are 71.7% and 87.4% in rural and urban areas whereas for females it is 42.8% (rural) and 70.5% (urban). Historically, a variety of factors have been found to be responsible for poor female literacy rates. These include:

- Gender based inequality.
- Social discrimination and economic exploitation.
- Occupation of girl children in domestic chores.
- Low enrolment of girls in schools.
- Low retention rate and high dropout rates for girls (Census 2001)
8.2 Marital Status: The burden of child marriage is mostly borne by girls with early pregnancy increasing the risk of maternal mortality. According to the 2001 census the average age of marriage in India is 18.3 for females and 22.6 in males. The average age of marriage in Madhya Pradesh is 17.0 for females and 20.4 in males with a gap of 3.4 years between the genders (Census 2001).

8.3. Religious diversity: 91.1% of population comprises of Hindus, the other religions include, Muslim (6.40%), Jain (0.9%), Christians (0.30%), Buddhists (0.30%), and Sikhs (0.20%), (Census 2001).

8.5. Occupation: 42.74% of the population in MP are workers. 81.02% of workers are in rural areas while 18.97% of them are based in urban areas. The population is categorised into various groups according nature of their work of which, cultivators (18.29%), agricultural labourers (12.26%), and rest 57.25% non workers. Agricultural labourers and cultivators constitute nearly 31% of the population. The gender differences in the workers are also obvious 62.78% of males and 37.23% of females. Children (5 to 14 years) constitute 2.03% to 10.11% among the workers (Census 2001).

9. Marginalised populations

9.1 The Scheduled Castes:

9.1.1 Demography: The State holds 8th rank in terms of the SC population among all the States and Union Territories. The Scheduled Caste (SC) 9,155,177 constitutes 15.2 percent of the total population (60,348,023). The growth of the SC population during 1991-2001 has been 22.4 per cent.

Majority (75.5 per cent) of the SC population resides in the rural areas. Among the districts, Datia has the highest proportion of SCs (24.9 per cent), followed by Ujjain (24.7 per cent) and Tikamgarh (24.3 per cent). Jhabua district has the lowest proportion of SC population (2.8 per cent), preceded by Mandla (4.6 per cent) and Dindori (5.8 per cent) districts.

9.1.2 Sex Ratio: The overall sex ratio of the SC population in Madhya Pradesh is 905 females per 1000 males.

9.1.3 Literacy: 28.5 per cent and 13.9 percent of the SC population have attained education up to primary and middle levels constitute respectively. Only 10.8 percent are educated up to higher secondary level while 2.5% are graduates & above. Rest of the SC population is without any education or have studied below primary level. Male and female literacy is 72.3 per cent and 43.3 per cent respectively.

9.1.4. Occupation: Agricultural labourers constitute the highest proportion (42.5%) among all workers. Cultivators account for 27%; Other Workers constitute 22.7%.

9.2. The Scheduled Tribes:

9.2.1. Demography: The Scheduled Tribe (ST) 12,233,474 constitutes 20.3 per cent of the total population (60,348,023). Madhya Pradesh holds 1st position among States/Union Territories in terms of ST population and 12th rank in respect of the proportion of ST population to total population. The growth of the ST population during 1991-2001 has been 26.4 per cent, which is 2.1 per cent higher than the overall growth of total population (24.3 per cent). The State has a total of forty six (46) Scheduled Tribes.
The Scheduled Tribe population in the State is exclusively rural, with 93.6 percent residing in rural areas. At district level, highest ST population is concentrated in Jhabua district (86.8 per cent) followed by Barwani (67 per cent), Dindori (64.5 per cent) and Mandla (57.2 per cent) districts.

9.2.2. Sex Ratio: The overall sex ratio of the ST population in Madhya Pradesh is 975 females per 1000 males.

9.2.3. Literacy: Among ST literates, 57.3% have attained education below primary level or without any educational level. 24.8% and 9.7% have completed primary and middle levels respectively. 6.6 % have completed their metric level. Graduates and above are 1.4% while non-technical & technical diploma holders constitute a tiny proportion. Male and female literacy is 53.5% & 28.4%.

9.2.4. Occupation: Cultivators and Agricultural Labourers together constitute 89 per cent of the total workers. ‘Other Workers’ constitute 10 per cent. Cultivators’ constitute the highest proportion 46.8 percent among the total while Agricultural Labourers account for 42.1 percent. (Census 2001)

10. Indicators of health

10.1. Mortality Indices-

10.1.1 Infant Mortality rate (IMR) and Child Mortality Rate (CMR): The census 2001 shows an absolute difference of 13 points in IMR in comparison with that of 1991 Census, (107 census 91 to 94, census-2001). IMR in rural areas has come down by 17 points contrasting with that of 13 points in urban areas. Madhya Pradesh (94) along with Delhi, Uttar Pradesh and Orissa had IMR rates of 80 plus in comparison with a national average of 54.

This closely follows the under five (child mortality rates) mortality rates 102 in 2001 with that 159 in 1991. This accounts to differences of 57 points. The census 2001 figure (102) is nearly twice in comparison with national average of 59. However, there is difference of 5% between male and female CMR rates, 39.22% difference between rural and urban areas.

SRS data shows that IMR has been on a slow decline from 82 in 2003 to 72 in 2007, there is an actual decline of 2.6 percent in the overall IMR, but 2.2 percent in rural areas and 1.5 percent difference in urban areas. The district level data indicate that, 26 districts have infant mortality rates above the 80 and 14 districts have IMR above 100; these also represent the high levels of child mortality rate mortality rates of more than 90\(^1\). (Source: Infants and Child Mortality rates in India District Level Estimates, PFI)

10.1.2. Maternal Mortality Rate (MMR): The maternal mortality rate of MP was 498 in 1997 and declined to 379 in 2003. According to NFHS 2005-06 MP also accounts for less than 40% of births being attended by skilled health personnel; 27.9% of mothers are given postnatal care within two days of birth. 57.9% of pregnant women are anaemic (MP Public Health and Family Welfare portal, Sample Registration System)

10.2. Nutrition: Mortality Rates are also determined by the nutrition status of the population. According to the first-ever India State Hunger Index, Madhya Pradesh has the most severe level of hunger in the country, followed by Jharkhand and Bihar. The status of nutrition in the children are quite worse especially among children below 3 years, 60.3% (62.6% rural) of are underweight, of which 33.3 (32.9% rural) are wasted, and 39.9 (41.6 rural) are stunted. The rate of anaemia is also quite rampant which involves 82.6% (84.9% rural) of children (6-35months) and 57.9% (62.4 rural) of pregnant women. NFHS 3 has projected that only ICDS services are only accessed up to 20 percent or more of their births in the past six years. (Source: India Hunger Index, NFHS 3)

\(^1\) The districts of Annupur, Alirajpur, Ashoknagar, Burhanpur, singurali and Khandwa are not included due to data deficiency
10.3. Immunization: Madhya Pradesh ranks 20th among states with the full immunization coverage. NFHS also emphasises on BCG (80.5) DPT (49.8) Polio (75.6) and Measles (61.4). The NFHS 3 shows that 40.3 percent of children are fully immunized in comparison with 22.6 of NFHS 2. 68.7 percent of vaccinated children live in Urban Areas in comparison with 31.5 percent with rural areas. Five percent of children do not receive any kind of vaccination and 25% are in possession of the immunization card. There are also gaps in the coverage of immunization schedule. (Source: NFHS 3)

10.4. Human Development Index: The rural and urban divide in terms of population and health status, physical and social infrastructure is obvious. There has been emphasis on development of infrastructure, communication, and industries which are reflected in Human development Index, from 0.245 in 1981; 0.328 (1991) and 0.394 (2001). According to the national Human Development Report, 2001, MP ranks 12 among Indian states. The latest estimate for longevity, measured as life expectancy at birth was 59 years for males and 58 years for females (corresponding to the period 2001–06) which is lower that the national average (NHDR 2001, MP HDR 2007)

10.5. Housing, Water and Sanitation: There have been consistent efforts to improve the basic infrastructure, and the 2005 Human Development Report is indicative of it. Only one third i.e. 34.8% of the population is in possession of pucca houses. The remaining 61.5% and 3.6% are in possession of semi pucca and kaccha houses. Among the enumerated houses, 69.98% have electricity, 29.92% use kerosene for lighting purpose while 0.81% have no source of lighting. Parallel to this 76% of houses have no toilets. In terms of access to water resources 24.5% of houses have access within households, 51.1% get it from nearby sources and the rest (24.25%) access it from far away sources. Sources of water include taps (25.3% of houses), hand pumps (39.18 %), tube wells (3.93%), wells (28.99%) and others (2.57% of houses). Furthermore 34.2% of household have drainage facilities (7.7 % closed drainage, 26.48% open drainage) while the remaining 65.8% are yet to receive such facilities (Census 2001 MP, MP HDR 2007)

10.6. Availability of Roads Transport (Connectivity): Length of National Highways in km/1000 Sq. Km for Mp is 0.1 to 20 kms (India National Portal). MP has an average coverage of 52 kms per 100 sq kms. MP also accounts for 68% village roads and 15% of major district roads 6% of national highways and 11% state highways. 56.6% of human habitats are to be connected (MP HDR 2007). Average distance covered by the Sub-centres, PHCs and CHCs is 34.10, 262.21 and 1115.86, Sq Kms respectively. Whereas the average distance for HSC is 3.29kms, 9.13 and 18.84 kms for PHC and CHC( MP HDR 2007 RHS March 2007)

10.7. Disability: According to census, 2001, 2.33% of population in MP has disability of which 58.54 percent are males 41.45% are females. The type of disability is more pronounced in the form of, seeing (45.16%) and movement (35.20%) while mental status (8.18%) is being preceded by hearing (6.06%) and speech (5.38%). (Census 2001)

10.8. Fertility and fertility preferences: There has been a decline in the total fertility rates from 3.8 in 2003 to 3.12 in 2005-6, as per NFHS 3; 81.9% of women preferred 2 children. Female sterilization (44.3%) seems to be the preferred method in family planning, while the IUD’s (0.7%) seem to be least preferred method followed by pills (1.7%) with rural usage of 0.3 and 1.1% respectively. (NFHS 3)

12. Access to health Care
### 12.1. Public Sector:
The health system needs revival in terms of the infrastructure and man power. RHS 2007 shows that a sub centre covers an average of 6 villages and 5024 (including the tribal areas) while a PHC has 8 sub centres (3 above the prescribed norm) covering 48 villages and a population of 38626. The CHC has a 4 PHC under its supervision and covers 1,64,374 population which is nearly 2/3 more than the prescribed norm covering about 205 villages. At the same time there are discrepancies in the infrastructure and man power available with public health systems which are presented in the table below.

<table>
<thead>
<tr>
<th>Sub centres</th>
<th>Primary Health Centres</th>
<th>Community Health Centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required In position</td>
<td>Shortfall</td>
<td>Required In Position</td>
</tr>
<tr>
<td>10402</td>
<td>8834</td>
<td>1568</td>
</tr>
</tbody>
</table>

#### Vacancy Position at Glance (RHS March 2007)

<table>
<thead>
<tr>
<th>Position</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auxiliary Nurse Midwife</td>
<td>1393</td>
</tr>
<tr>
<td>Multi Purpose Worker</td>
<td>610</td>
</tr>
<tr>
<td>Lady health Visitor</td>
<td>116</td>
</tr>
<tr>
<td>Health Assistant</td>
<td>24</td>
</tr>
<tr>
<td>Medical officer</td>
<td>280</td>
</tr>
<tr>
<td>Specialist (surgeons, obstetricians and gynaecologists; and paediatricians)</td>
<td>444</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1204</td>
</tr>
</tbody>
</table>

### 12.2. Private Sector:
A survey done in 2007 on the distribution of health care providers with regard to sector of work (public/private), rural–urban location, qualification, commercial orientation and institutional set-up revealed the following:

- Of the 24,807 qualified doctors mapped in the survey, 18,757 (75.6%) work in the private sector.
- 15,142 (80%) of these private physicians work in urban areas.
- The 72.1% (67793) of all qualified paramedical staff work in the private sector, mostly in rural areas.

The paper empirically demonstrates the dominant heterogeneous private health sector and the overall the disparity in healthcare provision in rural and urban areas.²

### 12.4. AYUSH Sector:
There are about 57 AYUSH hospitals, (34 Ayurveda, 3 Unani, 20 Homeopathy) with 2981 (1626 Ayurveda, 250 Unani, 1105 Homeopathy) beds and 1623 (1427 Ayurveda, 50 Unani, 146 Homeopathy) dispensaries and 633 (625 Ayurveda, 8 Homeopathy) manufacturing units (AYUSH Dept. MoHFW GOI).

### 13. Health Human Resources:

#### 13.1. Medical training:
There are about 31234 registered practitioners in MP, with 9 medical colleges of which 5 are Government and 4 private with a capacity of 350 undergraduate students, 96 post graduate students. Medical Council of India has recommended withdrawal of recognition of the degree and stoppage of admissions to Central Govt. quota for govt. colleges (Rewa, ² Where is the public health sector?': Public and private sector healthcare provision in Madhya Pradesh, India, Ayesha De Costa and Vinod Diwan Health Policy Volume 84, Issues 2-3, December 2007, Pages 269-276
Gwalior, Jabalpur, Indore and Bhopal) for the year 2008. There are 9 MD PSM post graduation admissions per year of which 6 (Rewa, Gwalior, Jabalpur) are not recognised. There are 7 dental colleges with an annual student intake of 560 (MCI).

13.2. Para medical training: Madhya Pradesh 2 LHV training centres (Govt) and 26 general nursing schools, and 30 ANM training centres (29 Govt) with intake of 150, 852 and 1510 students respectively. There are 48 colleges which offer graduate and post graduate courses to 2480 under graduate and 265 post graduate students annually. Nursing council of Madhya Pradesh has 52,302 registered nurses. There are 36 pharmacy colleges with annual intake of 2098 (MahaKoshal, Nurses Council, India Education).

13.3. AYUSH training: AYUSH sector has 57593 (47602 Ayurveda, 609 Unani, 9380 Homeopathy and 2 Naturopathy) registered practitioners. 57 under graduate AYUSH colleges include 17 Ayurveda, 4 Unani, 19 Homeopathy with annual intake of 2360 students (715 Ayurveda, 180 Unani, and 1735 Homeopathy) of which 4 colleges offer post graduation (18 Ayurveda, and 6 Homeopathy) to 24 students. (AYUSH Dept. MoHFW GOI).

Conclusion

There are significant gaps in health infrastructure and in health personnel in Madhya Pradesh particularly in the public sector. There are deficiencies also in the quality of medical education evident in the recommendation for de-recognition of some medical colleges. There is a great dearth in teaching capacity for post-graduates in public health/ preventive and social medicine and even here there are deficiencies in quality. This is in a state where health indicators are one of the worst in the country, despite the progress that has been made over the years. There is therefore a need for initiatives like the proposed Community Health Fellowship Program in MP to help strengthen the public health system and community participation and support for the same.
Cluster Approach for Field Placement of CH Fellows in MP
With lists of Organisations in Five Clusters

The field placement of CH fellows who will be based in NGOs will be organised around five clusters of districts in different regions of the State. This is to facilitate closer communication between Fellows who are working in somewhat similar situations/regions and for the organisation of monthly cluster meetings of fellows once a month for sharing and learning. Cluster based teaching-learning is an important part of the process of learning through study, action/work, and reflection. The hub of the clusters each have academic institutions and resource groups/individuals who will be called in to provide inputs at the cluster meetings and for professional support to the Fellows as required. The clusters have been identified based on field visits made to different districts from July-December 2008 using a snowballing technique of searching for field NGOs and resource organisations. The five clusters that have been presently considered are:

I. Bhopal as hub for central MP – covering the districts of Bhopal, Raisen, Sagar
II. Indore as hub for western MP – covering the districts of Indore, Barwani, Khargone, Alirajpur, Jhabua
III. Jabalpur as hub for eastern MP, especially the southern parts – covering the districts of Jabalpur, Chhindwara, Seoni, Umeria
IV. Rewa as hub for north eastern MP – covering the districts of Rewa, Satna, Sidhi and Chhatarpur
V. Gwalior as hub for northern MP- covering the districts of Gwalior, Bhind, Morena, and Shivpuri.

This allows for placing 20-30 fellows and for the planning and provision of adequate organisational and professional support and supervision. This grouping may evolve over time as the team identifies new resource groups and individuals. The number and variety of resource groups and persons vary in the different clusters. However the clusters with more limited access will be given additional inputs and attention by the CPHE team. Groups from Chhattisgarh who have already been contacted will also be drawn in to interact with and support fellows in eastern MP.

A listing of some organisations already identified in different clusters is given below. We have lists of 3-400 member organisations in MP of state branches of federations such as VHAI and CHAI. Visits by the CPHE team have been made to most of the organisations mentioned below and discussions held with a larger number of individuals. Contact details are available with the team. They have not been given to protect privacy but are available on request.

The clusters with lists are given in the next pages.

I. BHOPAL CLUSTER

Bhopal is the state capital with the Secretariat and Directorate of the State Ministry and Dept. of Health & Family Welfare. The State NRHM secretariat is located here. The State Health Commissioner is the state NRHM Mission Director. The NHSRC state facilitator for community participation is based in Bhopal. It is intended to maintain good working links with state level officials of the MP public health system. Contact has been initiated from February 2008 when an official visit was made by the present CPHE coordinator in her capacity as a member of the national ASHA Mentoring Group.

DFID-UK has a very large health sector project in MP with the Technical Assistance Support Team (TAST) located in a building which also houses the NRHM MD. Contact has been established with some staff. There are a large number of state level NGOs, federations, donor agencies, and resource groups working in health and related fields since long. They will provide invaluable support to the MP-CHF
established 1955, P and close communication has already been established with many of them. To make optimal use of all these resources and to enable state level coordination the CPHE – MP team will also be based in Bhopal.

**Resource Organisations and Institutions**

<table>
<thead>
<tr>
<th>No.</th>
<th>Organization and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dept of Community Medicine, Gandhi Medical College (GMC), Royal Market, Bhopal – 462001, MP. established 1955, has a large staff, field centres in Obaidullahganj and in urban poor areas.</td>
</tr>
<tr>
<td>2.</td>
<td>Madhya Pradesh Vigyan Sabha (MPVS) Village Sagonikala, Post Kolua Khurd Raisen Road, Bhopal (MP) PIN-462 021 (Field offices in Bhopal, Chhindwara Districts Tamya Block, Betul District</td>
</tr>
<tr>
<td>3.</td>
<td>MP TAST (Technical Assistance Support Team), DFID UK, Bank of India Building, 3rd Floor, NRHM Office, Jail Road, Bhopal – 462 011, MP Focus on Social Development, Equity &amp; Access</td>
</tr>
<tr>
<td>5.</td>
<td>Jan Swasthya Abhiyan National Secretariat, C/O Madhya Pradesh Vigyan Sabha, Village Sagonikala, Post Kolua Khurd Raisen Road, Bhopal (MP) PIN-462 021</td>
</tr>
<tr>
<td>6.</td>
<td>Facilitator - Community Participation (NHSRC), ASHA Resource Center, Directorate of Health Services, 4th Floor, Satpuda Bhawan, Bhopal.</td>
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<tr>
<td>8.</td>
<td>MP Voluntary Health Association (MPVHA), State Training and Research Centre E-8, Arera Colony, Bhopal</td>
</tr>
<tr>
<td>9.</td>
<td>Medical Counselling Centre H.O 13-14, Panchseel Nagar, Bhopal – 462 003 They focus population activities and social sciences, are a Mother NGO for the RCH program, do ASHA training and work in Bhopal, Chhindwara and Betul districts</td>
</tr>
<tr>
<td>10.</td>
<td>MP Bharat Gyan Vigyan Samiti (MPBGVS), 32 R(SBI), E-7, Arera Colony, Bhopal</td>
</tr>
<tr>
<td>11.</td>
<td>Samavesh, E1/138, Arera Colony, Bhopal 35 team members work in different districts including Harda,</td>
</tr>
<tr>
<td>12.</td>
<td>Treasurer, Catholic Health Association of India (CHAI), Forum Director of MP and CG Region, Vikas Bhavan, KRRP Campus, E/6, Pvt Sector, Arera Colony, Bhopal – 462 016.</td>
</tr>
<tr>
<td>13.</td>
<td>Bhopal School of Social Sciences, Habibganj, Bhopal 462 024</td>
</tr>
</tbody>
</table>
14. **Department of Sociology, Women’s Study unit,**
   Bharkatullah University, Bhopal.

15. **Samata**
   Women’s unit MP Bharat Gyan Vigyan Samiti (BGVS), Bhopal.

16. **Catholic Health Association Madhya Pradesh (CHAMP)**
   Asha Niketan, Bhopal.
   Have a large network of hospitals and health centres in MP

17. **EKLA VYA,**
   Bhopal
   Long experience of innovative and socially relevant work in MP

18. **SAMARTHAN**
   Bhopal

19. **NIVEDITA,** Bhopal
   ASHA training in Bhopal and Raisen District.

20. **Mahila Chetna Manch,**
    Bhopal
    (Large organization working in several district with women SHG’s and on Health).

21. **EKTA Parishad,**
    Gandhi Bhavan, Bhopal
    (State wide movement – with a rights based approach)

22. **SAMVAD**
    Bhopal
    (Right to Food Campaign)

23. **Sambavana Trust and Hospital**
    Bhopal
    (Democratic organization with women and communities affected by the Bhopal Gas Tragedy)

24. **Centre for Advanced Research and Development (CARD)**
    E-7/ 803, Arera Colony,
    Bhopal – 462 016

### II  INDORE CLUSTER

Indore city headquarters of Indore district is the business capital of Madhya Pradesh and is often referred to as ‘little Bombay’. The Holkar Kings ruled over a wide area of the Malwa region and developed several educational institutions. It is the largest city in MP and is industrialising fast and experiencing the impact of globalisation with a lot of in-migration. In contrast districts of western MP have a large *adivasi* population with Bhils, Bhilalas, Barelas as the major groups. The areas are remote with widely dispersed habitations, poverty, and poor access to health care facilities. There are a fair number of resource groups, institutions and individuals in this cluster, second only to Bhopal.

**Resource Organisations and Institutions**
1. **MP Voluntary Health Association (MPVHA),**  
   Near Bilawdi Lake, Indore, MP.  
   (This is the state office of a large network of health related NGOs in MP. It is a member of the Voluntary Health Association of India (VHAI), Delhi)

2. **Dept of Community Medicine, Mahatma Gandhi (MGM) Medical College**  
   Agra Bombay Road, Indore – 452001  
   (The medical college was established in 1948. The Dept. has a large staff of about 14 postgraduates in Community Medicine, with an intake of two post graduate students every year. They have field areas and undertake research programs)

3. **Indore School of Social Work,**  
   14, Old Sehore Road, Indore – 452 001, MP.  
   (One of the oldest School’s of Social Work in the state. Their post-graduates work in many NGOs in the region)

4. **Indore Social Service Society,**  
   C/o Bishop’s House, PB.No. 168, Indore – 452 001

5. & 6. **a) Lok Vikas Anusandan Trust and b ) Lok Biradari Trust**  
   402, Ishan Apartment, 13/2, Snehlataganj, Indore 452 003  
   (The Trust’s undertake development work and publish books/booklets in Hindi on development issues. Involved in some health work)

6. **Deenbandhu Samajik Sanstha**  
   N-14 Saket Nagar Ext.  
   Near Genious temple School, Indore M.P.  
   (Work with the urban poor with a right’s based perspective. Also support other networks and campaign’s in the region including the Jan Swasthya Abhiyan in western MP)

7. **MPVHA, Khoj Project,**  
   Khargone, Khargone District, MP  
   (Community based health and development project)

8. **MP Urban Health Resource Centre**  
   204, Maurya Palace, 5/1 Diamond Colony,  
   3rd Floor, New Palasia, Indore 452 001  
   (Started as environmental health centre, in 2005 became the UHRC work in 75 slums in Indore through 9 partner NGO’s and 7 CBO’s. Also work in 8 cities/towns in MP)

9. **CECOEDCON,**  
   Centre for Community Economics and Development Consultant Society  
   Indore. (They are a branch of a large Jaipur based NGO, work with the urban poor)

10. **Shilpi Kendra**  
    22, Shanti Nagar, Indore  
    (a collective of social workers and activists support and participate in health related campaigns including occupational health issues such as silicosis)

11. **CRY Coordinator and Fellow,**  
    Alirajpur, Alirajpur district, MP  
    (work on children’s issues including health with a rights perspective. Support Khedut Mazdoor Chetna Sangathan, Alirajpur)
<table>
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<tr>
<th>13. ASHA Gram Trust, Barwani, Barwani district</th>
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<tbody>
<tr>
<td>(80 bed hospital, Paramedical training school, Community based rehabilitation of Persons with Disability, Community mental health programme, Samarth residential daycare unit for children with mental retardation, Artificial limb production unit, works in three blocks of Barwani district)</td>
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<th>14. SATHI-CEHAT team</th>
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<td>Paati Block, Barwani Dist, MP</td>
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<tr>
<td>(Involved in Community Health Worker and ASHA training as well as with Community Monitoring of health services. Active in the Right to Health campaign)</td>
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<tr>
<th>15. Christian Hospital, Jobat, Alirajpur district, Madhya Pradesh – 457 990</th>
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<tr>
<td>(120 bedded hospital. They have a ANM training school and a community health program covering 30 villages)</td>
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<th>16. Adivasi Sevashram Trust, Jhabua, Jhabua district, MP</th>
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<tr>
<td>(Work on Education, Social Development, Livelihood, Nutrition, Children issues, and Health)</td>
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<tr>
<th>17. Jeevan Jyothi Hospital, Meghnagar, Jhabua District, MP</th>
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<tr>
<td>(100 bed hospital with community work)</td>
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<tr>
<th>18 Christian Hospital, Tandla, Jhabua District, MP</th>
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<tbody>
<tr>
<td>(Hospital with community work)</td>
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<tr>
<th>19 Manthan, Barwani Town, Barwani District, MP</th>
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<tr>
<td>(work on water, dams and development issues)</td>
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### III JABALPUR CLUSTER

<table>
<thead>
<tr>
<th>1. Department of Community Medicine, Netaji Subash Chandra Bose Medical College- (NSCBMC) Jabalpur – 482003</th>
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<tbody>
<tr>
<td>(Established in 1955 the medical college has a Dept. of Community Medicine with several staff with postgraduate qualifications. Undertake field work)</td>
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<tr>
<th>2 Diocesan Social Service Society</th>
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<tr>
<td>C/O Bishop’s House, Sneha Sadan, 599, South Civil Lines, Jabalpur 482 001, MP</td>
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<tr>
<th>3. Xavier Institute of Development Action and Studies (XIDAS), P.Box-5, 599, South Civil Lines, Jabalpur-482001 Madhya Pradesh</th>
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<tr>
<th>4. MPVS Field Office (inTamaia and Pathalkot covering Tamia and Perasia Blocks) Chhindwara District, MP</th>
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<tbody>
<tr>
<td>(ASHA training and Community Monitoring and Planning)</td>
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</table>
5. ASHA Trust, 
Junnardeo, Chhindwara District, MP

6. Christian Hospital & Training Centre, 
Lucknadon, Seoni District, MP 
(Cover two blocks)

7. Maria Matha Hospital, 
Umeria, Umeria District, MP

IV Gwalior Cluster

Resource Organisations and Institutions

1. Centre for Integrated Development (CID), 
49-Ravi Nagar, KVN Lane, Gwalior - 474002 
Also do fieldwork in Shivpuri Dist with a Rights based approach. Involved with ASHA training

2. Gajra Raja Medical College, 
Katora Tal Road, Gwalior – 474009, MP 
(started in 1946 the medical college has a well established Dept. of Community Medicine with qualified staff and an intake of postgraduate students)

3. State Institute of Health Management and Communication, 
Gwalior, MP. 
(undertake the training of trainers for the ASHA program and other national health programs for the entire state)

4. SAMBHAV 
Gwalior, MP. 
(Working for 25 years in community health and eye health in Gwalior and Shivpuri Districts)

5. DHARTI 
Morena District, MP. 
(Involved with ASHA training; VHSC formation and training. Was linked to Action Aid)

6. Government Mental Hospital, 
Gwalior, MP 
One of the few mental health institutions in the state.

V Rewa Cluster

A field visit has only been made to Sidhi district so far which is one of the five districts in MP in which Community Monitoring is being pilot tested. The CPHE team also knows staff from the Chhatarpur Christian Hospital, as one of them is mentoring the EHA team which was selected through a competitive process to participate as a research team in an inter-country study on Learning from Comprehensive Primary Health Care in an effort to revitalise Health for All. CPHE is the Asian hub for this study. Further visits will be made to this region to contact other NGOs and institutions.
## Resource Organisations and Institutions

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<tbody>
<tr>
<td>1. <strong>Dept. of Community Medicine, Shyam Shah Medical College Rewa – 486001, MP</strong>&lt;br&gt;(The medical college started in 1963)</td>
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<td></td>
</tr>
<tr>
<td>2. <strong>Christian Hospital, and Prerna Project,</strong>&lt;br&gt;Mohoba Road, Chhatarpur, Madhya Pradesh 471001&lt;br&gt;(100 bed hospital started in 1937, with community based health work)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Christian Hospital,</strong>&lt;br&gt;Burhar Road, Shahdol, Madhya Pradesh</td>
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LINKAGES

11. With ‘Public Health’ Providers

We know today that the system of medical education has not prepared medical graduates to go to serve in rural areas and urban slums where the majority of the population lives. The question that arises is: do we need highly trained medical graduates to tackle common and minor ailments? The global experience of developed and developing countries show that properly trained public health and health care providers can do this job effectively, efficiently and safely. Why, then, not in our country where there is no shortage of human power, where it has only to be provided the opportunity to develop skills suitable for the services required? Public Health and Primary Health Care training courses need to be developed nationally delivered decentralized near work places and assessments to be done locally & used for further training.

Community Health has two dimensions – medical and non medical. The non-medical dimensions that impinge heavily on public health such as education, housing, water, sanitation, environment, law and finance, need human power specifically trained for these skills and not medical graduates. Today we have no such training programs or cadres. The Public Health component in the curriculum of the undergraduates is inadequate and needs to be strengthened and spread over the entire period of their training – i.e. 1st Year to Final Year (Linked with recommendations in 2.8 above, specifically 2.8.2). The medical colleges award MD degrees in Community health/Public Health and the training seats available are only 269 across the country for medical graduates only.

Public Health Capacity Building

11.1.1 A massive expansion of the Public Health Training facilities is required to include 3 levels of Public Health workers to work in the community, at the Primary Health Centres, community Health Centres and district hospitals as follows: -

1. Diploma Course – 1 year
2. B.Sc. Course – 3 years for lateral entry and 2 years for Diplomates
3. Masters in Public Health 3 years for B.Sc. & 5 years for 10+2 students

11.1.2 Graded responsibility with emphasis on practical “hands on training” is essential. The diploma and B.Sc. should be open to all students of 10+2. They can be attached to departments of Community Medicine in all medical colleges, can be run by all Universities, all district hospitals and Public Health Foundation of India.

11.1.3 The Non-Government Organizations (NGOs) & Community Based Organizations (CBOs) working in the field should be inducted as trainers to provide expertise and training to all levels of students for the public health cadres. These courses offered should have a strong practical orientation and include project work in appropriate field settings.

11.1.4 The curriculum should include principles of public health, introduction to biology of health and disease, nutrition, survey methodology, surveillance systems, behavior changes, communication skills, health systems in India, national health programmes, basic lab methods relevant to public health, food and water safety, air quality testing, environmental sanitation, emergency medical care, disaster response, occupational health and introduction to health management.

11.1.5. The masters programme must provide structured learning in public health related principles. They should integrate the disciplines of epidemiology, biostatistics, demography health economics, behavioral and social sciences, health communications, ethics human rights, health management and planning, environmental and occupational health which equip the students with the knowledge and skills to enable them to contribute to strengthening of
health services health policy and research. These should be open to physicians, non-physicians and B.Sc. graduates. They can be run by all medical colleges and Universities.

11.1.6 Community Medicine / Public Health Specialists
While the above 3 levels of public health professionals will help strengthen the public health system in the country – the existing MD course in Preventive and Social Medicine and Community Medicine will continue to provide higher level specialists who will support the planning, higher level programme management, higher level administration of the public health system and national health programmes and the training and research efforts at State and Central level.

Public Health System Building
11.2.1 A specific public health cadre needs to be established in the state and central Ministry of Health to provide career growth for these personnel up to the level of the Director General of Health Services. Their emoluments should be in line with the state medical cadres with an added hardship allowance to make it more attractive, acceptable and prestigious. The postings will start from the PHC level and proceed upwards to include municipalities, industrial settings and Government cadres. In future, a Public Health Council is needed to be set up by the government in collaboration with the key institutions and associations of public health professionals in the country to accredit these courses, monitor and evaluate standards and evolve methods of registration and continuing education to strengthen public health capacity building. A statutory health council should be charged to monitor the functioning of these Public Health providers at all levels. National course modules should be prepared for decentralized delivery and assessments made both formative and summative at completion of the course and used for preparing a cadre merit wise.

In Conclusion
1. Urgent need for strengthening public health / primary health care In a study conducted in rural UP in 1995, only 3 % of the medical practitioners were MBBS graduates or allopathic practitioners while 68 % had no training in any form of medicine. If one is to learn from these experiences and correct them, then Public Health & Nursing Courses are a “must” to provide appropriate and safe health human power for the masses rural or urban. In all professions, different grades of service require different levels of skills. An average engineering diploma does not possess the same level skills as the average degree holder but each is vital to any project for their specific skills, similarly at every level of health care specific skills are required and Public Health workers can acquire them, medical graduates are not required to deliver these services.

2. Dialogue and partnership with the community health network in the country
Finally, a strong countervailing health oriented movement has been initiated by health and development groups, consumers and people’s organizations, civil societies, that will enhance the role of the community, patients, consumers and the parties in the entire debate on reform in the health and medical sector. Change has been directed and controlled for too long by professional needs, rather than people’s health needs. This movement is bringing health care and community oriented medical education with its orientation to people’s needs rather than the medical market. Future initiatives should be taken by the Health Ministry, Planning Commission and other Councils - who will take up the responsibility to implement the above recommendations to continue such dialogue and partnerships.