

# “The Struggle for Health in South Asia: An Alternative Thinking for Solutions”

## Report of IPHU short course, November 2016, Kathmandu, Nepal

### Background

The South Asia is home to over one-fourth of the world’s population and also shoulders significant global disease burden (World Health Organization, 2007). The socioeconomic policies initiated by the governments of the South Asian regions favour the private market forces over people's welfare. This prompts to poor health and living conditions rendering people to endure the brunt of inequity.

Reducing Health inequities is instrumental in enabling individuals to participate with their full potential in the Society. Therefore, it was critical to bring together the health activists and the like-minded people from South Asia to a common platform. So that, they can share experiences and learn to address and improve the health situation in their respective country. Deliberations and discussions were carried out by the representatives of countries belonging to the South Asian region. The outcome of the deliberations was to conduct The International Public Health University (IPHU) Course on “Struggle for Health in South Asia” at Kathmandu in the month of November.

The objectives of this course were to analyse the situation of health in the region via sharing of experiences and knowledge. Secondly, to also act as a platform for the participants/activists to collaborate with each other for the common aim of ‘Health for all’.

### Selection Process

The process of selecting participants commenced with the call for Expression of Interest. This information was circulated in the People’s Health Movement circles of South Asia. The modalities chose for circulating the information/applications were emails, phone calls and Social media. Interested participants were required to apply with filled application Form.(Annexure-1)

**Nepal**-The selection of participants occurred in two different phases. Host nation Nepal came forward to take up its own process of receiving and selecting the participants. In Nepal, the applications were received until 19<sup>th</sup> of October. Along with emails and social media, an advertisement was also published in the local newspapers requesting interested individuals to apply for the course. Following the scrutiny of applications, a round of personal interviews was conducted for some candidates. After interviewing, 15 participants were selected based on their performance in the interview.

**The remaining South Asian countries**- i.e. Pakistan, Sri Lanka, Bangladesh, India and Myanmar had decided to have their applications forwarded to a common email ID -

[IPHU\\_kathmandu@gmail.com](mailto:IPHU_kathmandu@gmail.com) which was created for this purpose only. All the applicants submitted the filled application form to this email. The last date of receiving the application form was 15<sup>th</sup> of October. It was also informed at the earlier stages of filling application that a token

amount of 30 U.S.D as the registration fee and all the remaining expenses i.e. cost of flight ticket, transit to and from Tribhuvan Airport, Hotel Accommodation and food will be provided by the organisers.

Good responses were received on the call of Interest and the number of applications received from various regions is listed in table 1.1. Later these applicants were scrutinised based on their experiences in activism and the work in the field of health. A list of prospective participants was prepared and the individuals were contacted for confirmation. Responses received from the applicants and selected participants according to their respective country are listed in table 1.1.

India	26	7
Pakistan	14	5
Bangladesh	20	5
Srilanka	13	2
Nepal	65	15
Myanmar	1	Applicant did not respond to the confirmation emails

Table 1.1

### Travel and logistics

The participants were informed that the cost of flight ticket, transit from and to Tribhuvan Airport-Kathmandu, Hotel accommodation and food would be provided by the organisers. All the confirmed International participants were coordinated for their travel from PHM secretariat located at New Delhi.

The flight tickets for international participants were booked such that participants would arrive at Kathmandu on the afternoon/evening of 22<sup>nd</sup> November and would depart on the 30<sup>th</sup> November. The international participants other than Indians required VISA to enter Nepal. The participants requiring VISA were advised to either apply for VISA in their home country or apply for the VISA on arrival.

The local participants in Nepal were asked to arrange their own travel. They were informed that the cost incurred would be reimbursed on producing the original travel bills/invoices.

### Preparatory work in Nepal

An organising committee was constituted in Nepal to coordinate the work to be done for the course. The organising committee chose RECPHEC (Resource Centre for Health) organisation as a secretariat to deal with the preparations, expenses and receipts. Many staff members from RECPHEC were involved in the preparatory as well as day to day activities during the course.

### Venue

The organising committee scouted for venues for the course. The prerequisite for the selection was to have a venue where accommodation and a conference hall was available to accommodate 50

people. Additional requirements were the availability of the sound system, Projector/screen, electricity backup and Wi-Fi facility.

The first priority was to look for the possibility in the universities/colleges/institutions/NGOs. However, after a thorough search, it was felt that none of the places had such facilities where 50 persons could be accommodated; also they did not fulfil the other requirements.

In the next stage, hotels in and around Kathmandu were searched and finally it was decided to conduct the course at Hotel Marshyangidi in Thamel. The hotel was selected as its accommodation and a conference hall had capacity seat 50 participants in the same place. The hotel also had the necessary additional services. The venue was also fixed because it was located in the heart of the city and was close to Tribhuvan Airport and local bus Station.

## Volunteers

A sizeable number of volunteers were required to coordinate and help in the daily functioning. For this, a call of interest was given out in the Institute of Medicine (Tribhuvan University). The institute is a centre that has actively had PHM students committee among the public health students.

It was specified in the call of interest that the volunteers shall be able to attend all the sessions during the course and would be awarded a volunteer certificate for their contribution. In the end, a team of 12 volunteers was selected by the organising committee.

## Academic Background

### Sessions and Topics

After discussions and suggestions, it was decided that the course will have sessions on the topics that are relevant and common to understanding of the participants. The sessions were framed in order to address the aims and objectives of IPHU in the regional context.

The sessions intended to cover Primary Healthcare, UHC, Political Economy of health, Social Determinants of health, Effect of Globalisation, Trade and Economy on Health, Human Resources for Health, Gender and Health and Medical Education.

The key aspect that was considered while framing the sessions was to have more interactive and discussed based style of teaching. In this regard, most of the sessions had group works activities facilitating discussions among the participants.

### Resource persons

The sessions prepared required to have Resource persons who are able to impart a local, regional and international understanding on themes selected.

It was decided that a large portion of the sessions would be dealt by Resource people from Nepal. It was also necessary to have few resource persons who had the experience from previous IPHU.

### Reading Material

Reading materials were sent to the participants on the email and also given in pen drives. The reading materials were decided keeping in view the themes/sessions that were covered during the IPHU.

Along with thematic related reading material, Peoples Health Charter, Alma Ata Declaration and Global Health Watch-4 were distributed.

### Collaborations

An interesting part of the IPHU was having a joint session with the like-minded organisation on one of the themes. Public Services International (PSI) was also conducting the workshop in Kathmandu on 'The working conditions of Healthcare Workforce'. PSI is an international organisation which works with trade unions in the sector of public services. The workshop happened to be in the same week as that of IPHU.

This opportunity was utilised to conduct a joint session wherein the participants of IPHU and PSI attended common sessions for a day. The joint session were well received by the participants of both the events, and health activists could interact and share learning and experiences with trade union.

### Field visit

A field visit was planned on the 6<sup>th</sup> day of the workshop to Pharping area of Kathmandu District. In Pharping, it was decided to visit a community-based NGO. The NGO has established a community hospital and programmes in health awareness and education in the area

It was felt that this visit would act as a refresher from the daily sessions at the conference hall and would be a learning experience.

### Group work and presentations

The purpose of IPHU is to have shared, discuss and contemplate on the role of health activists in the achievement of Health for ALL. Regular Group work and presentations were planned in this regard. The group works would also allow participants to mingle and learn from each other.

Three types of group work were planned for the course.

- Analysing the situation of health in respective country
- What are the necessary actions to be taken up for Health for all in the respective country
- Thematic group works were in participants would choose from below themes and make a presentation on the issue.
  - Globalisation and Health
  - Universal Health Care
  - Social determinants of Health
  - Health Workforce

Following is the schedule that was finalised for the course "Struggle for Health in South Asia"

Date	22	23	24	25	26	27	28	29
9.00 - 9.30	Inaugural	Feedback	Feedback	Feedback	Feedback	Feedback	Feedback	Feedback
9.30 - 11.00	Session (9.00 – 10.00)  Self Introductions (10.00 – 11.00)	Political Economy of Health, Globalization and Health, Access to Medicines  Amit Sengupta + Sumana Shrestha	Role of State in Health System Development, How health systems are organised: Concept of PHC and UHC: How does it differ?  David Sanders	Trade and Health  Amit Sengupta and Susana Barria	Medical Education and Training of Health Workers  A. Karki + David Sanders	Field visit	Gender and Health  N.Sarojini	Thematic Group presentation
BREAK								
11.30 -13.00	Introduction to PHM -- Origins, vision, Programs; Introduction to the IPHU  Amit Sengupta, Susana Barria	Formation of Thematic and Country Groups. Explaining the tasks and outputs from group work	Thematic Groups (Group Work)	Privatisation of Health Services  PSI	Thematic Groups (Group work)	Field visit	Country Groups (Group Work)	Country Group presentation
LUNCH								
14.00 -15.30	The People's Charter on Health  Amit Sengupta, Susana Barria	Development of presentations on Country Situations (Group Work)	Conflict and Social Transformation (Madhusudhan subedi)	Informalisation of Employment and the Health Sector: Implications for Quality of Health Services  PSI ( Santosh & Ananya)	Social determinants of Health, including environment and health  S. Onta	Field visit	Panel discussion: Building the Movement for Health	Certificate distribution and Closing
BREAK								
16.00 -17.30	The Right to Health and Equity in Health Shanta Lal Mulmi	Presentations on Country Situation in Plenary	The crisis in nutrition and Health  David Sanders	Health workforce migration  David Sanders & Jasminsha ( Nursing Association- kerala)	Country Groups (group work)	Report and discussion on field visit	Thematic Groups (Group Work)	

## Feedback and Evaluation of course

A feedback session was conducted every morning (9 to 9:30) about the previous day programme. Participants were also given forms to evaluate and provide feedback on the IPHU course.

## Day wise report of Struggle for Health in South Asia

### Day I – November 22nd

#### Inaugural Session

The IPHU Nepal 2016 was formally launched with an Inaugural Session.

The moderator of the session Ms Sumana Shrestha invited the dignitaries Prof. Dr. Mathura Prasad Shrestha, Dr. Amit Sengupta, Prof. Kedar Bhakta Mathema, Prof. Dr. Sharad Raj Onta, Prof. Kedar Baral and Dr. Arjun Karki to the dais. Prof. Dr. Sharad Raj Onta, on behalf of the organizing committee, welcomed the participants of IPHU, guests, volunteers and supporting team members of the IPHU. Highlighting the objectives of the course, he mentioned that IPHU course was designed to create an opportunity for all of us, as health activists, to be together, share experiences, learn from each other and to accumulate strength to fight together against the hurdles of accessing health for people created by present day world economic relation.

Prof. Dr. Mathura Prasad Shrestha, who has been associated with PHM since the founding of Peoples Health Movement (PHM) inaugurated IPHU Nepal course by lightening a traditional lamp *Panas*. In his inaugural speech, Prof. Shrestha emphasized that health should be understood

holistically rather from only biomedical point of view and state should take the primary responsibility of its people's health.

Following that, Prof. Kedar Bhakta Mathema, former Vice Chancellor of Tribhuvan University and a reputed educationist, remarked that an excessive privatization in health care was a disaster in health care delivery system since it created more gaps and discrimination in the society. He made a point that we all must stand and fight against the existing disparities in health and ongoing mindless commercialization of medical education.

Dr. Amit Sengupta, of People's Health Movement, expressed his view regarding health as a mirror of whatever we do in the society, right and wrong. Also emphasized on urgent need of solidarity among health activists to bring positive change in health.

Prof. Kedar Baral, the acting Vice Chancellor of Patan Academy of Health Sciences (PAHS) expressed that PHM has created a new world view where health issues and actions are critically analyzed.

Prof. Dr. Arjun Karki, coordinator of the IPHU Nepal expressed a vote of thanks to all the participants, guests, organizers and volunteers along with field coordinators of people's health movement for their valuable time to gather and share their insights in the opening session.

### **The Struggle for Health**

Dr. Amit Sengupta

"Health is not about big hospitals and experts in the country...and there is a crisis in health since people are still dying due to lack of health services" - the session on "The Struggle for Health" was kicked off by Dr. Amit Sengupta. He mentioned, how tuberculosis was eliminated from United Kingdom even before the medicine rifampicin was invented. It was discussed that health is not only a medical issue but also a social and political one. He also reflected as to "*What good does it do if we treat people's illness and then send them back to the conditions that made them sick?*"

Dr. Amit further added, 'We live in earth where there is gross inequality in health and wealth. Therefore, our health is defined and determined by politics'. He also shared the major outcomes of People's Health Assemblies– I, II & III, and 'The People's Charter for Health'.

Major highlights of the session were:

- PHM is a movement which believes that Health is a human right and not a privilege
- PHM is a global network bringing together grassroots health activists, civil society organizations and academicians from around the world
- Global Health Watch, an alternative World Health Report, International People's Health University (IPHU), Democratizing Global Health Governance initiative (WHO Watch), Health for all campaign at local and global levels as some of the key programs of PHM.

Dr Amit concluded that desirable change can be brought through 'Educating', 'Mobilizing' and 'Organizing'.

### **Right to Health and Equity in Health**

Mr. Shanta Lall Mulmi

The session on 'The Right to Health and Equity in Health' was conducted by Shanta Lall Mulmi. As a Secretary of PHM Nepal and Executive Director of- Resource Centre for Primary Health Care (PHM), Mr Mulmi shared experiences of struggles for ensuring health right of people.

Major highlights of the sessions were:

- Health as a fundamental human right has been incorporated in the constitution of Nepal. Free healthcare services and free maternal services are also provisioned in Nepal as a result of peoples struggles .
- Growing market forces and unregulated private health care institutions are emerging threats to Nepalese health care system.
- Insurance scheme has been introduced in Nepal as an approach to ensure Universal Health Coverage and the health rights of people, despite having known of its limitations that it disregards the equity aspects in health.
- It was explained that, there is an urgent need to advocate for accessible, acceptable, affordable and available quality health care services on a regular basis as these are citizen's fundamental health rights.

#### *Day 2 – 23rd November*

Day two commenced with recap of the major discussions of day one. Participants shared their experiences having involvement in NGO sectors and their role and challenges being faced as PHM activists at national and international level. Prof Dr. Sharad Raj Onta added a remark on ongoing struggles that, it is essential to have common consensus on what we are struggling for and how it is embodied in Peoples Charter for Health.

#### **Globalization and health**

Dr Amit Sengupta

The first session of the day was on the topic '**Globalization and Health**' facilitated by Dr. Amit Sengupta. Illustrating the story of seven blind people interpreting an elephant, Dr Sengupta explained how different people from different quarter may have different perception about globalization. He added that understanding about globalization was primarily based on their standpoint in the similar way those blind people drew the incomplete image of elephant since they could only touch the elephant partially.

Dr. Amit clarified the concept and origin of globalization with its historical background from the era of post-colonial crisis to the present day neoliberal economic relation, which is also known as capitalism. It is all about mindless consumption which has created and increased the gap between rich and poor in all aspects of life including health status.

Sharing the history of globalization, Dr. Amit revealed that it proliferated after World war II. He illustrated a deep outlook on how the concept of globalization emerged and followed its subsequent effects. The period, 1945–1970, termed as the "Golden Age of Capitalism" was the period of relative peace and economic growth. The countries in Asia and Africa were breaking the shackles of colonialism and were engaged in building their own countries. The industrialized countries lacked the market compared to their production capacities. Stagnation of economic growth in developed countries urgently needed market for the consumption of their products. Opening markets in developing countries and free flow of capital and products to these countries was facilitated by globalization process. The capitalist banks started "pushing loans" to countries in the developing world. Loans were made available at lucrative rates and the countries were advised to seek loans to pump imported consumer goods into domestic markets. The entire system collapsed under its own weight- the loans were unviable – country after country was unable to pay back and fell into the debt trap.

The global police on economic affairs - the International Monetary Fund (IMF) stepped in. Advice of IMF to get out of the fast emerging debt crisis was simple - take more loans to repay the loans. But this time the loans came with conditionality – that is structural adjustment programme (SAP) with focus on three major aspects: Privatization, Liberalization and Globalization. SAP also forced the government to step back from providing basic social services to the people in health, education, food security, etc. In health sector, SAP resulted in less government funding, user fees, selective primary health care and provisions of safety nets for poor.

Dr. Amit stressed, nowadays the global economy became more and more dependent on flows of capital in and out of countries, speculative capital that contributed little or nothing to building productive capacities. Artificially hiked consumption was paid with money that people borrowed but couldn't afford to pay back. As a result, the globe is confronted with crisis after crisis. The main root of crisis can be traced to global economic inequality, dominant role of the financial sector, unequal global economic integration and ineffective and undemocratic global governance.

The cutting down of state funding through SAP, privatization and marketization of health services marginalized the poor people and deprived them of accessing health services. Consequently, health gap between the people was further widened.

Having session on the underpinnings of globalization, floor was made open for participants to analyze the impacts of globalization on health critically. Dr. Sharad Onta briefly added a remark on how the removal of public subsidy in oral rehydration solution and vaccines since mid 1990s in Nepal affected poor people's health.

#### *Country Group work*

The session on globalization and health was followed by country group work. All the participants were divided into country groups. Five different country groups were formed from Bangladesh, India, Pakistan, Nepal and Sri Lanka and were assigned to analyse their country health situation critically being based on the impact of globalization. For group exercises, participants were also provided with an outline for group work, consisting of:

- Description of health system of own country,
- Basic health indicators and its 5 years trends,
- Health financing and,
- Major issues and challenges in health sector.

After the group exercise of one and half hour, each country group presented their country health situation with critical analysis of equity and health financing mechanism of the country. Each of the groups also shared the challenges that their country health system is facing. One of the common challenges, as most country groups presented, was donor driven health programs based on their interest rather than the country specific need.

Also, emerging and reemerging diseases and epidemiological transitions are huge challenges most country groups participants sought. All the presentations were supplemented with inputs from facilitators followed by question answer sessions between presenters and audiences. Day two sessions were wrapped up by 5:30 pm.

#### *Day 3 - 24th November*

Day three started with the review of major learning and reflections of the previous day. Participants discussed their understanding of donor driven policy and programs in their respective area of work/study. They suggested the need for in depth discussion on the root causes for the



mushrooming of private hospitals and excessive privatization of health care services to be more critical. Also People's health movement should be made more visible through regular actions.

### **Primary Health Care, Health System and Universal Health Coverage**

#### **Prof. David Sanders**

Prof. David Sanders started the session with the brief history of health care system before the concept of Primary Health Care came into existence. It was explained that, Limitations of hospital based curative system, several movements initiated from grassroots, community based health initiatives and large scale country programs were the triggers to set the conception of PHC. The concept of primary level care should not be equated/confused with that of first contact of services, rather PHC is a comprehensive care at all levels. Five principles and 8 elements of PHC were briefly reviewed to see the missing elements. Also, PHC has a strong sociopolitical implication which addresses social, political and economic conditions determining health of people.

After overview of the concept of PHC, Prof. Sanders talked about the assaults to derail PHC. They were Selective Primary Health Care, Structural Adjustment Programme and Health Sector Reform. He also talked about some global initiatives like GAVI and Global Fund which were donor driven and less intended to bring sustainable improvement in people's health. He highlighted rapid growing inequalities between and within countries as main challenges of PHC.

Prof. Sanders explained WHO health system framework and the need for inter-sectoral action to address the social determinants of health as depicted in WHO health system framework. His concluding remark was health system should be based on PHC approach and focus should be given to universal health care rather than Universal health coverage.

### **Conflict and Social transformation**

#### **Dr. Madhusudhan Subedi and Ms. Sumana Shrestha**

Dr. Madhusudhan Subedi started the session with the sharing of various case studies from Nepal depicting the causes and effects of social conflicts in the society. He discussed how social transformation is not just an individual matter but was also linked to the environment/society he lives in. social transformation is either brought through internal effort in the society or sometimes through external forces too.

He felt that social transformation is a prerequisite in the pursuit of Health for All. It is a necessary one as the population feels that better health is their right and is also attainable, thereby making the people to struggle towards Health for All.

### **Double burden of Malnutrition**

#### **Prof. David Sanders**

Double burden (underweight and obesity) of disease is emerging more prominently at global level, Prof. Sanders stated. Illustrating the example of child malnutrition, he explained the layers of causes of under-nutrition among children. The basic causes of child malnutrition are poverty and socio economic factors. Underlying causes include household food insecurity, early stoppage of breast feeding, and no immunization. Similarly there are immediate causes namely inadequate dietary intake and presence of other infectious diseases. These causes interact with each other to make the child more prone to the under-nourished condition.

To explain the situation of obesity, Prof. Sanders shared the concept of food groups. Various data from different countries like Brazil and South Africa were referred to reveal the fact that consumption of ultra-processed products had significantly increased in the recent years which resulted in various nutritional disorders like under nutrition among children and obesity among the adults. Rapid increment in the number of supermarkets have made ultra-processed foods more available to the consumers, Sanders pointed.

Furthermore, the issues on Ready to Use Therapeutic Foods (RUTF) for the treatment of undernourished children and Popularly Positioned Products (PPPs) were discussed to illustrate how the use of ultra-processed foods is being promoted in health care system. He raised a question? Who are being benefited with these approaches? Markets? Donors? Or People? Besides, some remedial measures for healthy life were discussed. At the end of the session, participants and facilitator had discussion on unclear issues of the content. Also participants from different countries shared how the nutritional problems are growing in their respective countries and what is being done at national level with a short critique.

*Day 4 – 25th November*

### **Joint Session with Public Services International**

The 4<sup>th</sup> day of PHM-IPHU Nepal was jointly organized in collaboration with Public Service International (PSI). Participants of PSI programme and IPHU course participated the sessions together. Prof. Dr. Sharad Onta started the program with a welcome note to all participants. Mr. Gargeya Telakapalli, gave a brief review of Peoples Health Movement- its origin, motives and ongoing campaigns.

Ms. Susana Barria introduced PSI as a global trade union federation which fights for human rights, social justice and universal access to quality public services. Susana shared her work experiences in this field and highlighted the key issues which must be addressed as an urgency to ensure the health rights of all people:

- Privatization of health care services and Unregulated private sectors
- Minimal investment in health sector and also presence of Powerful transnational companies in health sector
- Working conditions (environment, facilities, promotion, remuneration) of health professionals in public sector

### **Trade and Health**

#### **Dr. Amit Sengupta and Susana Barria**

Dr. Amit Sengupta and Susana Barria conducted the first session of day on Trade and Health. Discussing on the relation between trade and health Dr. Sengupta reviewed Structural Adjustment Programme and explained how it affected country's capital, industrial sector and market. Although World Trade Organization was formed for the promotion of economic growth and thereby alleviate poverty across the world, but it failed to do so. Details were given on transition from General Agreement on Tariffs and Trade (GATT) to World Trade Organization (WTO) and its impact on trade and health all around the world pointing out that only the developed countries could be benefited from the agreed trade laws. Dr. Sengupta summarized WTO Agreements related to health as:

- Technical Barriers to Trade (TBT)
- Sanitary - Phyto-Sanitary Measures (SPSM)
- Trade Related Intellectual Property Rights (TRIPS)

- Trade in Services (GATS) and the four modes

Trade Related Intellectual Property Rights (TRIPS) was discussed at length. TRIPS requires its member countries to establish minimum standards for protecting and enforcing intellectual property rights. It was the first instance of trying to enforce similar Patent Laws across the globe. TRIPS includes several areas such as: Patents, Trademarks, Copyrights, Geographical Indicators.

Dr Sengupta shared an example how this affects the global economy and health by comparing the drug price by Indian company and international price. Cipla's offer for triple therapy of ARV in February 2001 was US\$350 per patient per year against \$10,000 offered by MNCs. Current prices for 1st line triple ARV therapy is approx. US\$99. Introduction of generic versions of antiretroviral therapy is credited with triggering off price reductions from multinational drug companies. He cited an example of Rwanda as the largest genocide in the history. According to him, only 5 or 7 drug companies could decide whether millions of people can live or die.

Further Susana explained about Trade in Services Agreement (TiSA); the basic philosophy of which is that governments should not provide services directly, rather regulate the service provisions provided by private and commercial entities. According to Susana, issues around trade and health have legal and technical components, but more importantly they are political in nature. So, activists of PHM and other civil society organizations need to understand these issues and build international solidarity to fight for these. In line with this, he discussed about the patent treaty in India and displayed some pictures where peoples were protesting against it.

### **Health workforce crisis: situation, trends, migration and possible solutions**

#### **Prof. David Sanders**

Previously, health workforce used to be understood in a very narrow frame comprising of only doctors and nurses. Today, concept has been widened. The tremendous health improvement in maternal and child health is not only due to the efforts of doctors and nurses, But also due to the role of Community health workers. Therefore, the concept of health workforce should ideally incorporate health workers from every level of the Health Systems.

Prof. Sanders, pointed to Africa, which bears 25% of global burden of disease and yet countries in the region face the severe health workforce crisis. Nearly similar situation exists in South Asian countries.

Brain drain especially of doctors from countries of South Africa to countries like Canada, UK and USA is happening at a fast pace. It is estimated that Ghana alone lost £35 million as training costs of health professionals who left the country for UK during the period from the year 1998 to 2004. For thousands of South African physicians emigrating to and practicing in Canada since the end of apartheid (1994-2011), South Africa lost \$50 million as public training costs. Between 1985 and 1990, the training cost of about 60,000 professionals who left the continent was estimated US\$ 1.2 billion.

At the second part of the session, Prof. Sanders discussed about task shifting. Task shifting to well trained and motivated middle level workers were found to have positive outcomes. In Malawi, no significant differences were found between the post-operative outcomes from Clinical Officers and Medical Officers, measured by various indicators such as post-operative wellbeing, stillbirths, and neonatal mortality. In Benin, much higher percentages of children with diarrhoea received ORS and were appropriately treated with an anti-malarial by nursing aides compared with nurses. He then talked about community health workers (CHWs). CHWs are one of the cornerstones of

comprehensive primary health care. In countries where Community Based Maternal Neonatal and Child Health (CB-MNCH) programs have been implemented, dramatic improvements have occurred. Examples are Iran, Malawi, Nepal, Rwanda, Thailand and Brazil when political commitment sustained. Most of the improvement in health programs in Nepal at tertiary level is attributed to CHWs, therefore, Nepal also sets an example in this case.

Professor Sanders concluded that health work force is crucial for overall development of health sector and even more important are the roles and impacts of workers like community health workers working at the grassroots. A motivating environment for all health workers in the country will help to gain many more health goals.

### **Non-standard work and quality of health services**

#### **Mr. Santosh Mahendrakar, PHD scholar**

The next session of the day was on Non-standard work and quality of health services. Mr. Santosh Mahendrakar facilitated the session and shared the findings of a study conducted in Public Health Institutions in Delhi about non-standard work and quality of health services. The major findings he highlighted were;

- There were 10 fold increase in various health professional education institutions in ( mainly private sector) Delhi during the last few years. These professionals mainly included medical, nursing and paramedical.
- It is noted that generally the standards and quality of all the courses including MBBS, Nursing, Paramedics have been deteriorated over the years. Reasons for such deterioration need to be urgently explored.
- The study revealed that Physicians have domination in the overall health care system.
- Various health related professional associations are increasing over the years. However, the positive impacts of such growth seen in terms of job security and other well beings of health professional are very minimal. The entire contractual staffs have been found facing job insecurity.

The session raised several issues for discussion among the participants. These issues were lively discussed.

### **Experiences from struggles by Nurses in state of kerala**

#### **Jasminsha, United Nursing Association (U.N.A)**

Jasminsha was a participant from the PSI workshop. He gave an overview of movements done by Nurses in the state of kerala for decent conditions of work and about United Nurses Association, which he represents.

He also spoke at length about the issues faced by nurses who migrate to other parts of the world like west asia and Africa. He said that at times nurses would apply for employment through employment agencies. These agencies would post nurses in countries and locations which are ravaged by internal conflict and war. An example of the Indian nurses working in Syria, yemen and sudan was discussed and how the government of India had to interfere for their safety and bring them back home.

#### *Day 5 - 26th November*

Fifth day of the course started with the review of day four where participants shared their major learning reflections. The participants recalled the sessions and acknowledged that they could

understand the situation and working condition of different categories of health workforce in the region and in Nepal.

### **Health Profession Education**

#### **Dr. Arjun Karki**

The session on Health Profession Education was facilitated by Dr. Arjun Karki. Initially human resource for health (HRH) has been discussed as one of the critical components of health care system to make it functional. Illustrating some statistics, it was explained that with increasing number of the health workers, the survival chances of mothers, infants and children have dramatically increased.

Besides, in order to provide better care with improved quality health workers must be knowledgeable, skillful and dutiful. But the increase in privatization of education has been lowering these qualities. While discussing on the roles of health workers, it was felt that there is a mismatch between medical education courses that we are being provided and the real problems that we are facing. He stressed that, unless medical education focuses on the prominent factors such as environmental, socio-economic factors, we cannot achieve better health.

### **Integrating clinical care and public health**

#### **Prof Dr. David Sander**

Prof. Sanders began the session saying that the concept of PHC had strong sociopolitical implications. It also addressed the underlying social, economic and political causes (determinants) of poor health. However, medical care remained only for providing remedy to selected sick individuals focusing on bio-medical aspects of health and diseases.

Reviewing the concept of Comprehensive PHC (CPHC) he shared a history how the true essence has been distorted in the coming time. In 1980s, focus on cost-effective technologies and a neglect of social and environmental determinants led to substitution of "selective" for "comprehensive" Primary Health Care. Professor Sanders cited the example of "Child Survival and Development Revolution" acclaimed by UNICEF. SAP (Structural Adjustment Programme) in 1980s and 1990s advocated for globalization, privatization, liberalization and introduction of health sector reform based on market principles, economic efficiency and cost-effectiveness which ultimately resulted in medicalization of PHC.

The World Health Report, 2008 has been referred to see the statements such as "Health systems focus disproportionately on narrow specialized curative care". "Health systems where a command and control approach to disease control focused on short-term results fragments service delivery". "A Health system where *laissez-faire* approach has allowed unregulated commercialization of health is flourishing".

This has created the unwanted schism between the clinical care and public health, Prof. Sanders stressed. It is urgent that this schism is healed. Thus, the population perspective and concerns for the public's health should be reintegrated into the clinical departments of medical schools where they once flourished.

### **Social Determinants of Health**

#### **Prof. Dr. Sharad Raj Onta**

The session was facilitated by Dr. Sharad Onta. He says that, Health cannot be imprisoned in biomedical and technical frame, since health is affected by the circumstances where one is born, grows, works and lives. These socially constructed realities affecting health include socio-cultural, economic, political and other determinants. As Dr. Onta stressed, these determinants do not work alone, they synergize to each other and often they are interlinked at the global level.

To support this concept, health indicators of Nepal were reviewed to see the disparities among ethnic/caste groups, education level, regions, and wealth quintiles. Thus, conclusion was made; Difference in health status is not only due to biological factors rather, social and political inequities are the lead contributors.

#### *Day 6 – 27th November*

On sixth day of the course, a field visit was organized to Pharping which is a village in southern part of Kathmandu district. The motive was to acquaint participants with the initiatives of people in managing health and integrating health with other development agenda.

After an hour of travel the group reached Pharping. The participants were welcomed by the monks of local Monastery, where the participants were briefed about the projects. Then the participants visited projects of the community based NGO on health, education and environment.

#### **Health component**

A community based hospital 'Manmohan Memorial Community Hospital (MMCH) was established with the initiatives from community people. This hospital provided good quality health services in minimum affordable cost. People from Kathmandu, Lalitpur and Makwanpur are the major beneficiaries. During interaction, Dr. Suman, one of the medical officers working in the hospital briefed about the hospital services. The peculiarity of the hospital was that it originated from a small 'Roadside Clinic' with no permanent infrastructure. It is now established with 50 beds hospital where outreach clinics, telemedicine services and weekly specialist services are available. Also, the hospital has fully functional pathology lab, X-ray, ultrasound and ECG service with 24 hour ambulance services..

In further discussion, the management told the group that hospital is not free from problems and challenges. High turnover of doctors and other technical staff remains a primary challenge. Lack of fund for further infrastructure development continues to be a challenge for the organization.

#### **Education component**

There was a community initiated school named as 'Shikharapur School.' This school is known as the first boarding school in Pharping region established in 1986 A.D. Through its outstanding results, it has been recognized for quality education.

This community run school undertakes several extra-curricular activities besides academic classes. According to Mr. Niroj Shrestha, General Secretary of A School for Community (ASC), the school is also running different educational programs having collaborations with Shikharapur Community Campus, Shikharapur Community Study Center and Shesh Narayan Women School. One of the famous programs is 'Open school' where school drop out students and children deprived of school can join classes and continue their education. In addition, adult women and elderly are encouraged to join academic classes who could not continue the education in their early life.

#### **Environment component**

Under environment component, a house was constructed with the use of bottles named 'Bottle house'. It was low cost building (less than 10% of total cost of concrete house) where all the used bottles were used supported by mud and sand. In this way, community demonstrated how environment friendly plans can be executed.

### **Reflections**

Feedback session was organized where participants shared their experiences and views:

"Community people have actively participated in the initiative and were reflected through their sense of ownership. The hospital was an example for managing referral system appropriately. Community people were found working in education sector too with a good collaboration with different other sectors. This was amazing. Besides, we were warmly welcomed by the community people. We are very happy for this. We wish the road condition to village would be good."

Participant from Bangladesh

"The field visit was a great opportunity and experience for us to understand Nepalese community. We could see hospital, school and community led development works which were all inspiring. In Nepal, health workers are dutiful and very much respected by the community. Therefore, health workers should have decent payment."

Participant from Sri Lanka

"Shikharapur is a beautiful place with pleasant weather where we could see Mountain View as well. Besides, community commitment and joint efforts for social works are additional beauties of the village."

Participant from Pakistan

"The concept of bottle house is very inspiring and can be replicated in other places of Nepal too. We felt community support is vital for the improvement of health care system. Also, community people could demonstrate clearly how educational programs can contribute to improve the health status of the entire community."

Participant from Nepal

"It was a very good learning experience. We were introduced with a community led health movement where community owns every facets of it."

Participant from India

### **Feedback and suggestions**

Participants reflected that it would have been better if an opportunity was provided to interact with grassroots directly and more time was allocated for field visit.

The field visit had another aspect too that is to visit a historic place of Nepal 'Swayambhunath', a famous monastery in Kathmandu and a symbol of religious harmony in Nepal since it has temples inbuilt in it and people belonging to all religions can visit. Participants appreciated this visit.

#### *Day 7, November 28*

The seventh day commenced with the reflections of the sixth day field visit. Participants were impressed with the organized effort of community members in managing health and education works simultaneously. Participants reported that the idea of "bottle house" was an excellent example to promote the reuse of materials.

### **Gender and Health: Gender approach to health**

## **Ms N. Sarojini**

After a short feedback session, N. Sarojini, focal person of SAMA, started the session on “Gender approach to health”. Commencing the session, she clarified the concepts of sex and gender: sex as biological characteristic while gender as socially constructed. Terminologies such as gender mainstreaming, gender equity, gender role socialization, sexuality and sexual minorities were also discussed through group brainstorming. She emphasized that various factors play role in the construction of gender roles ranging from home environment to schools and larger societal level determinants. Whenever we talk of gender, women are referred however, it implies to all; men, women and transgender. Sarojini clarified that as researches have revealed, in South Asian context women are more discriminated and hence the issue is more referred to women.

She added a note, women condition should not be generalized since they are not homogenous group. They have different status as per their social standing, caste/ethnicity, family backgrounds, education status, residency and different other socio-cultural factors. For example, studies have shown that, health condition of Muslim, Dalits and Tribal women are found poorer than other groups. Different government policies were reviewed briefly in the session to see how the criteria in policies exclude poor and minorities from getting different benefits, services and participate in development process. Facilitator threw light on the situation of homosexuals in South Asia. After listening to participants from all five countries, it was realized that except Nepal, all countries have criminalized homosexuality. There was an in-depth discussion on homosexuality and how they are denied of basic human rights including right to health services and its effect on their health conditions.

Other reemerging issues mainly trafficking, anti-immigration and phobias were further dealt. Facilitator focused to rethink if gender issues can be solved by adopting human rights principles. She asked further, would the determinants of gender inequality be addressed with our joint effort at different levels viz. individual, family, community and society? Facilitator Sarojini concluded with important remarks that these issues, as gender, are not well integrated in health policy and service agenda, without which justice for people we are talking cannot be achieved..

### **Panel discussion**

The second session was a panel discussion on the topic “Building the movement for health.” Five representatives, one from each participating country were selected as panelists. The program was moderated by Dr. Amit where Prof. Dr. Sharad Onta and N. Sarojini backed as experts. Other participants served as interactive audiences.

First, Dr. Amit discussed, a few issues with the panelist on taking the movement for “Health for all” ahead. Participants were requested to share their understanding on what should be done. The discussion is as follows:

Amit - How should the movement for health be understood?

Panel - The panelists discussed that

- Movement is a process of social mobilization where we advocate for human rights and just society.
- Movement is based on issues, rather than focused to individual problem.
- Movement is a continuous process, not an event with certain time limit. With this aspect, it differs from NGO which is usually driven by donors' interest and has certain time frame. Movement is self driven, led by people and has a larger purpose, broad outlook, clear



mission and vision therefore it continues. NGO is project based and has specific tasks to accomplish in certain time interval. Besides, NGO is accountable to donors; however movements are accountable to its people.

Amit- What principles should a movement has to? How do you made a movement broad?

Panel - The major arguments made were:

- Movement needs to involve all groups of people irrespective of caste, sex, wealth, nature of work one is involved into and other social hierarchies. Even people who are involved in private sectors, they can participate in movements. One of the basic tenets of movement is that it should not be the barrier to any people to participate in. However, adherence to the aims of peoples health charter was felt necessary.
- To make it broad, there is a need for strong network and the movement should be spread to all regions of the country.

Amit- Why do we need movement in health?

- Due to growing privatization, inequalities, inequities and disparities in health. Movement is a group effort and we need more movements for justice in health.
- People should be involved in movement for greater ownership and sustainability. Movement works with people not for the people. Therefore, it should start from below.

Amit- Is it so that movements are political?

- Movement is the struggle for our rights, therefore it is a politics.

Amit- What is the situation of health movement in different South Asian countries? Analyse as per movement principles.

- Movements in these countries are being much broader. However, more and strong network is needed. Movements should spread to all regions of the country.
- Currently the major issue on which South Asian countries are struggling is increased privatization in health sector.
- There is a need to create alliances. Currently, only health professionals and development activities are involved in the movement.
- Health movements should not be restricted to narrow definition of health and health care. Youths should also be involved in the movement and it should be broad to succeed.

Amit- Sometimes the organizations that start PHM are restricted by their vision, do not go to public. Is this right?

- Leadership of movement should be headed on rotation basis. It should not run by one organization or agency. This implies a movement leader should be able to transfer the spirit of movement to the public. Also it should have shared leaderships.

Amit- What is the benefit of small organization to be the part of larger movements?

- Movements provide vision to smaller organizations and opportunity to strengthen and expand networks. It also gives clues to smaller organizations to be based on issues.

Amit- How an individual can be a part of a movement?

- He or she can be dutiful to his/her job. This is a first step towards being involved in the movement.

Amit- What is the difference between organizing and mobilizing?

- Mobilizing is a part of organizing. After mobilizing, we need to organize. This implies discussions and decisions on how to plan, perform, and evaluate the movements.
- Internet activists can only mobilize, they can't organize. They do not have organizing strategies.

Amit- How important is global work to the local issue?

- We can learn from each other experiences.
- No issue is local. It is affected by and has effect to many parts of the country.
- Various ratifications, declarations are required to solve local problems. Examples are CEDAW, FCTC, etc
- Until and unless global activism is linked to local issues and specific context, it won't create a movement.

Amit- Can a movement be run without external funding?

- It is possible. We need to find out different resources rather than donor driven traps.

The panel discussion was concluded with the saying by Dr. Onta - "There are more criteria to exclude the people in the movement rather than include them. Therefore, we should not be obsessed by possession of ownership of movement in narrow sense, create alliances and involve as much as possible people in the movement. "

After a tea break, there was a presentation session by every country group on their country health situation, gaps, challenges and possible way outs. Presentation was followed by in depth discussion. All the sessions were then wrapped at 5:30 pm.

#### *DAY-8, 29th November*

The 8<sup>th</sup> day started with the feedback session of 'Gender and Health', conducted on 7<sup>th</sup> day. Participants acknowledged the sessions on gender and health since it was awakening on gender issues in South Asian countries. The participants appreciated the panel discussion - its facilitation and the contents of discussion.

#### **Thematic Group Presentation**

After the review session, thematic groups, comprising of participants of different countries in each thematic group, presented their works on the following assigned themes:

1. Globalization, Trade and health
2. Social Determinants of Health
3. Health Workforce condition in South Asia
4. Primary Health Care- Alma Ata Declaration principles of PHC Existing Health Care Model

#### **Globalization, Trade and Health**

The team members of the group, gave an introduction about what globalization is and how it has impacted the healthcare services across the world. It was felt that, the trio of liberalization, privatization and globalization have acted negatively on health.

The team described how sections of population in developing as well as developed countries were plagued by socioeconomic conditions that only increased illness. Examples of the changes in South Asian countries after the pro-globalisation reforms in 1980s and 1990s was elaborated.

### **Social Determinants of Health**

After a brief introduction to the topic, the team members started discussing the Social Determinants of health in South Asia. South Asia is known to have many types of discriminations based on gender, caste, religion and ethnic issues. It was felt that there would be no progress in the Health for All in this region until and unless the Health Systems address these determinants of health.

Examples were given as to the health situation of women and sexual minorities. Caste also being a major determinant to health. A case was made as to how the MDG data showed the variations within countries.

### **Health workforce condition in South Asia**

The team discussed the crisis, overload that is being faced by health workforce in the background of neoliberal policies taken for Human resources for Healthcare. The team members explained that privatization of health services has had a negative effect on the working conditions of Health workforce.

An increasing contractualisation of employees was a common problem across the southasian countries. None of the countries in southasia followed the “ Global code of practice on the international recruitment of Health personnel”. Another common problem in the region were the unmet demands and exploitative working conditions of Community Health workers (CHW).

### **Primary Health Care- Alma Ata Declaration principles of PHC Existing Health Care Model**

The presentation was started with the PHM video on Universal Healthcare. The members of the team discussed the importance of Primary healthcare as a holistic answer to the health crisis in the region. It was discussed that, selective primary healthcare interventions in the region have not been able to deliver Health for All.

The presenters also elaborated on the issue of universal health coverage. Universal Health Coverage ( insurance model) was seen as an initiative that was not enough to achieve better health and was actually derailment of the demand for “Universal Healthcare” and Health for All.

Southasian countries were being pushed to undertake the insurance models by pressure from

Each of the presentations was followed by active discussion among the participants. The participants shared their views on each of the themes. Some of the participants asked the group for clarification of some of the issues.

### **Country Group Presentation**

After the presentation by thematic groups, country groups presented their works. Each country shared their country's health situation using a framework of equity and justice. Also they shared about their plan to build the movement for health in their country. In their plans, three agendas were included:

- Steps for building the movement
- Approaches to participate in the movement and

- Communication strategies within the movement

After that, three priority campaigns of the movement were identified and shared by the groups. Campaigns were designed based on the most important issues of the country. They further explained how these campaigns are relevant in the country.

After the completion of all presentations, facilitators Dr. Amit Sengupta and Dr. Sharad Onta provided their inputs with a critique on each presentation.

#### *Closing Session*

In the closing session, certificate of participation was distributed to participants by the participants themselves in turn. The letter of appreciation was provided to the volunteers of IPHU, who significantly contributed to the success of the IPHU Nepal 2016.

The PHM - IPHU Nepal 2016 was declared closed with closing remarks and vote of thanks by Mr Shanta Lal Mulmi. The closing of IPHU course was followed by cultural program where participants danced and sang together.