People's Doctor

Dr John Cherian Oommen

Christian Hospital, Bissamcuttack

"Our lives do not belong to us; all we are and all we have are gifted to us in trust, to be used for others."

Dr John Cherian Oommen, the deputy medical superintendent of Christian Hospital, Bissamcuttack, lives by his statement. Dr Johnny as he is popularly called, is a physician and a trainer; a public health consultant and an entertainer; a spiritual thinker and a communicator. Based in Bissamcuttack in south Odisha, he lives locally but engages globally, striving to bring together the conceptual and the practical, the idea and the expression.

Bissamcuttack, a village with a population of about 9,000, is in Rayagada district of Odisha. This mountainous region is rich in natural resources such as minerals, forests, and water but also plagued by underdevelopment - richly-endowed and poverty-stricken at the same time. Dr Johnny describes it as the 'M' area – where M could be mountains, minerals, mining, Maoists, malaria, malnutrition or maternal mortality in a long list. Missionaries from Germany first came to Koraput in 1882 and to Bissamcuttack in1905, but could not achieve much in British India.

History of Christian Hospital

Christian Hospital, Bissamcuttack is a 63-year-old, 200-bedded multi-disciplinary mission hospital where Dr Johnny chose to serve.

In 1953, Dr Elisabeth Madsen, a middle-aged spinster from Aalborg in Denmark read about the grim health situation in southern Orissa – as the state was known then. With a desire to improve the situation, she sold her medical practice and approached the Danish Missionary Society (DMS), offering to go to India. They informed her that they were no longer sending missionaries. A determined Madsen raised sufficient resources and came to Orissa in 1954, where she started seeing patients in the verandah of a church in Bissamcuttack.

Madsen then bought the land where Christian Hospital, Bissamcuttack (CHB) now stands, built a small dispensary and started visiting houses, to treat patients. As the number of patients grew, she started training local residents to perform simple procedures such as administering injections and dressing wounds. The service was still dependent on her. When an episode of illness forced her to return to Denmark for treatment, the hospital had to be

shut for a year. After her return, the hospital gradually grew to have 40 beds. By then it cost Rs 4 lakh to run the hospital, out of which DMS was contributing 75%. When DMS could no longer support CHB, Madsen realised the necessity of CHB being self-sufficient.

It was November 1975 when Dr Virendra Kumar Henry, a surgeon from Chhattisgarh and his wife Nancy, a nurse from Ohio, USA, came to CHB. Over the next four years, they put several systems in place and managed to reach a point of self-sufficiency, which continues even today. In the 1980s, the Henrys increased the number of beds to 120 and upgraded the hospital in other respects too. They developed it into an institution where the marginalised would not feel intimidated. The single storey buildings, wide spaces where people can feel at ease, collection of fee only on completion of consultation, besides various cost-packages were all part of the system they designed, to cater to the proletariat.

Over the years, they started a nursing school, a community health project covering more than 50 Adivasi villages and night classes using bi-lingual education methods. In 1980, a second community health project was started in Dakulguda village, by the nursing department, under Nancy's supervision. In 1986, Dr Henry started the New Life English Medium School. Madsen returned to Denmark in 1988, where she passed away in 1991.

CHB is now a 200-bed hospital, employing 300 staff. An average of 15 surgeries and 10 deliveries are conducted per day, at highly subsidised costs. The School of Nursing that offers two courses has 120 students from different parts of Odisha.

Johnny first came to CHB in 1987 and involved himself in all the community programmes. According to him, the long, stable leaderships have supported CHB's growth. He further observes an interesting localisation of leadership over the years. The first was from outside the country, the second was an Indian but from outside the state, the third was from Odisha but outside the district, and the fourth is from the Rayagada district where CHB is also located. Johnny has been working in CHB since 1993.

Formative education

John Cherian was born in Bharananganam on 11 October 1962, to Rev A C Oommen, a Christian pastor and theologian and Rebecca Varkey, a teacher. The family comprising mostly of pastors and teachers, hails from Kaviyoor, a village near Tiruvalla in central Kerala.

Though Johnny was born in Kerala, he grew up in Vellore in the cosmopolitan campus of Christian Medical College (CMC), since his father Rev Oommen was CMC's chaplain. Johnny studied in Vidyalayam in the CMC campus and later in the Ida Scudder School. Having grown up in a medical campus, Johnny had made up his mind while in school, that he would not study medicine.

He felt he was more of an arts person, with a keen interest in history and literature. His family decided to send him to Kerala for his higher secondary (pre-degree) education, to enable him to discover his roots and to learn Malayalam, his mother tongue.

At SB College in Changanaserry, Johnny got his first taste of hostel life, college politics and the real world. His application for commerce stream went in late, and so he joined the world history and economics stream. Though he loved the subjects, his class was involved in a strike every other day and he did not get to learn anything. He approached the principal, who coaxed him to take the only seat available in the science stream.

Role of religion in work

Born in a Christian family, going to church was a part of life, but there was nothing personal about it for Johnny. Through the two years he was in hostel, he and a cousin who shared his room, studied the Bible, trying to understand what their Christian faith meant. This reaffirmed what he had learnt at home: that we do not belong to ourselves, but to God and that we are created to be of service to others.

The next turning point came during study holidays, just before the final exams. An atheist friend and he would spend hours engaging in philosophical discussions about life, its purpose and the like. The words 'when the prime minister and I were born, we were both born naked', uttered in anger by an alms seeker, triggered a debate analysing life through atheist and Christian lenses. They realised that the family one was born into gave opportunities that others did not get. They were tempted to quit college and serve the poor - just prior to the final exams!

Then came the moment of enlightenment: that all one had, was a gift from God, given in trust, to be used for people who lacked opportunities. His atheist friend challenged Johnny to apply for MBBS at CMC, suggesting that God was at work making events happen as they did. Johnny applied for medicine at CMC, Vellore and literature at Madras Christian College, hoping to become a journalist or a doctor. Either way his aim was to work for people who were not endowed with the opportunities that he was. He was selected by both the institutions. He opted to study medicine at CMC, Vellore.

He joined the MBBS course at CMC in 1980. He was an active student, captaining the basketball team, serving as secretary for the Student Christian Movement and as president of the students' association among others. After completion of MBBS, he served the first year of CMC's two-year mandatory service period at Community Health and Development (CHAD) unit, the CMC's community health programme.

He learnt about Christian Hospital, Bissamcuttack (CHB) after a chance interaction at the college canteen, with the son of Dr Henry who headed the CHB then. Learning about

Johnny's interest, Dr Henry wrote to the principal of CMC, seeking permission for Johnny to serve his second year of service period in Orissa. Secretly thrilled, Johnny kept a straight face through the interview with the principal and then rushed to book his tickets before the principal could change his mind.

Johnny came to CHB for the first time on 30 November, 1987. He realised that it was everything he had ever dreamt about. He went back to CMC in 1989, to do his MD in community medicine. After completing his post graduation in '92, he worked for a year in CMC's physical medicine and rehabilitation department before coming back to CHB in July 1993.

The family front

As a student Johnny knew he wanted to work with vulnerable communities in remote areas and he had decided that marriage would not fit into such work-life scheme. However, after one year in Bissamcuttack, he realised that it would be too lonely to stay single.

Mercy Abraham was born in Kerala and grew up in Bangalore and Madras. In 1983, she joined the College of Nursing at CMC Vellore to do BSc in nursing. Johnny and Mercy met for the first time at a Student Christian Movement conference organised at Serampore in 1984, with students from all over India attending the conference. Johnny and Mercy were selected as the representatives of their respective colleges. They became friends and continued to correspond over the years.

Mercy became a tutor in a nursing college and declined a job offer from the US, choosing to live and work in India. In January 1991 Johnny and Mercy discussed marriage and soon got engaged. They made a brief trip to CHB after their betrothal, so that Mercy could see the place and meet the people there. They got married in June 1991. Mercy enrolled for M.Sc. in nursing at CMC in June 1991. The couple came to CHB in 1993 after their respective postgraduate trainings. Their only child, a son named Ashish, was born at CHB the following year.

The initial years were difficult, with Mercy working at the School of Nursing in the CHB campus and Johnny going to remote villages for clinics, returning home late. There were no means of communication then. Mercy would spend the pitch-dark evenings terribly worried, particularly during heavy rains. Sometimes she would request Dr Henry to send the spare vehicle in search of the team and rescuing them on a couple of occasions from a vehicle breakdown.

There were harrowing experiences when a young Ashish suffered twice from heart failure brought on by pneumonia and asthma, convulsions due to high fever and even malaria several times, before he turned five.

When Johnny and Mercy were about to leave for Bissamcuttack in 1993, Johnny's concern was that it would be difficult to travel to Kerala where his parents were, in case of an emergency. His father, with steadfast faith, retorted: "If you believe it is God who is calling you to Orissa, then it is God's responsibility to organise my funeral! Either you believe, or you don't believe. You cannot ride two boats." Ironically, Rev Oommen passed away at Johnny's residence in Bissamcuttack, when Johnny was away travelling.

Mercy states that most professional and personal decisions are taken jointly after adequate discussions; except matters related to the kitchen she added with a touch of humour. Johnny was averse to certain technological gadgets. While their home has a vast library with an impressive collection of books, it was Johnny's father who bought the television. Ashish sometimes expressed his discontent by playing Harry Chapin's *Cat's in the cradle and the silver spoon* – a song which talks of a busy father and a longing son - loudly when Johnny came home from long trips.

Career trail

When Johnny finished his MBBS, he considered working in Kalrayan Hills in Tamil Nadu, where hardly any medical facilities existed. However his college did not allow him to transfer his two-year service bond from CMC to the Kalrayan hills. So he spent the first year at CHAD, Vellore. Rules changed subsequently, enabling him to go to CHB. Johnny said in retrospect, "If you make yourself available to God and to the needs of people, everything will fall in place."

MITRA

When Johnny joined the community health department of CHB in July 1993, there were two small ongoing projects. One run by the nurses, focused on mother and child care in nine villages. The second was a community health project, revamped and re-focussed in 1994 under the operational name MITRA – an acronym for Madsen's Institute for Tribal & Rural Advancement. MITRA, meaning friend, focused on community development across tribal villages. In MITRA, there was a team of ten, mostly the local people. The work included running village clinics, adult literacy programmes and tree plantation drives.

Johnny spent the first six months accompanying the team to each village, listening to people, learning their culture and language and discerning their needs. According to Johnny, MITRA is a relationship with people. He feels that in every small act of a person, there is a bigger meaning and if one does not reflect on it, one loses an opportunity to learn. A key method of working therefore is through detailed team and individual reflection exercises and writing – which he finds cathartic.

Johnny used the 1978 Alma-Ata Declaration theme of 'health for all' as reference when he started his work in '93. When people died of ailments for which there did not seem to be a ready solution, Johnny and MITRA got a clear direction after interacting with the community.

(i) The power of community participation:

In the remote hill village of Kachapaju, in 1994, a young boy developed tetanus and was admitted in CHB in a precarious condition. MITRA team members informed the villagers that if the boy had received three injections in his infancy, the illness could have been prevented. The villagers learnt that the injections were offered free by the government. The village leader then insisted that all the children in their village be immunised. In January 1994, 112 children from four villages, who would otherwise run away at the sight of syringes and needles, lined up for vaccination. This continued for three months, and then led to the mobile clinic and immunisation programme in the region. Social mobilisation and demand generation then became a principle for MITRA.

(ii) Community's aspirations as a guide

In a small tribal village, no child had been to school or taken immunisation, though the villagers wanted the MITRA team to come every month and treat the sick. Then in 1995 five young children died of post-measles broncho-pneumonia, a totally preventable condition. Sitting in the village the next month, sharing the pain of the people, Johnny acknowledged that he had failed and asked the villagers their dream for their village. Their responses included roads, irrigation canals and education, with healthcare getting the least priority.

Johnny realised that there was a mismatch between their dreams and his medical competence. Together, they decided to focus on education as the possible key to realise the other dreams. The MITRA team arranged for an educated tribal youth to reside in the village for a year, to run a school for children during the day and for adults at night. Within a year the results were obvious: several children enrolled in government residential schools, the village got bargaining power, and immunisation coverage reached almost 100%. A few years later the road and water-availability also happened. Then on, through 'community dream sessions', allowing the aspirations of the community to direct their course of action became MITRA's modus operandi.

(iii) Teams to the rescue

Runa Kolaka was one of the best village health workers in the MITRA team. Having conceived after a long time, she was attending a training by Johnny where he spoke about the dangers of a retained placenta in delivery. Apprehensive that she may find herself in the situation explained by Johnny, she made him promise that he would be there if she called. Unfortunately, when she went into labour weeks ahead of time and delivered in her home one morning, her placenta did not come out and she was bleeding profusely.

Runa's husband could not contact Johnny, who was away on a mobile clinic. The nearest primary health centre (PHC) was locked and there was no transport facility to take Runa to the hospital. By the time Johnny got the message and rushed to the village, Runa was long dead. The baby was still alive, but the umbilical cord uncut, as she had told her family that Dr Johnny would come. Shattered, he realised that one could hold any number of medical degrees, but one cannot save the world.

A review of Runa's death with the MITRA team led to the conclusion that Johnny's way of working, of being personally involved in everything, was creating an unhealthy dependence on one individual. He needed to change his way of working. So he built a team of nurses, who are easily recognisable in the villages by their green saris. Responsible for primary healthcare , they check villagers, for early diagnosis and treatment of health issues.

MITRA, the functional identity of CHB's community health department has a 35-member team, working with about 13,500 people of 53 predominantly tribal villages around Bissamcuttack.

Johnny emphasises the need for an insider perspective. This is achieved by having Adivasis among the staff, by developing young leaders from the community and not taking any initiative unless there is a demand from the villagers. The approach the team adopts is to first build relationships with the community and then to identify the unaddressed problem. They then try to share the pain of the problem and dream of possible solutions. Community aspirations spelled out during these sessions led to the articulation of the MITRA dream -

- Health for All
- Education for All
- Economic Security for All and
- Social Empowerment for All

Towards achieving these, the key activities of MITRA, led by Johnny include:

1. **MITRA Primary Healthcare Programme:** A team of six nurses and two facilitators – referred to as animators – work with 50 village volunteers in three geographical clusters towards the dream of Health for All. MITRA has two health centres with resident nurses. The team visits each village once or twice a month. Children's growth is monitored till they reach five. Those whose growth is off-track are given necessary assistance. Pregnant mothers are checked and counselled, illnesses are diagnosed and treated, chronic diseases are tracked and addressed and those needing hospital care are referred.

   The team notes down every detail. A health management information system based on the team's records tracks pregnancies, births and deaths in each village. The data provides diagnoses and indicators of health status that help fine-tune interventions as needed. Initially the focus was on malaria, malnutrition, tuberculosis and diarrhoea.

Then problems such as sickle-cell anaemia and childhood hypothyroidism that robbed the children of their quality of life and future came to be noticed and were included in the ambit of services.

Community-based clubs have been formed around these issues, with membership open to affected children and their families. Lately as there is an upsurge in non-communicable and lifestyle diseases such as hypertension, diabetes and chronic kidney disease, the team is trying to tackle the same.

2. **MITRA Malaria Control Initiative:** Malaria appeared to account for nearly one-third of all deaths in the villages around Bissamcuttack in the 1990s. The team evolved a community-based approach focused on personal protection against mosquito bites and malaria using medicated mosquito nets and neem-based repellents. This initiative created immediate and striking reductions in malaria, prompting even the World Health Organisation (WHO) to include the MITRA report in *Regional Health Forum*, the journal of WHO. Soon MITRA got to assist a network of NGOs in Odisha and help other states launch their own programmes against malaria.

   The advantage of being a professional working at the grassroots helped Johnny describe the hitherto unrecognised phenomenon, called mal-mal (malaria-induced malnutrition). MITRA's work showed that removing the malaria factor improved children's growth potential and nutritional status. This insight forms the basis of a unique initiative of the Odisha government to control vector-borne diseases.

3. **MITRA Training & Resource Unit (M-TRU):** Through training, consultancy and publications, the MITRA team shares the lessons they have learnt. With the support of Tata Trusts, the M-TRU team offers a six-week course in the art and science of community health, besides four technical workshops on community health every year.

   Representing M-TRU, Johnny has been serving as a consultant to the Odisha government's healthcare and dissemination programmes on AIDS, tuberculosis and malaria among others. He also serves as a trainer and consultant on the boards of other organisations. The M-TRU team has also produced booklets in Odia on critical health issues such as sickle-cell anaemia and hypertension.

4. **MITRA Residential School, Kachapaju (MRSK):** In the summer of 1997, a community dream session at Kachapaju village threw up the idea of an Adivasi school of their own. The villagers wanted a school true to their ethos, culture and language, where their children could get quality education and yet stay connected to their roots. Johnny decided to model it on Vidyalayam, his first school in the CMC campus.

   Despite many barriers, the dream became a reality in 1998, when as association of 16 tribal villages of the hills and MITRA-CHB opened a small school in the middle of the

forest. It is Adivasi in nature and curricular content, where children learn first in the Kuvi language and then mainstream into Odia and English.

The community worked together to construct the first building and continues to stay deeply involved. Led by the principal Chandrasekhar Ray with inspiration and backstopping by Johnny, the team at MRSK has developed it into a unique residential primary school, retaining their ethnic ideals.

After nearly 20 years, the school has 155 children up to fifth grade. Over 500 children from villages that never had access to a school before, are now educated, thanks to MRSK. The alumni now include over 100 matriculates, two *sarpanch*s (village council leaders), five engineering students, five government school teachers and three nurses among others.

Looking back, Johnny said MRSK was probably the best thing that happened to him and to the people there. Today MRSK is also the hub for all of MITRA's educational activities. Its Kuvi Culture Centre produces books in Kuvi language, raising the bar on tribal education.

There are also a number of other initiatives such as the following, that the MITRA team operates in partnership with the community.

5. Adding quality to education: This initiative helps village communities facilitate education in dysfunctional government schools by placing volunteer teachers there. Presently 23 such teachers volunteer in 13 schools.

6. Milla Kahini Basa: the name in Kuvi language translating as children's play place, is a playschool-cum-daycare centre for toddlers in tribal villages. This ensures that the children are safe and stimulated while the parents are out in the fields or forest. There are now seven such centres managed by young women of the respective villages.

7. MITRA Community Health Insurance Programme (M-CHIP): This is an attempt to help the community create their own health fund to protect themselves from sudden unpredictable health expenses. Run by women SHGs and village committees on membership fee and small premiums, the programme now covers about 5,000 people.

8. Ageing with dignity: This initiative has about 560 senior citizens enrolled through an annual subscription. It helps address key health problems of the elderly, besides providing solidarity and social support.

9. MITRA youth initiative: Started in 2014, it is a community-based response to help the confused and vulnerable youth. The MITRA team has seen suicides in this area for the first time in history. With first generation education, exploding media exposure, migration and confused value systems seem to be the causes. Theinterventions include

fellowships in healthcare and education, scholarships, coaching camps, exposure programmes, training in emotional resilience and the like.

All ideas, activities and projects undertaken at MITRA and CHB are meticulously documented and freely available for anyone to adapt or replicate in their own contexts, Johnny's copyleft approach as against copyright. He strongly feels that rootedness in the community is essential for policy making, else there would be a gross disconnect with the practical status on ground.

Money for MITRA – A tool, not a goal:

CHB's recurring annual cost of Rs 10 crore is covered by its patients. Infrastructure development including new buildings and large equipment has been made possible through the support of EZE and NMZ of Germany, and DCA of Denmark through the 90s and Friends of CHB in Denmark, USA, Germany and India subsequently.

MITRA has had an adventurous financial history. In the early years, from 1993 to 2001 to be precise, it received support from DanChurchAid, Copenhagen. Then for nine years, MITRA ran primarily on internal resources and contribution from friends and family.

In 2009, Tata Trusts learnt about CHB and the work of MITRA, resulting in a 3-year project that enabled MITRA to run a malaria resource centre, train a network of NGO partners of Tata Trusts in three districts and host a malaria control strategy across 650 villages.

In 2014, Tata Trusts provided a generous grant to re-develop the entire infrastructure of the hospital over a five-year period, with Johnny at the helm of the project.

MITRA currently has partnerships with Tata Trusts, Saphara of Ireland, Tambourine Trust of New Zealand, Friends of CHB in Denmark, VM Tarm of Denmark and Pieter Bastiaan Foundation ofNetherlands. Besides institutional support, a large number of individual well-wishers contribute ideas, time and money.

Influencing factors:

Dr Johnny's three different roles, namely, administrator at CHB, head of MITRA, and doctor to the community often overlap and pose dilemmas. Institutions run on an instinct of self-preservation. When he started, he swore to be on the side of the community, but the last couple of years in administration has him compromising his loyalty to the community, so as to sustain the institution. More difficult is the allocation of his time and mental space; he barely manages few days a year in the community now, drifting away from his original calling and perspective. Yet he goes to great lengths to maintain personal relationships, which are precious to him.

Johnny lists a number of factors and people who have influenced him in his personal growth, faith being the first. Religion, spirituality, God, and his search for the meaning of life have been critical, both as a purpose and as a support. For him, the ultimate aim in life is to know God, to love Him and to become more like Him. Family including his parents, sisters, Mercy and Ashish have been his core supports. Johnny credits his late father as the person he respected the most and learnt the most from.

A professor at Vellore observed several of his students going out full of idealism but getting burnt out too fast. He did a survey asking those working in the field what their need to sustain themselves was. The highest need that people said was, 'a sense of belonging to a group, the knowledge that somebody understands the madness I am doing and backs me up'. This led to the formation of the Focus Group in 1994 with three commitments - a commitment to Jesus as Lord and role model, commitment to the health needs of India and a commitment to each other. The group meets during a weekend every year, with spouses and children, serving as a safe space for direction, sustenance and sharing with peers.

The Henrys were like parents to him and Mercy. The MITRA team and CHB have been a big influence on Johnny. Madhabo Rona, Balakrishna Himirika, Majhi Pidikaka, Chandrashekar Ray, Atulya Bora, Stella Ekka and Surendra Gadika are colleagues he has worked closely with for several years and have a had a positive impact on him. The community that has made him a part of them has had a profound influence on him. For his education, he is grateful to CMC Vellore that also conferred the Paul Harrison Award on him.

Beyond CHB

Johnny is clear that nobody is indispensable and remembers a community gathering when the question 'What happens after you retire?' was posed to him. He recalled a close associate replying, "If God wills that work happen here, then if Dr Johnny is present or not, it will. If God wills that work doesn't happen here, then even if Dr Johnny tries, it won't happen". This is reinforced by the fact that CHB did not close down after the departure of Madsen or Henry but expanded instead.

Johnny plans to make a clean exit. "My father used to say 'when you leave the room, turn off the light and fan'. It means when you leave, your successor must get the freedom to do things his or her way, which will be different from your way," he said.

When asked if he would have started his own organisation had he not chanced upon CHB,Johnny said, "I am not the kind who necessarily feels that I have to start something new. I can work with what exists. To build on what is already there is strategically more cost effective and sensible. Also, I think I'm made to be a second-in-command. So I have always been a kind of a right hand to the person in authority and that is fine. It actually takes the pressure off me. Again, something my parents taught me is that our calling is to obedience,

not necessarily to success. So the aim is not to succeed in life, the aim is to surrender to a higher calling, to what God and the situation require of you. The story is not about us, but our contribution."

About Dr. Johnny Oommen

- Dr Johnny, the deputy medical superintendent of Christian Hospital, Bissamcuttack, Odisha brings healthcare and development to 53 predominantly tribal villages.
- Gets villagers to articulate their vision for their village through 'community dream sessions' and then works towards realising those dreams, with their participation
- With a 35-member team that is responsible for primary healthcare of villagers, early diagnosis and treatment of health issues has been possible.
- Gets community perspective by having Adivasis among the staff, by developing leaders from the community and by taking initiatives only when the villagers demand the same
- Increased literacy by starting a residential school that is Adivasi in nature and curriculum, where children learn in Kuvi language, their mother tongue, before starting to learn in Odia and English

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