

# **7<sup>th</sup> HM Patel Memorial Lecture**

## **“To Be The Change”**

Rediscovering The Spirit of Service in  
Health Care in India

by

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**Charutar Arogya Mandal**

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## **“To Be The Change”**

### **Rediscovering The Spirit Of Service In Health Care In India**

May I begin by thanking the Chairman, the CEO and all those here at Charutar Arogya Mandal for the totally unexpected invitation and opportunity given to me to be here today and to deliver the 7<sup>th</sup> H M Patel Memorial Lecture. When I received a phone call from Shri Sandeep Desai, I was sure he had got the wrong number. I live and work in small, off-the-map place, and the last thing you expect is to be invited to such a great honour as this. And then I read more of what you are standing for and doing here at Charutar. And I saw the list of illustrious people who have given this Lecture before me, and read their scholarly texts. And I said to myself – “Somebody’s made a big time mistake ! I hope I don’t let them down”. So as I stand here before you, I wish to do so with the humility of the knowledge that I have nothing to offer but myself, and reflections from my life journey, and hope that this may be of some inspiration and meaning to you, in your own journeys.

Over 50 years ago, my father and some of his friends quit College to follow Gandhiji. They were studying Theology in Serampore College near Calcutta, and in response to Gandhiji’s call for help, they landed up working in refugee camps in Ambala, loading and unloading passengers onto and off trains across the border, burying bodies, sharing the pain of our people. In May and June this year, I took 6 weeks off from work to sit at the feet of my 90-year-old father, and to listen to him – something I did not consider necessary when I was 17 ! As I listened to the stories of those days

and the many years since, I was amazed by the privilege we have to belong to our country; to the heritage of Gandhiji's personality and action. And so I would like to anchor my thoughts this evening around one of his oft-quoted, oft-misused statements, something I have come to discover to be true in my own life and experience:

*"You have to Become the Change You Want to See"*

I would like to first share the story of my journey thus far, to provide you the context from which these thoughts emerge. I will then share my reflections in three segments. And if you are still awake and with me at that time, I will try and sum it all up.

My Personal Journey:

I am originally from Kerala, but I grew up in Tamil Nadu, where my father was the Chaplain at the Christian Medical College & Hospital, Vellore. My mother, a teacher by training and a fulltime mother by choice, provided my 4 sisters and me the family we needed to explore the world from.

In my school days, I had sworn I would not do Medicine. But a chance encounter with an eloquent beggar stimulated a change in my thinking. The old man, irritated by the way he was treated by those he sought money from, cursed them all, and said – "The Prime Minister and I were both born naked. To hell with your money." This line captured the imagination of a friend and me, at that most vulnerable point in life – the study holidays just before the final Plus Two Exams. Our analysis of this statement led us to the conclusion, that nothing

we have is really our own, neither the material possessions nor the opportunities we got; they belong as much to the man on the street as to us. The temptation to quit college just before the exams was great, but the wisdom we arrived at was that all the opportunities we have must be used for those who did not get them. When you are 17 and you reach this Nirvana-like point, life takes a speed of it's own. My options were then Journalism and Medicine, and I landed up in the MBBS course at CMC, Vellore in 1980, convinced that this was for the greater cause. I am afraid Anatomy and Physiology classes were a poor culture medium for such noble naiveté, and philosophy has a way of evaporating with the next party. But when I finally got to Community Health in third year, it all came back again; the jigsaw pieces of the curriculum started making sense.

After my MBBS, I had two years of Sponsorship Obligation Service as is the rule in Vellore. The first year was in the Community Health Dept at Vellore itself. For the second year, I was sent to a mission hospital in Orissa in a place I hadn't heard of before. The Christian Hospital, Bissamcuttack was in the middle of nowhere, as I saw it then. But it was all I had ever dreamed about. That year there (1987-88) gave me a glimpse of what could be. I returned to Vellore to do my MD in Community Medicine, and in 1993, I returned to Bissamcuttack with my wife, Mercy John. She became the Principal of the School of Nursing and I took on the Community Health programme. This has now been our home, our work, our passion and our hobby for over 18 years.

Let me tell you something of the region, the institution and our work.

Bissamcutttack is a village of about 9000 people in Rayagada District of Orissa, in what the misery index people call the KBK region – Koraput-Bolangir-Kalahandi. What they do not tell you is that it is a really beautiful place, with negligible pollution levels, green hills and mountain streams. The Bissamcutttack Block has about 315 villages, with a predominantly Adivasi (62%) and Dalit (17 %) population. This is part of one of the most strategically crucial parts of India today – what I call the “M” area – Mountains, Minerals, Multi-National Companies, Malaria, Malnutrition, Maoists, and Many More M’s. But all this is nothing compared to the beauty of the region and the goodness of the people. The old India. The India that is fast disappearing.

In 1954, a Danish lady doctor called Lis Madsen, heard about this region with huge health problems and negligible health care access. She sold her practice, came to Bissamcutttack and started a small dispensary to provide basic health care to the poor. Over the last 57 years, this small effort has grown in response to need and through the life-investment of caring people, to become the Christian Hospital, Bissamcutttack of today – 200 beds and 250 staff on a 16-acre campus. Those who came before us struggled to establish a culture of caring and standards of professionalism; the difficult balance between situational excellence and social relevance. Dr Virendra Kumar Henry, Mrs Nancy Henry, Dr Padmashree Sahu are all stalwarts who led from the front. Today, we have an average of about 200 outpatients and 180 inpatients

in the hospital on any normal day. Around 2000 babies are born in the Labour Room each year. Over 4000 surgeries are performed in the 5 Operation Theatres. All this may not seem exciting or unusual in urban India; but the location makes it different. To be able to do this in a region like Koraput, makes it special. For our patients, there are very few alternatives, and that makes it even more important that we do our very best. Constraints are part of the game, getting caring and competent people being the most critical. But 57 years down the line, we have come to stay.

A hospital in as vulnerable a place as this cannot be just a hospital. We are part of the larger fabric of the place. And we have to widen our engagement with need. In 1978, we started a School of Nursing, that today has about 100 students; all from Orissa; being trained for Orissa. In 1986, we started the New Life English Medium School, which now has over 400 students, working their way towards the ICSE exams. Some of the first products of the School are now Engineers in different parts of the country, while others - one doctor, two lab technicians and more nurses have come back to serve in our hospital.

My passion is Community Health. Our Mitra programme works with about 12,700 people in 53 predominantly Adivasi villages. We set up a simple, manual Management Information System in 1994 which told us that our Infant Mortality Rate was a scary 201 per thousand live births. Under Five Mortality was at 356. A third of all deaths were Fever Deaths that appeared to be mostly due to Malaria. It was clear that what I had learnt in text-books and ivory tower class-rooms was

going to be grossly inadequate for the task at hand. We gave up on traditional, classical approaches to community health many years ago, and moved to Community Dreaming Sessions. The Mitra Dream is now 4 fold; We dream that one day all our people will enjoy Health For All, Education For All, Economic Security For All and Social Empowerment or Dignity For All. To us in the Mitra team, Community Work is a Relationship with people. The expression of that today includes a Primary Health Care programme managed by a team of Community Health Nurses. They run two village health centres, with monthly mobile clinic visits to 50 villages. The journey has been fascinating and stimulating. The marriage between the art and science of Community Health and Epidemiology (“Thinking Globally”) on the one hand and Grassroots Involvement with people (“Living Locally”) on the other, produces many an interesting off-spring. The Peoples Movement Against Malaria helped create innovative and scientific strategies for Community-Based Malaria Control. Ageing With Dignity is a programme that aims to sensitise our younger generation to respect and care for their elderly. The Sickle Cell Anemia Club is for families with homozygous Sickle Cell Anaemia who need the companionship and encouragement of others in similar situations. The Mitra Community Health Insurance Project is a small attempt by Women’s Groups to help each other with health care costs in times of illness. And so on. These are not huge, earth-shattering things. But together they offer some candle light in difficult circumstances. The Infant Mortality Rate has come down from 201 per 1000 live-births in 1995 to 99.6 last year. The Perinatal Mortality Rate decreased from 93 per 1000 births to 59 in the same period; a slow but steady change towards health.

Our Community Dreaming Sessions pushed us in another direction as well. The tribal elders told us that Health Care is nice but Education is more important. The single biggest game-changer can be quality primary education. But we, a nuclear super power, are unable to provide an assurance to children that our primary schools will be open and a teacher will be present, who will provide, at least, quantity of education, if not quality. In 1998, a Dreaming Session in the hill-tribe area, forced us to start a school of their own, true to their culture and ethos – the Mitra Residential School, Kachapaju, a joint project with 16 Malkondh villages. The School now is from Grade 1 to 5, with 155 children, learning together in their own Kuvi language and in Oriya. Spoken English comes in first year, and the fifth graders now learn to use computers: net books that have to be taken to another village for charging, as electricity has not yet reached MRSK.

But we can only take in about 30 children a year, and this from the 16 Malkondh villages. What about all the other children ? This led to the birth of another idea – the AQTE Project – “Adding Quality to Education”. This initiative now helps parents and village committees to ensure the Government Primary Schools in their villages function, by placing volunteer teachers hosted by them and guided by us, to actually get education going. This now consists of 22 such teachers with about 750 children.

But then older children are often the primary care givers for toddlers. Put them in school, and what will happen to their younger brothers and sisters ? So this led to the starting of

MKB's – ("Milla Kahini Basa" in Kuvvi means Children's Play Place) where an adolescent girl from the village – the Sishu Didi – is available to look after the children, guided by the Mothers Committee.

And the sky is the limit. So much to be done. Such fun. And we are privileged to still be around to see the difference happening. The Change we dreamt of has begun.

Now before I go totally overboard, let me also put down the needed Disclaimers or applications for Anticipatory Bail, as it were. All these things look great on Power Point Presentations. Reality is different. Life does not fit into PPTs. There are those inevitable days when you feel both Powerless and Pointless. And I do not want to present a rosy picture that is untrue and egoistic. We make mistakes and keep falling down. But I will still say – It's been a good journey, and we are enjoying the ride. And there's miles to go before we sleep.....

I would like to now move on to Reflections from this journey; thoughts that I would like to place before you for your consideration.

## **A. Re-visiting the Concept of Community Health**

The term 'Community Health' means different things to different people. To many doctors, it is essentially a boringly-taught subject from 3<sup>rd</sup> MBBS, which went by deceptive acronyms like SPM. To many clinicians, it is dismissed as poor medicine for poor people, doled out by some staff on a mobile clinic jeep in some God-forsaken village. To Hospital

Managers, Community Health is a romantic publicity stunt that drains the tight financial and man-power resources of a hospital; or on the other hand, a milk-cow that can bring in project funding, vehicles and salary support that can then be diverted for more “vital” areas in the hospital. Or is it the band-wagon and slogan for kurta-clad jhola-wallahs who swear by it in conferences but rarely live it out ? Or the fiefdom of fat consultants, who manage to rake in the moolah and take the high moral ground at the same time ?

Yes, Community Health can bring all these pictures to mind – and more. But what should it mean?

I would like to share a philosophical / ideological construct or thought sequence that undergirds our understanding of Community Health and forms the basis for the Mitra approach.

- A. The ultimate aim of all health work – be it neurosurgery or immunisation – is **Health For All**; the attainment of an acceptable level of health for all people; where health is defined as physical, mental, social (and spiritual) well-being, and not just the absence of disease or infirmity. Or Health For All as envisaged in the Alma Ata Declaration and reaffirmed in the Millennium Development Goals. (Maybe we should reaffirm that Health For All is different from Health Care For All – often mistaken for each other, but very, very different)
  
- B. Community Health (or Primary Health Care too) is one of the key approaches to making this happen. Simply put, **the aim of Community**

**Health is a Healthy Community.** All possible interventions that contribute to making a healthy community come within the potential mandate of Community Health work. This includes both the promotion of Helmet-Use and the treatment of Head Injury; the selling of Mosquito Nets and the treatment of Cerebral Malaria; Policy Advocacy, Research and Health Care Delivery.

- C. For Health For All to happen, it is not a choice between **Either** Hospital Medicine **Or** Community Health. It is **Both-And; Both** Hospital Medicine **And** Community Health. These are not competitors or antagonists, but two synergistic forces that complement each other, but approach the issue from different points on the spectrum of health and disease.
- D. If a Doctor or Nurse wants to move from A to B, what is the perspective change that needs to occur ? It is not just a question of taking a doctor, a nurse and a pharmacist and putting them under a tree in a village and seeing patients there. That is an Extension Counter of the OPD, not Community Health. It is not a question of Latitude but of Attitude; not of location but of perspective. You can sit in a hospital and practice community health; or go to a remote village and practice what is essentially hospital medicine. What are the key differences between the practice of Hospital-Based Medicine and Community Health?

i. **The Target / Beneficiary:**

In Hospital-Based Medicine, our target or beneficiary is the **individual** patient that presents to us. He or she can be from wherever in the world, but they become my focus by entering through my gate or registration process. I then take his / her history, do an examination, perform some lab tests, come to a Patient Diagnosis, make an Intervention Plan, and institute Follow Up.

In Community Health, the target or beneficiary is a Group, defined either geographically as the people of 'X' village or district or panchayath; or defined by some characteristic like age (the elderly or children) or problem (as in people with HIV or Disability). The Group is made up of individuals, but the focus is on more than just that; it includes their inter-relationships, their environment etc. The Process then is similar; we collect a history from the Group, of maybe Births and Deaths or Health Events amongst them. We do some examinations, like heights and weights of children. We do Epidemiological Investigations. We come to a Community Diagnosis that includes both things that are good and things that are bad; factors that are medical and factors that are not – like social and economic diagnoses.

We then together make an Intervention Plan and a strategy for Follow Up.

The processes are similar, but the target is different: Individual vis-a-vis Group.

**ii. The Starting Point:**

In Hospital-Based Medicine, the starting point is usually Disease. It is the sick who come to the hospital. And the aim is to reduce or cure the disease.

In Community Health, the focus is Health, and how to increase it. What can we do to keep people Healthy, is the question we ask. Both are in the same direction, but we start at different points on the spectrum. A Hospital Doctor interacts primarily with people who are sick. The Community Health Physician or Nurse or Social Worker deals with both sick and well people, the abnormal and the normal.

**iii. The Power Equation:**

In Hospital-Based Medicine, the power is in the Providers Hands, symbolized by the Doctor. The patients rotate around the hospital; they have to access it, and depend on it.

In Community Health, the Power is with the Community. The Health Care Personnel

depend on and facilitate Health.

The difference between seeing patients in the hospital and seeing patients in the community is a bit like the difference between seeing a tiger in the zoo and meeting one in the forest. In a zoo, one can make faces at the tiger or say Boo. The Tiger can at best roar and chafe at the bars. But if you meet a Tiger in the forest, it's his turf. You are very respectful. You say Namaskar and climb a tree !

**iv. The Indicators for Measuring Success:**

The success or performance of a Hospital is measured by the increase in patient numbers, bed occupancy rate and income earned from patient care.

In Community Health, all of these could be signs of failure. The indicators would be Decrease in Incidence and Prevalence of diseases, Mortality Rates, and maybe increase in Utilisation of Immunisation or Antenatal Care Services.

It is important to make sure the indicators you choose are appropriate to your goals. In many a SWOT Analysis, the labels on perceived Strengths and Weaknesses could do with an inter-change ! Many Hospital Managers see Community Health work

as a way to get more people to come to our hospital. Number of referrals is used as an indicator of good performance. Some others see Community Health as a threat to hospital viability; "If people don't fall sick, what will we do ?" This dilemma is true even for Mobile Clinic trips to villages. In reality, the issue is not so simplistic. Community health work tends to increase health care utilization but changes the kind of care utilized from late treatment of severe disease to promotion, prevention and early diagnosis and treatment of illness. And don't worry, society has a way of producing new work for health systems, when old issues get eradicated; remember HIV and Geriatrics and so on. And there will always be child-birth and psychiatry and trauma.

- E. A Caring and Scientifically Honest Hospital will necessarily also get involved in Community Health work of some sort. A Cardiologist who treats Ischemic Heart Disease but does not see the need for preventive cardiology is not being a good cardiologist. A good Oncologist who treats the disastrous complications of tobacco is inevitably drawn to the question of prevention of tobacco use. An Obstetrician who struggles to save mothers with ruptured uterus, inevitably has to ask what could have been done earlier in the chain of events that led to this tragedy. And so

on. These are, in that sense, not separate people or turfs; but complementary perspectives.

The Community Health Department of a hospital then becomes the Window of the institution. A Window in and a Window Out. The prism through which the hospital team is able to see the world outside, and the glass through which the community around is able to look into the hospital. The Community Health Team often becomes the face and the interface for the hospital with the community.

From your reports here in Charutar Arogya Mandal, I can see that you are doing most of this. But in the family of Community Health Professionals in most other parts of the country, we seem to have lost our soul. We preach without practicing. We guard our turf in the medical curriculum without being willing to rise to the standards that govern our more clinical colleagues. We have a terrific, exciting subject in our hands, but we manage to bore the daylights out of our students. I suggest that we need to perk up and make Community Health the inspiration for contextualization of the medical curriculum.

## **B. Some Specific Lessons I have Learnt on the Journey:**

### **I. To Ask “Why ?”**

Of all the words in any language, “Why” must be the most hated. Little children enjoy the Why-Game,

irritating adults with their constant, repetitive Why questions. (And so we send them to School. And then all their questions stop !) We need to constantly question the assumptions we depend so much on. We need to dare to ask Why. We need to encourage our students and our young people to chase their Why's.

In Public Health, we are finding the need to re-visit the Key Words we use. We have allowed some words and their connotations to define and limit our understanding of issues. In asking the Why question, I have found some of my closely-held ideas demolished. For example:

**Development:** What do we really mean ? Who is developed ? Who is not ? I find that most of us, knowingly or unknowingly, define ourselves as the gold standard of development. Communities then get classified as 'backward' or 'developed' depending on where they are in relation to us. And much of what we do in development work is to try and make them like us. When working with an Adivasi community whose social development is often far ahead of our urban upbringing, one runs into trouble. Before we do too much damage, it's a good idea to open up our own locked understanding.

**Malnutrition:** I find that the word sends our thinking off down one particular alley. The minute we say Nutrition or Malnutrition, we think Food. The Nutritionists will go off into a debate on Zinc and Magnesium. The Economists talk of Poverty and Purchasing Capacity. The Sociologists talk of Food Security and Food Diversity. And Doctors do Disease. After years of barking up the

wrong trees, we in Mitra asked ourselves – Why do we want to define what tribal people should eat ? We realized that we were getting terribly worked up about the Input factors, when maybe we should be looking at the Outcomes. What do we really want ? That all children should be healthy and well. We monitor their growth with measurements of weight and height to provide indicators of whether they are healthy or not. If the child is happy, healthy and growing well, it really does not matter whether they are eating newspaper or a five-course meal. The converse is also true.

While searching for ways to help our most malnourished children in our project area, we found that the problem was not with their food – it was in the fact that most of them were positive for Malaria all the time. We treated them for Malaria and put them on Chloroquine prophylaxis and their weights jumped significantly. This led us to a radically different approach to “Malnutrition”. We moved from comparing our Adivasi children’s weights with those of children in USA or Brazil, to actually doing Growth Monitoring; asking what is the weight change of this child since last month, and discussing that with the parents. We did mass surveys on point prevalence of malaria parasitemia in children under 5 years of age, and found an astounding 59 % of children positive, with or without fever. This correlated with similar work we are doing through partner NGOs in neighbouring districts.

It dawned on us that this was Malaria-Induced Malnutrition or “Mal-Mal” and we needed to look

at them together. In 2010, we started doing Mal-Mal Camps in our programme villages, for Active Screening and Treatment of Children for Malaria, embedded in our Growth Monitoring programme. This year, we are half-way through our second round of Mal-Mal camps and the impact is interesting. Point Prevalence of Malaria Parasitemia in the Under 5 Children of 27 high prevalence villages that have completed their second round of Mal Mal Camps has decreased from 71.5 % (430 / 601) to 44.9 % (260 / 578). The Nutritional Status and Growth Patterns of children also improved during this period. The percentage of children in Grade 2 and 3 Malnutrition decreased from 28 % to 21 %.

This taught us of the need to question the walls of the compartments into which we have boxed ourselves, that have limited our lateral thinking and integrated interventions.

**2. The Question of Viewing Points:** What we see seems to depend on where we look from. For example:

a. Provider / Consumer:

Education and Schools look very different depending on whether you are the student or the teacher, the parent or the Education Minister. Where you look from determines what and how much you see. The same is true of Health Services too. Our viewing point can blinker our view. Hospitals seem very different to patients as against to hospital staff. Health Planners very often

cannot see the issues that clinicians are seeing and engaged with. Public Health people like me very often miss the value of the individual in our pursuit of significance in statistics. For us to see the whole, we need to be able to step back and see from others' viewing points too.

b. Outside / Inside:

Similarly, in Community Development, I find we tend to look at people as if they are some anthropological specimens. We often think we know what is best for others, though we have not identified with the sweat and blood of their existence. To plan for true development, we need to find ways to step across the divide and see from the inside. The Insider Perspective makes us realize how hollow so many of our plans are, and the arrogance of our thinking.

I thought Roads should be the priority. My Adivasi colleagues told me that's because you don't walk enough.

I thought my programmes need to be Sustainable; the Tribal Leaders told me I was doing a good job of begging for resources, and I should do it some more !

c. India and Bharath:

We seem to be two nations in one; two different paradigms; two identities interconnected like Siamese Twins. In India, there is an IT Revolution

and growth and change and non-stop action and the benefits of liberalisation. In Bharath, the situation is getting tighter. Here too there is change, but at a much slower pace, thereby widening the gap further. The leaders rule from India. The voters live mostly in Bharath. And there is surface tension in the interface between the two. India and Bharath exist in the same place, like two sides of the same coin that never see each other.

When we stick to our viewing Points, refusing to budge, we fail to see the larger truth. We need to be willing to cross the boundaries and see from the other side too.

### **C. India's Credibility Crisis**

We are facing a Credibility Crisis in our country, a Cynicism Explosion. In Politics and in Cricket, we are realizing there is more to the game than we thought. The level playing fields of Business and Industry are not as level as they are made out to be. Our heroes come tumbling down, like Humpty Dumpty who cannot be put together again. There are very few people we know in our public life whom we can believe with absolute confidence. The Media makes and breaks reputations at breaking news speed, trading sensationalism for accuracy. Movements and Counter-Movements offer us fleeting hope before they sink under the weight of their own contradictions. Religions become more assertive, but the presentations of God lose credibility because of his defendants and proponents.

In this scenario, Health Care Professionals have an opportunity to be an alternative. The special place we have because of the pain and vulnerability of our patients could be a context to demonstrate honesty and credibility. But we have not been immune to the moral decay ourselves. Commercialisation and Greed have eaten into us like a cancer of our soul. The public now doubts us and justifiably questions our prescriptions for medicines or for life. The plastic in the environment is now in our souls; we can't feel anymore. We have lost our sensitivity.

And yet, all is not lost. Young people are the hope for a new paradigm. They have an energy that seeks direction. And they are searching for alternatives, for people they can respect, trust and emulate. For Gandhiji-like people. It is there hidden in our genes, but we need to rediscover our souls.

May I suggest three small ways to restore our soul-force:

**I. Focus on the Poor:**

They have something special to offer us. Their vulnerability can bring back the sensitivity into our systems. In a world where power is the name of the game, Opt Out. Choose to follow your heart. In whichever branch of medicine or health care we are in, make friends with the poor or the marginalized or the powerless. The market says focus on the rich and the powerful; or at least on their wallets. The soul of India says focus on the poor.

## **2. Share the Pain of People:**

How do we approach our patients – As an academic puzzle to be solved ? As a professional assignment to be fulfilled ? As a potential income source to be tapped ? As a potential litigant to be foiled ? We are taught that in professionalism we should stay on our side of the table and hand out the prescriptions to the patient on the other side. I suggest we should cross over; get alongside; so that we can share the pain of our patient, whether it be the physical pain of cancer, or the emotional pain of child-loss or HIV. Get alongside, feel the pain, and now it becomes us and the patient and family together against the disease or the problem. This opportunity to share the pain keeps us human. Our total dedication to social anaesthesia , to the avoidance of pain in our lives, makes our souls plastic.

A young man from a top institute in the country came to me for an internship. I gave him the assignment of visiting 10 mothers who had lost their children; to sit with them, listen to them and share their pain. And then to write up for me what he felt and how, from that perspective, we may have prevented this tragedy. He tried every possible excuse to get out of it. But he was a good guy with a twistable arm. He did it. And he cannot be the same again. The brilliant professional who I predicted was in line for a direct flight to a job in Geneva, is now working with the NRHM in a district in Central India.

Our young people are not callous or uncaring; maybe they are un-exposed and un-stimulated. They need the challenge of reality, to inspire them.

### 3. **Be-ing and Do-ing:**

When I began working in Community Health many moons ago, I thought I needed to save the world. I ran around chasing my tail, trying to set every wrong right. Over the years, I have learnt that we need to BE; that our Doing needs to be an outflow of our BE-ing. We see people “Do-ing” Gender Sensitivity Workshops which fail because they themselves are not gender-sensitive. Our students and our patients are not fools. They see through our charade. We can run a massive Anti-Corruption Campaign or an Anti-Malaria Campaign or whatever. But change comes, as Romano Guardia says – 10 % from what we say; 30 % from what we do and 60 % from who we are. People can sense fakes from a distance; they have seen so many like us. And so, as Gandhiji said – “We have to become the change we want to see”. If I want my students to be caring, I have to be caring. A lecture on Caring Techniques will not suffice. If I want my son or daughter to grow up to be honest, there is no way that is going to happen if I am dishonest myself. We can fool the whole world, but we cannot fool our own kids. We have to Be The Change.

To the students of Charutar Arogya Mandal I would say – You are greatly blessed and privileged to study here; an institution that aims and perseveres to be different; that believes in an alternative paradigm. What you do with the opportunity, is your choice. I want to challenge you to choose the road less travelled. Discover our country. Take a break at some vantage

point and visit Bharath. Understand the greatness and the beauty, the sadness and the joys of our people. Have the guts to say No to treading the beaten flight, and opt to Be the Change. This is not just relevant to the young and impressionable student. All of us in the health care profession need to rediscover our souls; to remember why we as little children said we want to be a doctor. It was not for the big car or the pay packet. So to all of us in the health care profession - doctors, nurses, allied health professionals, generalists, specialists and super-specialists – let us Be The Change in our own small corners.

Our history as a nation tells us what happened when one man from Gujarat decided to use the power of powerlessness; of vulnerability and integrity, to Be The Change. His footprints beckon.

Thank you.

## Brief Bio-data

- Name :** John Cherian Oommen, MBBS, MD
- Profession :** Doctor ; specialised in Community Medicine
- Date of Birth :** 11 October 1962
- Address :** Christian Hospital, Bissam Cuttack,  
Rayagada District, Orissa – 765 019
- Designation :** Team Leader, MITRA & Head, Community Health  
Dept. Deputy Medical Superintendent, CHB

### **Educational Qualifications :**

- 1985 : MBBS ; from Christian Medical College, Vellore, TN, India
- 1992 : MD (Community Medicine) from CMC, Vellore, TN, India

### **Work Experience :**

- 1985-86 : Rotatory Internship in Surgery, Medicine, Obstetrics, Paediatrics and Community Health, at CMC Hospital, Vellore, TN, India
- 1986-87 : Working with the CHAD hospital of the Community Health Dept, Vellore
- 1987-88 : In charge of Child Health at the Christian Hospital, Bissam Cuttack, Orissa
- 1989-92 : Undergoing Post Graduate training in Community Health in CMC, Vellore; MD Thesis related to Socio-Economic Risk Factors for Peri-natal Mortality
- 1992-93 : Medical Officer, Rehabilitation Institute, CMC, Vellore ; Primary responsibility was to develop a video-based Patient Teaching Module on Spinal Cord Injury
- 1993- : Head of the Community Health Dept, Christian Hospital, Bissam Cuttack, and Team Leader of MITRA (Madsen's Institute for Tribal & Rural Advancement)
- 2003-04 : On Sabbatical : worked in the Medicine Dept, Christian Fellowship Hospital, Oddanchattram

## **Present Responsibility : (Since 1993)**

Currently leading the Community Health Team of the Christian Hospital, Bissamcuttack. The work includes the management of MITRA – which has three units :

The Mitra Project – a comprehensive Health, Education and Development programme for 12,500 people living in 53 tribal villages,

The Mitra Residential School, Kachapaju – a community-based residential school for 150 children from 16 hill-tribe villages,

The Mitra Training & Resource Unit – that shares the lessons learnt in community health, through training, consultancy and publications, for NGO and Government agencies, both in Orissa and in other states. The mandate includes the Mitra-SDTT Malaria Resource Centre that provides technical support to grass-roots NGOs for Community Based Malaria Control.

## **Other Roles at Present :**

- Public Health Expert on the Technical & Management Support Team, Orissa Health
- Sector Plan, Government of Orissa, a think-tank under the DfID support to GoO.
- A member of Boards of mission hospitals at Nowrangapur, Lamptaput, Baripada and the ERBHS group of 10 hospitals in Orissa and Chattisgarh
- A member of the Council and Executive of Christian Medical College, Vellore
- A member of the Community Health Advisory Committee and the Communications
- Advisory Committee of the CMAI, New Delhi

## **Roles & Responsibilities Previously Undertaken :**

- Editor, Christian Medical Journal of India, New Delhi (2001-2005)
- Regional Secretary, Christian Medical Assn of India – Orissa Region (2005-2009)

### **Some Consultancy Projects Undertaken:**

1. Evaluation of the health work of the JELC at Doliambo, Koraput District, with preparation of a project proposal for the same (1997)
2. Midterm Evaluation of CASP PLAN Child Survival Project in Sangam Vihar, Delhi, for Plan International (1998)
3. Evaluation of Community Health work of Christian Hospital, Nowrangapur (1999)
4. Consultancy & Training Contracts for Lutheran World Service (India) (1999-2000)
5. Consultant for Prem - Plan International for Malaria Control in 8 districts of Orissa, between 2001 and 2006
6. Mid Term Review of Development Project of Mohulpahadi Christian Hospital, Jharkhand (2002)
7. Supporting the Design of Malaria Control Programmes for the District Administrations in Malkangiri (2000) and Kheonjhar (2001) Districts of Orissa
8. Consultancy and Training Inputs for the IPDP project of UNFPA in Rayagada District, Orissa (2002)
9. Design of a District Action Plan for IEC for ZSS, Rayagada, Orissa (1999)
10. One of three consultants responsible for writing up UNICEF's Base Paper for a Policy on Infant Mortality Reduction for Government of Orissa, (2001)
11. Evaluation of Community Health Programmes of CNI in 6 northern states.(2005)
12. Team Leader for Project PHMIS – "Peoples Health Management Information System" Project of Rayagada District, supported by Unicef, Orissa (2006). This included Epidemiology and Health Information Management Consultancy for the District Administration.

### **Main Areas of Personal Interest :**

1. Communication in Health
2. Primary Health Care
3. Community Based Malaria Control

**Contact Info :**

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