COMMUNITY HEALTH : :

the search for an alternative process

Report of a study - reflection - action experiment by
Community Health Cell, Bangalore.
January 1984 - June 1986.

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CON TEN T S

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To all our friends, colleagues, associates, and health and development activists, particularly in Karnataka, who gave us the opportunity to interact and reflect together,

To the 'medico-friend-circle' , especially many of its core group, for the stimulus and inspiration,

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To our familtes and particularly little Lalit •• who put up with it all,

MANY THANKS ~

The COMMUNITY HEALTH CELL

Team consisted of

Ravi Narayan

Thelma Narayan

K Gopinath

N Chakravarthy

The attainment of the goal ~ Health for All .

. by 2000 AD depends above all on three things

(i) the extent to which it is possible to reduce poverty and inequality and to spread education;

(ii) the extent to which it will be possible to organise the poor and the under-privileged groups so that they are able to fight for their basic rights;

(iii) and the extent to which we are able to move away from the counter-productive consumerist Western Model of Health Care and to replace it by the alternative model based in the community .

'Health for All - an alternative strategy'
Indian Council of Social Sciences Research &
Indian Council of Medical Research,
Study Group, 1981.

I N T ROD U C T ION

This reflection is an attempt to draw upon some of the rich experience in Community Health Care from many parts of India, and weave a framework for study and action. It bases itself on a series of interactions we have had with a large number of individuals and groups who were trying to understand the dynamics of the health care system in India and experiment with alternative approaches. These interactions have been through informal meetings, personal communications, field visits, group discussions and participation as resource persons in a number of training programmes.

These interactions took place over a decade (1976-86), during part of which we were based in the Community Medicine Department of a medical college in Bangalore, South India. We were part of a process of social orientation of the curriculum *in* that College, which included experimenting with health care project alternatives and innovative field training programmes.

More specifically it draws from two intensive phases of interaction - the first in 1982 when two members of our existing group travelled around many parts of India visiting Health and Development projects - and the second, a thirty month phase (January 1984 - June 1986) when the present team of four participated in the informal study-reflection-action experiment in Karnataka State entitled the "Community Health Cell'. During this second phase, our team also managed the organisational responsibilities of the Medico Friend Circle, a loosely knit national group of people interested in evolving more appropriate approaches to health care and medical education. This responsibility provided opportunities for interaction with a wider and varied range of people from different parts of the country.

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The basic objective of both these phases was to learn from the micro-level health care programmes that were going on in the country and evolve some macro-level generalizations and a framework to base further action. It was also our hypothesis that from an overview of this varied experiment action an approach to health care could be evolved, which we have called the COMMUNITY HEALTH APPROACH throughout this reflection.

The first draft of the report was prepared in April 1986 and was discussed with a network of colleagues. Responding to various suggestions, the report has been extensively rearranged and edited for a wider circulation.

The report is divided into Sections. We start with a background note which briefly describes the important developments in India in the last fifteen years (1972-86) to place this reflection in the right context.

A short note on methodological issues explains how these reflections evolved. This is followed by a free-flowing reflection arising out of our experience. In these we highlight our observations, broad conclusions, and some critical issues and concerns.

We then derive a set of principles of a Community Health Approach, arising out of an Indian collective experience. We would like to emphasise that these are exploratory principles and we hope will be subjected to further collective critical analysis in the future.

In the last section we enumerate a series of important tasks that those of us interested in health care approaches could apply ourselves to, so that a deeper understanding of 'Community Health' in the Indian context emerges, in the years to come.

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The appendices highlight :-

k. the sample of people, groups and situations with whom we have been in contact (Appendix A + B);

ii. a reading list of published literature in India since the 1970's which discuss approaches and shares this concern; these have not only stimulated deeper reflection but in many of them we have discovered a "resonance" to many of our own observations (Appendix C);

iii. a list of some mimeographed reports and proceedings of workshops and groups discussions as well as occasional papers associated with this emerging process in India (Appendix D);

iv_ a small resource inventory of materials generated by the Community Health Cell during the experiment (Appendix E).

We believe these reflections express, an emerging, collective thinking in the country. However, the very process of putting it together introduces an unavoidable personal bias of our team. We accept this limitation.

We dedicate this little book to all those who are concerned about the health of the poor in India. If it stimulates further reflection and clarity, debate and dialogue, dissent and constructive critical analysis among the network in India, we would have achieved our modest purpose.

Community Health Cell,
Bangalore.
March 1987.

Ravi Narayan
Thelma Narayan
K Gopinath
N Chakravarthy

HEALTH CARE IN INDIA : : A SITUATION ANALYSIS

Community based health action has been an important dimension of health planning in India since Independence. The constitution of India clearly recognises the Government's responsibility for health of all the people, and this commitment has lead to the evolution of a large number of health programmes and new thrusts over the last 38 years.

The development of the Primary Health Centre concept and subsequent development of such an infrastructure throughout the country; the national programmes for communicable diseases; the maternal and child health, nutrition and family welfare programmes; the training of an army of multipurpose health workers and public health teams; the efforts at reorienting medical and nursing education;
the establishment of research and specialised institutions have all been steps in this direction.

However, since the mid-sixties there has been a growing disenchantment with the models of development including health care services, which we adopted, somewhat uncritically, from Western industrialised nations. This stemmed from the growing field experience of the inadequacies of these models to meet the needs of the large majority of our people and a growing realisation that "development" is a socio-economic-political-cultural process, which must evolve its own local solutions. These solutions must involve, a critical appraisal of technological packages and their adaptation to fit our own, rather different social realities.

CONSTITUTIONAL PLEDGES

"The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.

It shall ensure
that the health and strength of workers men and women, and the tender age of children are not abused
that children are given opportunities and facilities to develop in a healthy manner

It shall make
provision for securing just and humane conditions of work and for maternity relief and
for public assistance in cases of unemployment old age, sickness and disablement, and in other cases of underserved want."

---Constitution of India

This disenchantment took many forms including the evolution of much analytical and imaginative writing, innovative field projects, ideologically based people's movements and protests. Besides questioning and challenging the assumptions and values of borrowed models and methods, there was also a re-examination and reappraisal of the experience and thrusts of the post-independence period as well as our own cultural traditions. This quest for new values, new attitudes, new processes of social change has pervaded all aspects of development in India and Health care is no exception.

Since the early seventies a large number of initiatives and projects have been established outside the Government system by individuals and groups keen to adapt health care approaches to our social realities and this response has grown. Broadly classified as voluntary organisations or NGOs, these initiatives were predominantly rural to begin with but in recent years the focus on tribal regions and urban slum communities has grown. Starting with illness care, most of them moved on to a whole range of activities and programmes in health and development, described later. Initially they developed independent of each other but over the years some networking and training programmes emerged,inspiring similar attempts elsewhere. As the phenomena evolved community development projects and community education experiments also began to add dimensions of health in their approaches. In more recent years further networking to share ideas and experiences, evolve some common perspectives and organise some collective action on broader health issues has taken place. We have been involved in many of these efforts and this study-reflection derives much inspiration from these.

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"We have adopted tacitly and rather uncritically the model of health services from the industrially advanced and consumption oriented societies of the West. This has its own inherent fallacies; health gets wrongly defined in terms of consumption of specific goods and services;

the basic values in life which essentially determine its quality get distorted;
over-professionalisation increases costs and reduces the autonomy of the individual;
and ultimately
there is an adverse effect even on the health and happiness of the people.

These weaknesses of the system are now being increasingly realised in the West and attempts are afoot to remedy them. Even if the system were faultless, the huge cost of the model and its emphasis
on over-professionalisation is obviously unsuited to the socio-economic conditions of a developing country like ours.

It is, therefore, a tragedy that we continue to persist with this model even when those we borrowed it from have begun to have serious misgivings about its utility and ultimate viability.

It is, therefore, desirable that we take a conscious and deliberate decision to abandon this model and strive to create instead a viable and economic alternative suited to our own conditions, needs and aspirations ".

---Report of Group on Medical Education & Support Manpower, Government of India, April 1975.

In 1972, India celebrated the Silver Jubilee of its independence. This milestone, was an important occasion for evaluation of past efforts, and the present situation, in order to gear up for the future. Many expert committee reports and policy statements following this year began to make critical observations about the inadequacies of the present health care model and exhorted all concerned, to search for more relevant alternatives. This in itself created a very supportive and encouraging ethos for the evolving "Community Health' movement.

The report of the GROUP ON MEDICAL EDUCATION AND SUPPORT MANPOWER (1975) set up by the Government of India and the report of the Study Group on Health for All : an alternative strategy (1980) set up jointly by the Indian Council of Social Sciences Research and the Indian Council of Medical Research are two key examples of this trend. The extracts from these two reports (see boxes) are typical examples of this introspective and critical self-evaluation in Government sponsored efforts. It is significant that at least in the "Health for All" study group representatives from the Social Sciences participated with health planners and representatives of the non-government health care sector (voluntary sector) for the first time - this being reflected in its realistic observations and assessment of the situation.

Nu doubt the action suggested by this study group on prospective action was somewhat ambiguous and not keeping in line with their own radical assessment of the situation. However, the point to be noted here is, that this dissatisfaction and the felt need for an alternative approach was voiced by the official health system and Government experts as well. Equally significant **in** the Indian situation is that this critical and reflective upsurge was not just a response to the Primary Health Care declarations but was a process, which had begun even earlier.

"No meaningful results can be obtained by a linear expansion of the existing health services or by tinkering with them through minor reforms. We have therefore proposed that this model should be totally abandoned and a new alternative model should be created in its place.

This new model differs from the existing model in several important respects.

It abandons the top down and elite oriented approach of the existing services and is based or rooted in the community and then rises to specialized referral services at the district and regional levels.

It gives up the over-emphasis which the present system places on large urban hospitals and creates a small community hospital of about 30 beds in each community to meet the vast bulk of its referral needs.

It moves away from the predominantly curative orientation of the existing services and integrates promotive, preventive and curative aspects at all levels. It redefines the role of drugs and doctors so that they remain the best agents of health care and do not develop a vested interest in ill health.

It gives up the centralized and bureaucratic character of the present system and adopts a decentralised, democratic and participatory approach which will involve the community intimately in planning, providing and maintaining the health services it needs.

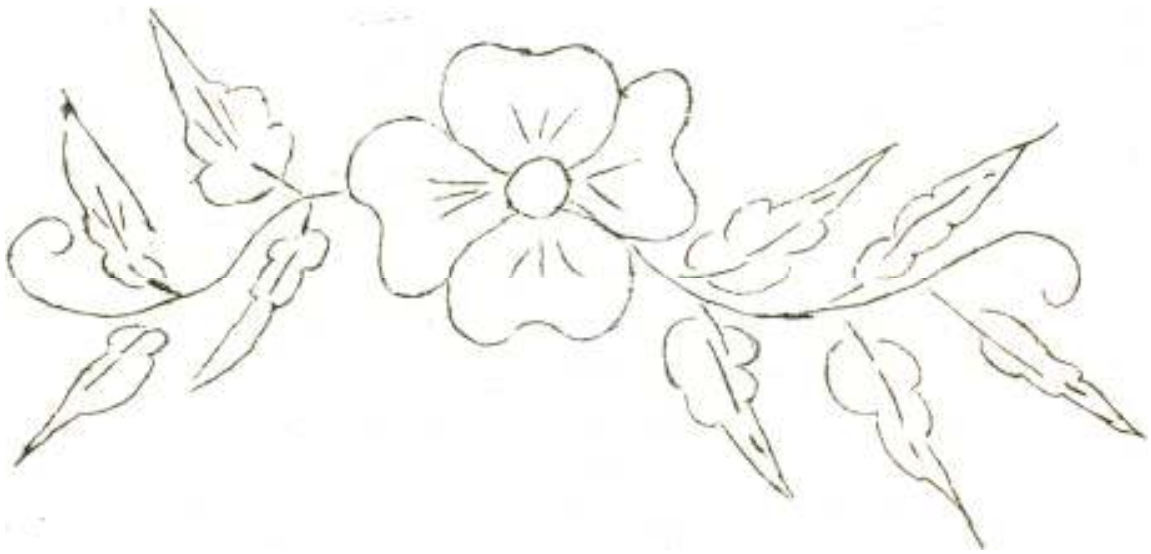
It strives to integrate the valuable elements in our culture and tradition eg. The ashrama concept, of stages in life, non-consumerist attitudes, sense of individual and community responsibility, yoga and simplicity and self-discipline as the core of a life-style

…**10**….

It also strives to create a national system of medicine by giving support to and synthesising the indigenous systems.

Finally it abandons the over-expensive model of the health care systems in the developed countries and creates an economic model which will provide a better quality of health service at a much smaller cost which will be within the reach of the country "

Health for All: an alternative strategy
ICMR/ICSSR Study Group, 1981.



Networking among individuals and groups around issues of health care began in the early seventies. The medico-friend circle - a pioneering example among these, was a loose-knit network, (of all those who shared a common conviction and understanding that the present health services and medical education system was lopsided in the interests of the privileged few and must change to serve the interest of the large majority - the poor people of India) that began in 1974. It saw itself as a thought current upholding human values and certain new attitudes in health care and medical education (see box) and 'offered a forum for debate and dialogue to share experiences and experiments' and tfor taking up issues of common concern for action'.

While the medico-friend-circle represents a network of individuals, the All India Drug Action Network which emerged in the early eighties is another pioneering example of networking around a common· health policy ,issue. Keen to promote a rational drug policy and more rational prescribing practices in the Indian situation, this network includes a large number of health groups and associations, consumer groups, social activists, trade unions, university departments and hospital associations. This is again a significant development since the Health for All study group had warned in its report ·'that eternal vigilance was required to ensure that the health care system does not get medicalised, that the doctor drug-producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health'.

In the last decade many more initiatives arid networks have emerged representing the rich diversity of this ferment.

works towards a pattern of medical care adequately geared to the predominant rural character of our country.

works towards a medical curriculum and training tailored to the needs of the vast majority of the people in our country.

wants to develop methods of medical intervention strictly guided by the needs of our people and not by commercial interests.

stands for popularisation and demystification of medical science.

believes in a democratically functioning health team and democratic decentralization of responsibilities.

stresses the primary role of preventive and social measures to solve health problems on a social level and the importance of planning these with active participation of the community.

works towards a kind of medical practice built upon human values, concern for human needs, equality and against negative, unhealthy cultural values and attitudes in society e.g glorification of money and power, division of labour into manual and intellectual, domination of men over women, urban over rural, foreign over Indian…

believes that non-allopathic therapies be encouraged to take their proper place in the modern system of-medical care

-- medico-friend circle -- perspective and activities.1984

The peoples science movements in Maharashtra and Kerala states (Lok Vidnyan Sanghatana and Kerala Sastra Sahitya parishad) are prototypes of science movements that are beginning to address health issues in their campaigns. The LOCOST experiment in low cost, quality tested supplies of drugs to voluntary health organisations and small hospitals in Gujarat is another, more focussed but relevant example. The inclusion of wider 'health policy' and social issues on the agenda of junior-doctor movements, the emergence of the Socialist Health Collective, the regional or state level drug-action forums are more examples. The establishment of the Asian Community Health Action network, encompassing much of Asia, is another example of commitment to similar concerns in health care and symbolises the fact that this trend, being described in India, is part of a much wider regional trend.

The Voluntary Health Association of India(which began in the early seventies as the coordinating Agency for Health Planning was a more formal attempt to bring together this growing commitment to alternative and community approaches to health care. As a federation·of state level networks linking over 3000 health institutions and community health programmes in the country VHAI has been spearheading various aspects of a 'health for and by the people' approach through informal workshops and training programmes.

In the early eighties two other formal coordinating agencies of hospitals and dispensaries under 'church' sponsorship, the Catholic Hospital Association of India (around 2000 member hospitals and dispensaries sponsored by the Catholic Church) and the Christian Medical Association of India (around 300 protestant institutions and about 5000 individuals associated with these institutions)

"What is our new vision of health care?
'Community Health'. We begin with the Community. Our goal is a healthy community. We believe in health by the people ••••

We promote social justice in the provision and distribution of health care ••••

We encourage people to demand health services as a human right ••••

Our old health services have been built to favour the educated, the privileged and the powerful…

We wish all goods and services to be more equally shared with the whole community ••••

We assist in making community health a reality for all the people of India, with priority for the less privileged millions, with their involvement and participation through the voluntary health sector."

-- Introductory pamphlet Voluntary Health Association of India.

"Health is the total well being of individuals, families and communities as a whole and not merely the absence of sickness. This demands an environment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as spiritual needs are· met ••••

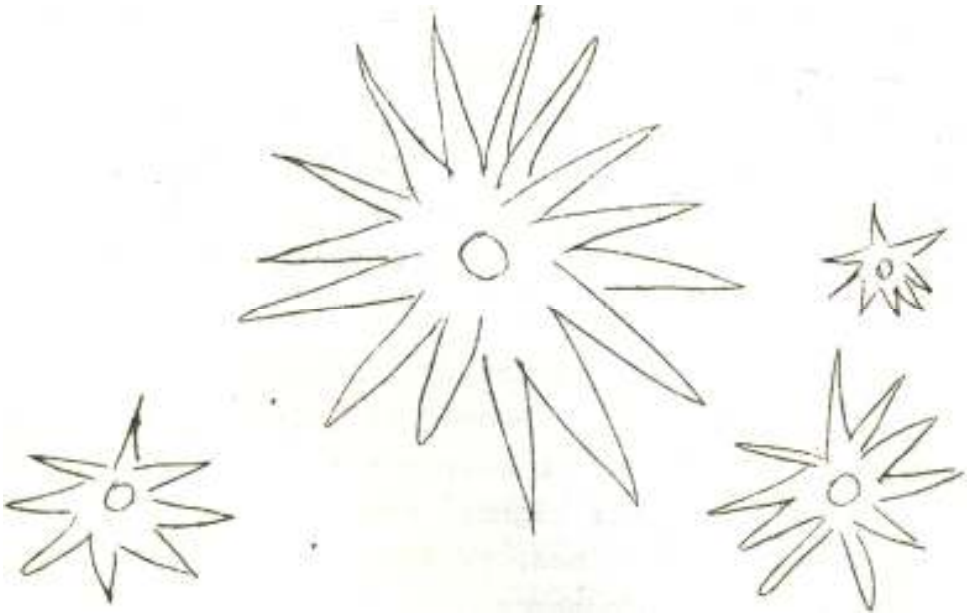
The concept of Community Health should be understood as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right. Thus it is beyond mere distribution of medicines, prevention of sickness and income generating programmes

Policy statement of Catholic Hospital Association of India, 1983 •

have both begun to reflect this changing trend in policies and programme directions. (See boxes). Their policy statements illustrate their awareness of our 'health care' realities and their attempts to respond to these needs through a re-orientation of their earlier preoccupations.

A very recent addition to this trend analysis, though more comprehensive and scholarly,is the rather voluminous 'Epidemiological, socio cultural and political analysis' of the health care situation in India(Banerji 1986).
This attempts to formulate the postulates of a new theory a new framework within which the'evolving health care' fcrm8nt could be placed (refer box)

In much of this literature and policy statements the term 'Community Health' is constantly used. Our reflections are,therefore a small contribution and attempt to add some clarity to this evolving 'approach' in the context of the Indian situation.



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”CMAI emphasises its commitment to Community Health - an approach that takes into consideration the needs and problems of the community and begins with a strong community based primary health care system. Community Health care starts with people - the community and is a process that recognises their right to health care. It enables or empowers them to work together to promote their own health and to demand appropriate health care services. It encourages people to take responsibilities for their own health and to influence decisions that affect their future. It expects health care services to be relevant, low cost, effective and acceptable to the people.”.

Policy Statement, 1986; Christian Medical Association of India.

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If The Asian Community Health Action Network views health as the physical, mental, social, spiritual, economic and political wholeness of the individual and the community . . . . . .

It believes that health problems and priorities should be viewed in· terms in which the community sees them and that the community should be actively involved in the planning, implementation, monitoring and evaluation of health care programmes •••

It seeks to spread a philosophy of community. based health care that envisages a process of self-reliant human development for the oppressed poor in Asian communities which will result in genuine social change …

An introductory pamphlet of Asian Community Health Action Network, 1982.

"Health service develcpment is thus

a) a socio-cultural process;
b) a. political process; and
c)a tec0nological 'and managerial process with an epidemiological and sociological perspective.

There is often a lag between socio-cultural aspirations of the people and their articulation by the political leadership; the lag is much more between aspirations of the political leadership and the community health physicians who have -the responsibility for building the needed edifice of the health services. The task is to narrow, if not totally eliminate, lags that may exist within the three tiers

Formation of a critical mass of community health physicians and other members of the team which can take full advantage of the scope, offered by the base **(i.e.** the complex of ecological, epidemiological, cultural, social, political and economic factors) are needed and require a new approach to education of community health physicians and other members of the team."

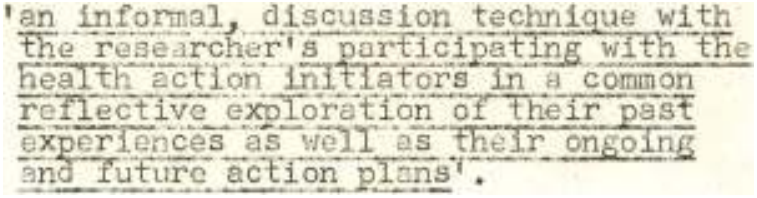
- D. Banerji (1986)

THE PROCESS OF REFLECTION .. A METHODOLOGICAL OVERVIEW

The reflections in this report have arisen out of the interaction with a large and growing network of individuals and groups concerned about the inadequacies of the health care system and involved with a wide range of health action initiatives.

The purpose of the entire study-reflection-action experiment, by the small team from the informal Community Health Cell was to build a framework for an alternative approach to' health care, based on a diversity of micro level experiences. The idea was to identify the philosophical assumptions, goals and methodologies arising out of the on-going, experiential process and probe the richness and diversity of possibilities. An explorative, tentative methodology had to be evolved since health was being studied as an enabling/empowering process in the community and orthodox research strategies were felt to be inadequate.

The methodology used could be summarised as:



The outcome of these discussions were further supplemented by personal communications, field visits, group discussions and interactions during some training programmes.

The need for an explorative and somewhat empirical methodology arose out of our own learning experiences during the years in a department of Community Medicine

where we were involved with the evolution and development of seven community based health care programmes. This was further encouraged by the experience in 1982 when we visited health and development projects in many parts of the country.

Based on these earlier experiences, we opted for a more non-formal methodology on the following assumptions:

I.) A large number of the health action programmes under review, have evolved out of a realization that the institutional based medical model of health care which we have adopted and developed in the last few decades in India, does not meet the needs of the rural communities, particularly the more marginalised sections.

These alternative approaches in response to an unmet social need have evolved through adhoc and empirical explorations by people who were not primarily health practice researchers. This means that the programmes are not projects with specific objectives and measurable predefined end points but are the outcome of a dynamic process that is based on experiential learning, group reflection and health team--community interaction.

ii) The process of evolution of these programmes is characterised by incremental additions of new components of action; mid-course corrections; and modification of on-going programmes: most of these changes based on team and community feed back. Certain constraints that are obstacles

to a more creative development in government related health care services such as centralised top-down planning, inadequate resources and supplies, political interference in decision making etc., are not usually operative. While these characteristics encourage innovation, they a1so reflect the differences in situation and in a way make it more difficult for the application of health practice research methodology based on “management by objectives" principles.

iii) Apart from purely technological or managerial innovation many of these health action programmes also are involved in awareness building, community organisation and conscientization. In addition, there are socio-politica1 and socio-cultural dimensions which are essential parts of the process.

The ‘medical model’ of health care looks upon health as s commodity to be provided or obtained. Researchers have automatically internalised this assumption and use industrial management techniques to study the provision service. These techniques invariably ignore 'socia1 processes' or are inadequate to study them.

iv) The dynamic interaction which is taking place between teams of health action initiators and the community is to be seen in the context of a gradual paradigm shift in health policy thinking of 'medicine as a providing process' to 'hea1th as an enabling process’. While it is easy to delineate variables affecting a 'providing

process', those affecting an 'enabling process' are still inadequately identified or understood. A lot of explorative work is required to identify potential variables of the 'enabling process' so that attempts to define, quantify and monitor can be initiated.

v) Evaluation of health projects often tend to focus on achievements and success stories ignoring failures and unexpected events. This bias often creeps in because the evaluation reports are responding to needs and pressures by funding agencies or support groups. In addition, by their attempts to impose parameters and criteria to measure and 'objectify' the process, evaluators and researchers often miss the 'process dimension' of the action.

The process of study was, therefore not a formal one in the academic sense i.e., planned research protocol, clearly defined objectives, pre-tested questionnaires, formal interviews and statistical analysis of data.

We spent a lot of time with health action initiators as individuals and groups, listening to their experiences and reflccting on their past experiences and their future action plans. The dialogue was done in a non-threatening way with the researchers sharing their own experiences and often planning initiatives together. Individuals and groups, therefore, perceived researchers as participants of the learning process and were not forced into 'an object of study' relationship. Hence successes, failures, achievements, difficulties, misgivings and anxieties

during the process of action could be probed and reflected upon.

As we heard more and more accounts, common situations, responses and problems emerged. At the same time we were able to appreciate the diversity and differences as well.

Our attempts were to identify indepth aspects of the process and not just to 'assess' or ‘evaluate’ experiences and the non-threatening, participatory dialogue situation helped this greatly.

We are well aware that 'traditional academic circles' may frown upon this non-fornml methodology as inadequate, non-objective and perhaps even biased or invalid.

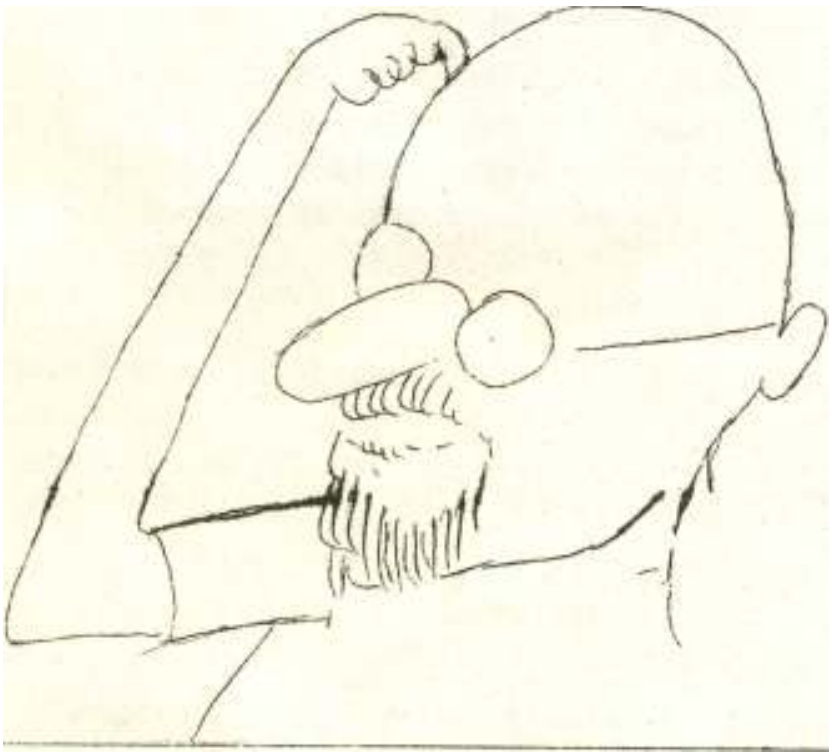
We were trying to build a collective understanding of community health emerging from the experiences of an increasing network of health action initiators and delineate as many aspects of the process as we could so that they could become part of a framework for further action research in the future.

The conscious decision to adopt a more informal methodology is, however, not a rejection of the need for a more well defined and formulated epidemiological/sociological study of the evolving community health process. It was basically a precursor step to understand and outline the wider dimensions of the process so that future research could be broad based and relevant.

The fact that health practice research and health care evaluation studies particularly at a community level, find such little coverage in the volumes of ‘disease-oriented’ reports that emanate from our teaching and research institutions nears testimony to the lack of interest among researchers towards community based processes.

The exploratory meetings organised by the Indian Council of Medical Research in 1976 and 1980 to look at alternative health care approaches were welcome steps in this direction; but this was not adequately followed up and continues to be a neglected area.

The challenges of study continue to daunt those of us who are interested and involved in the process. Our attempts were just a beginning.



COMMUNITY HEALTH IN INDIA

1. Ill health in the ultimate analysis is predominantly a product of an unjust socio-economic-political-cultural system which results in inequality of access to resources and opportunities that make health possible. An assault on ill health must, therefore, inevitably become part of a development and social change process which seeks solutions for the issues of social injustice of which most of the existing diseases are symptoms. Health action has, therefore, to be a means not an end; an "enabling" process not mere provision of a package of services.

2. Health action aiming towards the states of 'physical, mental and social well being' (WHO definition) among individuals and in the community must, therefore, include activities beyond the diagnosis of illnesses and the prescribing of drugs. They should include preventive, promotive and rehabilitative activities, health education and demystification of medicine; popularisation of health producing activities and attitudes, programmes to strengthen the people's traditions of self-care and attempts to increase the individuals, families and communities autonomy over their own health. Most crucial, however, is that health action should include an awareness building dimension and organisation of people and communities to get the means, the opportunities and the supportive structures that make health possible.

3. For too long 'health' and 'medicine' have been used synonymously. This has resulted in a medicalisation of health - wherein health is mistaken to be a process primarily related to doctors, nurses, hospitals, dispensaries, drugs, clinical and laboratory investigations, surgery and medical technology.

In the last two decades the incompatibility between "health" and "medicine" has been increasingly recognised and a complete paradigm shift in attitudes, values and practices has to be seriously considered.

4. The hospital based medical system - the hub of the present health system has been critically evaluated and subjected to an increasing degree of social audit, identifying a wide range of characteristic values that are found to be incompatible with a health generating process. These values include compartmentalisation and organ-centred specialisation, hierarchical team functioning and non-participatory decision-making, high technology, the water-tight division of responsibilities with an over-emphasis on the role of doctors, mystification of medical knowledge, the preoccupation with physical illness and the disregard for the psychological, social, cultural, political and ecological dimensions, the encouragement of consumerism and the increasing clinical and socio-cultural iutrogenesis. All these characteristics, however, evolved due to a historical and growing preoccupation of the system with individual-patient-focussed-illness-care, and an increasing subservience to the drug and technology industry. In the light of the more comprehensive understanding of "health" and "health care" emerging in the last two decades there is an increasing need to place the hospital-medical-technology model in the right perspective and accept its useful but limited role.

5. The commercialisation of "medicine" and "health" and its conversion to a commodity to be promoted, advertised and sold with a profit motive is another evolving process in society. The doctor-drugs-medical technology industry axis is gradually making medical care itself outside the reach of the common man. This commercialisation phenomena are symbolised by :-

increasing commercialisation of medical practice and the gradual transformation of what was essentially a "cottage industry" to a "corporate industry";

the unplanned growth of the pharmaceutical industry the growth responding to industrial imperatives rather than 'health of people' imperatives,

-- the continued political rhetoric of more doctors, more hospitals, more medical colleges and more specialists means more health for the people and this inspite of increasing unemployment and underutilization of the services,

-- the increasing practice of excessive and unnecessary laboratory investigations and equally excessive and unnecessary surgery stimulated by a profit motive, and more specifically in the Indian situation and in Karnataka State by the mushrooming of so-called capitation fee medical colleges where access to medical education is based not on academic or "social" merit but on the parents ability to pay for the seat.

6. What is most heartening, however, is the fact that this situation described in the preceding paragraphs has not gone unrecognised and very unambiguous and probably prophetic observations have become essential parts of official documents today.

The Health for a11 study group (mentioned earlier in chapter – 1) has warned:

(1) "There is always a dangerous turning point at which the overproduction of drugs and doctors create a vested interest in the continuance or expansion of ill health. It is not generally recognised that we are dangerously close to this explosive point."

(11) "A linear expansion of this model and the consequent pumping of more funds into the system will merely add to the "existing waste and make the ultimate solution of our health problems more difficult.

We are also convinced that mere tinkering with the system, through well meant but misguided efforts, as better training, better organisation and better administration will also not yield satisfactory results. This is precisely what has been done during the last thirty years; and the meagre results obtained are a strong pointer to the futility and wastefulness of continuing the same policies. "

7. The social disparities and the health needs of the masses as well as the inadequacies of the present health system have challenged and stimulated individuals - doctors, nurses, health and development activists to search for alternatives which are more suited to the lives and needs of the large majority of people and are also more committed to health promoting activities and attitudes. Starting from the early seventies a growing number of health care projects have developed in the country committed to creating more relevant alternatives. Each project has evolved in the context of the local social reality and the local health situation and hence has evolved its own characteristic process of action, package of services and local organisation. This process of evolution is more important than the resultant mix of activities. Unfortunately much of the existing focus of reporting of these projects has been to portray them as the alternative model. Our experience of studying many of them convinces us that many ideas, experiences, components of service and the dynamics of action from these projects taken together would help build an alternate approach and none are independently the complete alternative. Hence learning from the commonness of approaches and identifying the rich variations that exist would be a more meaningful way of deriving the new approach.

8. Over the years our contact with many people involved in this process, has helped us to identify the commonness and differences which are in themselves important to understand the process. The large number of individuals, groups, projects and initiatives involved differ very widely in their individual or project focus;

their ideological background;
their understanding of the development process in the country at national, state and regional levels;
their perceptions of government developmental efforts;
their conceptions of their own role in the development process;
their funding,
their understanding of others involved in a similar process,
their understanding of training, research and networking needs;
their perceptions of their own future.

9. We discovered that though they all did not necessarily agree or appreciate all the dimensions of community health which we have pooled together as axioms they did share the following common perspectives

a) Health was a process beyond the distribution of medicines by doctors or nurses.

b) Health was a process beyond institutional systems such as dispensaries und hospitals-big or small.

c) Health was a process initiated in the community, with its increasing involvement.

d) Health was a process of education and awareness building and the pedagogical objective was not just information transfer but conscientization.

e) Health involved a process of community organisation, often focussed on the increasing involvement of the more underprivileged and marginalised segments of the community.

f) Health was a process in which non-professionals, consumer, lay public and the average citizen had an increasing role to play.

g) Health was a process involving individual and collective responsibility as well basic human rights.

h) Health was a process intimately linked up with the process of development and the building of more just socio-economic -political-cultural relationships in society.

10. Broadly speaking the approaches commonly evolved included many of the following~

a) An attempt to integrate health with development activities.

Recognising ill health as the product of poor nutrition, poor income, poor housing and poor environment many health projects had gradually got involved with agricultural extension programmes, water supply and irrigation programmes, housing and sanitation schemes, income generation schemes; basic education including literacy, non-formal education and adult education programmes. Many projects which had started with a development focus were in turn adding a health care dimension to their activities.

b) An attempt to give a preventive, promotive and rehabilitative orientation to health action.

Most of these health projects had moved beyond the medicalised concepts of health symbolised by drug

distribution to activities - focussed on individuals and groups that present ill health and promote well being. Immunization programmes, maternal and child health care, family welfare activities, environmental sanitation, particularly safe water supplies, and sanitary disposal of excreta, sullage and refuse, nutritional supplementation and nutrition education and school health programmes were the commonest components.

Rehabilitation as a health-oriented action was seen mainly in the context of people suffering from leprosy.

c) Search and experimentation with low cost, effective and appropriate technology.

Many projects had tried to evolve or promote more appropriate health care technologies. The emphasis was not only on it being low cost but also on it being more culturally acceptable, demystifying and more within the operational capabilities of local people and health workers. These included improved dai (TBA) kits, nutrition mixes prepared from locally available foods, indigenous MCH calendar locally manufactured lower limb prosthesis, bangles and tapes to measure nutritional status of children, low cost sanitation options, home based oral rehydration solutions, herbal and home remedies from the backyard or kitchen and so on.

Two additional areas of technological appropriateness which had been experimented with in many of these projects were:

i) Health communications - Attempts had been made to use low-cost media alternatives like flash cards and flip charts and also to adapt local folk media and traditional cultural/art forms like puppetry, kathas (story telling), street theatre, music and dance forms particularly those which were common features of the festival culture in India. In tribal regions effective adnptation to 'nachna' (song and dance improvisations) was a common feature.

ii) Recording and evaluation techniques

Many projects have evolved simple methods of recording quantifying and keeping track of health activities or materials resources utilized by the health workers. These were geared to the capacities of local people (if they were people retained) or to the capacities of the local health workers. Many were geared to get over the constraints of illiteracy.

d) Recognition, promotion and utilization of local health resources.

Local health resources include local family based traditions of health and self care as well as traditional systems of medicine and their practitioners. Many health projects had created positive relationships with local dais (traditional birth attendants), traditional healers, folk medicine practitioners and the practitioners of various non-allopathic systems of medicine practiced, locally. This relationship had gone beyond a mere association to an acceptance of some of the medical and health practices of these systems, by the projects themselves. Promotion of

locally available herbal medicines and home remedies was an important component in many.

E) Training of village based health cadres

Training of locally selected individuals in the village in basic health care activities minor ailment treatment, first aid, recognition of illnesses needing higher levels of referral and care, nutrition, maternal and child health care, family welfare motivation, environmental sanitation, identification - reporting - basic measures in communicable disease control especially malaria, leprosy and tuberculosis, mental health care and so on·has been probably the most characteristic feature of all these projects. The selection methodology, the training methodology, the range of skills and the scope of training, the plan of activities and the remuneration and community support of these health workers reflects a wide diversity - but the most important result of this trend has been the conscious demystification of health issues and the creation of better informed village-based individuals who are available to help their own people in times of crisis. The pedagogical approach in the training session will determine whether these village workers will become ‘lackeys of the existing system' or the 'liberators of their people' as David Werner has warned from his Mexican experience. In many projects, however, we discovered that once health workers had been helped to understand the situation and plan and decide on local health actions, certain leadership qualities did emerge and action on issues wider than health was generated. In a fishing community women health workers had effectively organised people to protest against the local

bus system which refused to allow women to carry their baskets of fish on the bus to the local market. In many plantations health workers called link workers had emerged as local union leaders. Such situations were not at all unusual.

f) Increasing community participation in health decision making

In addition to training village level health workers, many of these projects have attempted to involve the community or their representatives in the planning and decision making process through the organisation of local village health committees consisting of both formal and informal leaders. Many had involved existing youth groups, mahila mandals (women's groups), farmers associations and co-operatives and teachers and religious leaders. This is a very important trend and a rather challenging approach. For community participation to be a genuine process of enabling people to take responsibilities for their own health services two pre-requisite conditions are essential :

j) Firstly the involvement of all sections of the commu**nity**. In the stratified village set-up with certain caste and class groups dominating decision making and exploiting certain other groups, purposeful involvement of disadvantaged and oppressed sections of the village often mean even exclusive involvement.

ii) Secondly the health action initiators must be willing to learn from the people and their own experience of local culture and social reality. This means a 'de**de**mocratic dialogue' on equal terms and involvement in

all aspects of decision making not just participation in programmes organised by the health team.

These two pre-requisite conditions have evolved to varying degrees in the different projects and hence the nature of particip2tion is a variable.

g) Initiating community organisation

The qualitative difference from the above approach is only of emphasis. Many projects have themselves **ini**tiated or catalysed the development of youth clubs, mahila mandals, farmers associations and various group activities recognising the need for local organisations to participate in planning and sustaining health actions.

This action has also emerged from the observation that even the poor and marginalised are not themselves a cohesive group or a 'community' in the real sense. They have internalised various social, cultural, political, religious divisions that divide society at large. Hence building group relationships and group organisations around issues and common actions are themselves pre-requisites **for** community health actions.

h) A quest for financial self-sufficiency and generation of local resources

Many projects have concentrated on the dimension of financial participation of the community as a dimension of community participation. These projects have therefore concentrated on generating local finances through insurance schemes, adding health functions

to dairy and other cooperative, graded payment of services listed to family income, festival collections and so on. Experience has, however, cautioned that an exclusive pursuit of this objective can often result in the very exclusion of those sections of the community which need the health services most especially when the purchasing capacity of people is so skewed.

Many projects have, however, widened this approach of generating local resources to means local resources - material, structural and human - that can be harnessed to support health actions. These have included grains for nutritional programmes, accomodation for clinics and programmes, basic supportive services by volunteers, grain banks, voluntary labour, building materials and so on.

i) Education for Health

'Health' education has been an important approach in most projects moving beyond the ‘conservative’ health education approach which usually includes information transfer on available health services and do’s and don’t’s for individual health. The efforts have been demystifying and conscientizing, helping groups to understand the broader issues in health care as part of a wider awareness building process. These have been specific components of health actions or have been introduced as components of existing adult education and non-formal education programmes. As people discover the cause of illnesses that they commonly experience, and identify their roots within their own social situation, they are prepared to do something. This has meant that this approach has often served as a starting point for individual or group

Education. School health programmes where teachers and high school students are oriented to do something about their own health, that of their own families and their community, share the same vision.

j.) Conscientization and political action

There are some projects where the health teams based on their own experience have begun to show a deeper understanding of issues for conscientization and recognise the need to support political action especially those of 'peoples movements' and mass organisations. This support may be through the organisation of health activities particularly for members of such movements or the addition of health demands on the agenda of people's struggles. In the South, especially the demand for a provisions of a water supply has often become such a rallying point.

ii) Do all these approaches taken together make up an **al**ternative approach to health care? Or, are there any additional dimensions - which are crucial for the evolution of a genuine process of community health?

We discovered that there were additional dimensions basically linked to new values and new attitudes which ultimately decided whether a project initiated by a community health team actually resulted in a genuine process of enabling people to build the health of their community or degenerated into an institutionalised effort providing a mix of community based services.

These were:

a) A democratic, participatory process in the community

Community health action had to be essentially a democratic, participatory, people and community building and empowering process.

This value - system had to be gradually internalised by the action initiators in all their interactions with the community. These interactions had to be 'as between equals' and it was necessary to make a conscious attempt to prevent poverty, social status, illiteracy, culture and professional education, from becoming barriers to genuine dialogue. When the action initiators were able to see their own education, skills and opportunities as a social investment of resources to be made available to the community-based decision making process and not direct it, such dialogue was established.

b) A democratic, participatory process in health team work

A democratic, participatory, non-hierarchical team building and team empowering value system had to be consciously internalised in the inter and intra-team relationships. This was crucial since all the initiatives had a large team of people involved in action and in the absence of this ethos in their inter-relationships health workers could not genuinely build a different value-based approach with the community. Accepting that the experiences and understanding of the field level realities of all the

health team members are equally crucial to evolving team decisions was an important first step.

Other features were :-

- respect for each members skills and potentials, appreciation of each members expectations and personality,
- greater understanding through mutual, non-threatening feedback on work and relationships,
- growing dialogue among members of positive and negative experiences and feelings, doubts, **in-**securities and plans for future,
- confronting entrenched social divisions like professional/non-professional, medical/non-medical, technical/non technical, intellectual/manual, masculine/feminine, expert/generalist and so on,
- common sharing of work reward and recoqnition, and rationalising of economic support and use of facilities.

c) A social analysis built on the local reality

It is necessary for community health action initiators to be realistic and analytical about ·the nature of the community in which they work. This analysis must help to build a process based on common interests but must be acutely aware of conflicting interests as well.

Community health action would invariably increase local tensions since any process in a socio-economically and culturally inequitous and unjust social system, aimed at increasing the participation and organisation of the large majority - the poor in the village will by opposed by status quo forces

and all those who draw greater advantage from the present system.

Rooted in the people and committed to a process of health building through the people's own actions, decisions and struggles, all those involved in genuine 'community health' would support and participate in the process as it goes beyond health issues.

d) Health action as 'means' not 'ends'

If health projects, health struggles, health activities initiated in the community are seen as 'means' to a community health building process and not just as 'ends' to tackle individual illness or ill-health then a new attitude moving from a 'project mentality' to a process emerges. Health action initiators with this attitude would be willing to disband, reorient, metamorphose or change their focus and action towards more relevant directions as they evolve through the community based decision making process. Such an understanding of process would also mean a concentration on human resource development and not structural or material. This would also prevent institutionalisation and bureaucratisation of the process.

12. A word of caution: community medicine and Community Health

One of the important insights we got from the study of such·a large number of initiatives was that all community based health projects are not always 'community health' oriented, even if they happen to use the expression in their objectives or go by that label.

Those of us trained in medicalised hospital systems and (unfortunately, there are still no alternatives to this base for basic medical education) used to the hospital culture in organisation, method of functioning and team work are not always able to make the necessary attitudinal changes when initiating community based health action.

Many of the projects were extensions of the hospital system in their organisation and methods of functioning. True to their medical roots, many of them for instance distributed drugs, vaccines, vitamins, ORT, nutrition supplements with the same- 'dependence creating mentality'. Their teams were hierarchical and in the absence of participatory decision-making within the team, the claims of community participation were unjustified. The water-tight division of responsibilities, the compartmentalisatien of health, development and educational activities, the over-professionalisation, the clear distinction between 'providers' and 'users', the quest for efficiency and cost effectiveness over-riding process building needs, the preoccupation with targets and even a degree of profit orientation, clearly indicated that they had unconsciously internalised many components of hospital culture without subjecting them to a critical review to evolve a new health enabling approach.

Even though on a superficial overview their community based actions appeared different from hospital activities, a deeper understanding of the pervading value system showed that they were just community based extension of medicalised forms of the health system.

Due to this orientation, therefore, many of the projects had evolved highly organised systems of health care delivery - cut off from the lives of the poor people in their own communities. They were bureaucratic, project-oriented and at best no better than the existing primary health centre of the Government model, except that they were more organised, more efficient, probably more costly but no less irrelevant.

Without getting involved in semantics, we feel that such projects and initiatives should be called ·community medicine' projects instead. They could be called community health projects in as much as they identify these hospital derived attitudes, confront them in their actions and evolve a process built on 'health enabling' attitudes.

Our study revealed that this shift was possible and many medicine-·oriented projects were shifting to new values and attitudes in action encouraged by a combination of

a~ frank team evaluation;

b. participatory evaluation by the community, especially the poor;

c. willingness to reflect and critically analyse experience in the context of a social analysis

13. The Community Health approach and the existing medical system

The community health approach has evolved from the attempts of a large number of people concerned about the present medicalised approach to health care and its inadequacies in responding to the needs of the large majority - the poor and marginalised groups in society. Most of the people involved in developing components of this new approach have themselves had much of their training and experience initially in the hospital-dispensary oriented system. Some of the approaches have emerged from a confrontation of the existing value system and culture of the western-technological model of health care of which the hospital and dispensary are characteristic examples.

Does this mean that the 'community health approach' and the existing medical system of hospitals, dispensaries, health centres, doctors, nurses, drugs, technology, centres of specialisation, education and research are incompatible?

While recognising the need for a 'paradigm' shift in attitudes and approaches from the 'provision of medical care' to the 'enabling of community health' we feel that these are neither mutually exclusive nor incompatible.

It is necessary to recognise that many aspects of the value systems of existing highly technological western models of care which we have inherited and continue to transplant in our country are somewhat counter-productive to the goals of community health.

It is necessary to recognise that by their very nature, such highly capital intensive technology systems skew health services in favour of those who can afford to pay for them. Gradually the forces of a market economy of which such a model is an integral part, alienates the structure from the poor and underprivileged and all those who basically cannot afford the luxuries of the type of health such systems symbolise.

However since community health is basically a new vision, a new value system and a new attitude it can confront and pervade the entire existing superstructure of health care.

This superstructure of health care includes:

- the hospitals, dispensaries, specialist centres, health centres under government and non-government voluntary agencies and private initiatives;
- the medical, nursing and paramedical education and training centres,
- the specialised research centres, the professional medical and nursing associations and the regulatory councils and committees,
- the doctors, nurses, paramedicals and health auxiliaries.

Arising from community based experience as a new vision, community health has to challenge the superstructure to become

a) more 'people' oriented
ie sensitive to the realities of life of the large majority of people - the poor and underprivileged.

b) more 'community' oriented
ie understanding health in its community sense and not·just as the problem of·individuals,

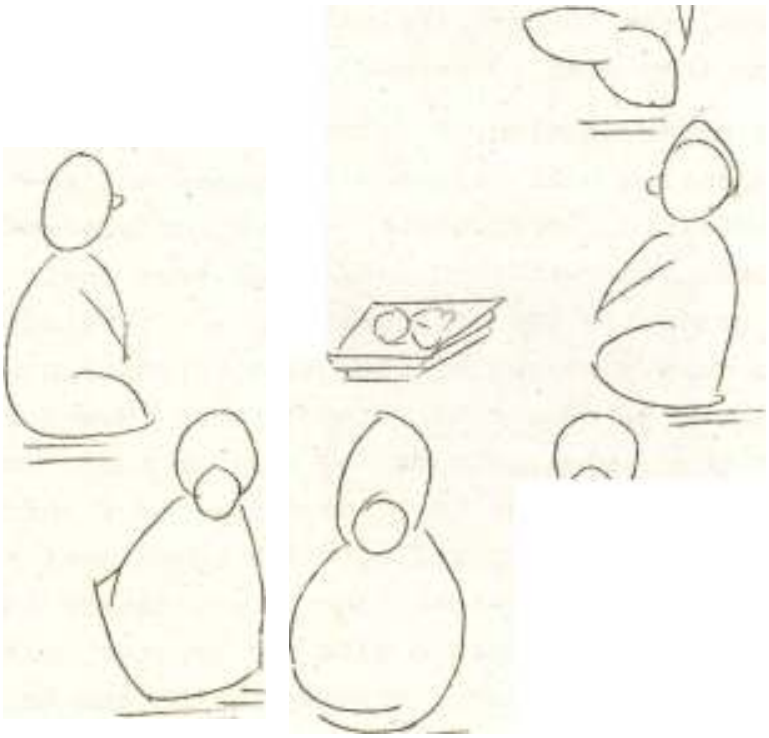
c) more socio-epidemiologically oriented
understanding health in its holistic sense - which involves the biological, social, economic, cultural, political and ecological dimensions.

d) more democratic oriented
ie more participatory and democratic in its growth, planning and decision making process,

e) more accountable
ie ·increasing subservience of medicine, technology structures and professional actions to the needs and hopes of the people, the patients, the consumers, the 'beneficiaries' and the communities which they seek to serve.

This confrontation of value systems and re-orientation will help the superstructure and its different elements to emerge from their present ivory-towered isolation and irrelevance and gradually become supportive infrastructure of a more just and healthy society. However this change cannot be miraculous or based on just good intentions or any amount of wishful thinking. It must be a serious commitment to social analysis, participatory evaluation and critical self-searching for greater relevance by all those concerned with planning and decision making in the present superstructure.

Already in the last few years we have seen examples of policy formulating committees in government and in the non-governmental network and some institutions, centres and departments initiating this process.
We are firmly convinced that it is possible.



THE MOVEMENT DI~~NSION

1. Our study of the dynamics of community-based health action and the evolving approaches from micro-level alternative experience brought us in touch with an increasing number of initiatives all over the country and newly emerging trends which indicate that "Community Health" could well become a movement linked to a wider development and social change process in the community.

This is particularly significant since for long the meaning of "community health" was viewed differently in "health circles" divided by two conflicting schools of thought described succinctly in the mfc anthology **(1981)**.

A failure of newly emerging health projects seeing themselves as part of a larger social change process and a failure of development organisations, the political party system and mass movements in recognising the value and deeper dimensions of health.

This division was created by a double failure. (See box P46)

POSITIVE TRENDS

2, In recent years there is a discernible change in the overall situation, with these clear-cut divisions getting blurred and many new developments which augur well for the movement 'dimension' of community health. The developments include :-

a. ,Government policy Reflections

As has been described in Chapter One, many governmennts, policy formulations and expert committee reports have been critically evaluating the inadequacies of the present medical model and reflecting on new approaches.

n)

"One school feels confidently that the panacea for the health problems of the people has been found. It is the alternative approach of health care delivery usually meaning utilization of non-professionals and appropriate technology in health care.

Another school is equally confident that the only real cause of ill-health is the present economic system and nothing can be and should be done to solve health problems unless the present economic-political system is changed by revolution.
The first leads to ill-£ounded euphoria The second to inactive cynicism towards the burning health problems of the people.”·

Many decision-makers, administrators and technocrats within the existing system are aware and sensitive to these new approaches.

b) "Village Health Worker Army"

A growing army of villagers and lay-people have been trained by Governmental and Non-governmental agencies all over the country. Whatever the quality or orientation of training, taken· in the overall sense, this has initiated a phenomenal process of spread of health knowledge and this is bound to have far-reaching consequences. The development and easy availability of a large number of number of health training manuals are themselves a phenomenal process of demystification of health.

c) Non-medical health activists

A growing number of individuals involved in development efforts, non-formal education and social change are beginning to recognise and appreciate the varied dimensions· of health. Social workers, journalists, teachers, consumer groups, non-medical scientists, lay public are becoming increasingly involved in health care issues.

d) Health in the education process

Health issues are increasingly becoming part of the syllabi of the formal educational system as well as a component of adult education and non-formal education efforts allover the country. School health programmes have begun to increasingly focus on "education for health" programmes directed towards school children and teachers. Science education experiments (eg. "Kishore Bharati and Eklavya" experiments in Madhya Pradesh) have also introduced health aspects in the innovative curricula developed by them.

e) Heal th on the agenda of science popularising movements

Movements for the popularisation of scientific attitudes in the community like the Kerala Sastra Sahitya Parishad and the Lok Vigyan Sanghatana (Maharashtra), and the Karnataka Rajya-Vigyan Parishad are good examples of people-oriented science movements who have adopted many health issues for their awareness building and issue raising Jathas and exhibitions. Numerous smaller efforts are emerging all over the country.

f) Health linked to issue based environmental movements

The last decade has seen the emergence of a large number of peoples' movements and protests around forest issues, environmental issues and social problems in which the 'health of people' is an intrinsic component though not always stated so explicitly. (Refer - State of the Environment Report, CSE,1984)

g) Health on the agenda of mass organisations and mass movements

The trade union movement in the country has shown an increasing interest in health issues, particularly workers health, though the interest still falls far short of the needs and possibilities. Many independent trade unions have supported health projects or health personnel and some have shown interest in training of health workers from among their members. The Chatisgarh (CMSS project) is a good example of how deep this interest can develop.

The women's movement has also begun to appreciate the importance of health issues and include some aspects on their agenda e.g. issues relating to Family Planning.

The SEWA movement in Ahmedabad (Self Employed Women's Association) is a significant example. The involvement of Mahila Mandals at the community level in health action is also a significant development.

h) Health orientation of coordinating groups and agencies

The medical system in India is divided into governmental and non-governmental effort, the latter adding to 20% of the total infrastructure. The voluntary Health association of India is a federation of statelevel networks of health projects and initiatives in the voluntary sector. Committed to a health philosophy since its initiation they have been responsible for much of the networking efforts and primarily of collating and producing a wide range of health oriented literature (in English and regional Languages) in the country. More recently two of the other large coordinating groups of church sponsored h2alth and medical institutions -the Catholic Hospital Association of India and the Christian Medical Association of India-have also reformulated their policy focus towards community health from the previous curative/hospital orientation.

i) Health care issue networks

In medical, nursing professional circles there is a growing sensitivity to broader issues of social change and 'community health' and a recognition that 'health' is more than a narrow technical or professional enterprise. By and large the established 'professional system' has not gone beyond rhetorical statements but small networks of socially sensitive groups have emerged in all parts of the country. The 'medico-friend circle' which began in the mid-seventies was a 'thought current' which slowly began to evolve and consider new approaches.

For most of the seventies it was a small and atypical and probably pioneering effort. The eighties have however seen the emergence of numerous mfc type responses localised to cities, regions or networking around ideological positions (Socialist Health .Collective) or emerging from medical student and junior doctor movements. This often unconnected but 'generational response' is a significant development. Networking around health care issues and the emergence of broad fronts such as the All India Drug Action Network is another important trend in the country. That over thirty or more health groups, development groups, science education movements, trade unions, consumer groups, academic departments, associations could come together to commit themselves to a wide range of efforts to promote a rational drug policy in India geared to the health needs of the people is characteristic of the possibilities for the future.

Taken together, all these developments, often independent of each other, create the necessary ethos and preconditions for the possibility of a wider, more intensive movement towards health policy and health structural changes emerging in the country.

3. Negative trends

There are many negative trends as well and these could well become obstacles for a genuine process of 'community health' emerging in the country. Hence the positive trends, though calling for guarded optimism should be seen in the context of these negative trends.

The negative trends are :-

a) Commercialization of Medicine

Medicalisation, Professionalization and a consumerist orientation of medical and health care is increasing and is symptomatic of a general trend in the country. The recent entry of the corporate sector in a big way in what was traditionally a cottage industry of private practice is a case in point. The 'mushrooming' of capitation fee medical colleges and 'high technology' investigation centres in the private sector are other components of this trend.

b) Mushrooming of 'health' projects

Health projects are mushrooming all over the country supported by a combination of economic and social factors. Initiating forces include - Foreign funding agencies vying with each other to invest in the alternative. Industrial houses investing in rural development; Professionals getting involved for prestige, status and power; Religious and social organisations competing for relevance or membership and so on - using health services to achieve other ends. This band-wagon nature of the growth of health projects out of context of a social analysis, could make much of these efforts counter productive to the g031s of community health. Most of these projects are characterised by a lack of understanding of peoples needs and aspirations; lack of skill in working with people; lack of understanding of the paradigm shifts in attitudes and approaches and insensitive to existing social reality.

c) Inadequate networking of efforts

'Community health' catalysts and action/project initiators are not adequately networking to share perspectives, support each other, evolve a common understanding of what is in reality a very complex and dynamic process.

The inadequacy is characterised by the following trends.

1) Development circles in India have been divided by ideological divisions into various groups. Right and Left, Gandhian and Marxist, Christian and Hindu. The Christians are divided by denomination - Catholic and protestant and by theology - evangelisation or liberation; the marxists into various groups reflecting the schisms of the Left at an international level; the Hindu - by philosophy traditionalists and vedantists, and by caste - scheduled, backward and forward. These divisions have a phenomenal ability to creep into networking efforts thus issue based movements become difficult to sustain over a long period. The trends in development networking has shown some of these trends but the experience of medico-friend circle, the voluntary health association of India, the All India Drug Action Network and Asian Community Health Action Network give some experience of new possibilities in health.

d) Inadequate Research and Lobbying

Networking efforts have not resulted in adequate critical evaluation of efforts, research on developing overviews, communication of shared perspectives to key planners and decision makers and an active participation in public debate on government health policy. Thus research, documentation, and lobbying efforts have been inadequate in quantity as well as somewhat 'amateurish' in methodology - definitely not in consonance with the rich experience generated at the micro level.

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Much of the communication, lobbying and participation in policy planning and debate has been done by 'Charismatic health action initiators' as individuals and not adequately as representatives of this generational response. This dialectical tension between individualism and collectivity has prevented the movement from spreading as much as it needs to, considering the issues and gigantic efforts required.

e) Status-quo forces

The ability of the existing status-quo forces dominated by the 'hares' to internalise and coopt many of the ideas and experiences of the community health approach into the policy rhetoric but defeating the spirit of the process in action must not be under-estimated. These status-quo forces exist in all sections and divisions of the system - governmental, non-governmental, professional, community. Hence paradoxical policies and programmes, initiated by any of these sections - governmental, non-governmental or professional-need to be evaluated by a social analysis and a participatory dialogue at the community level and pressure groups built to counter them at all levels.

A movement towards 'Community Health' can, therefore, be a bridge between the 'ill founded euphoria' of the alternative health care project enthusiasts and the 'inactive cynicism' of the socio-political activist, building a new common and more mutually supportive process. All those interested in Community Health have a tremendous challenge ahead.

TASKS FOR THE FUTURE

In the preceding Chapters we have described some aspects of the Community Health Movement, which is evolving in the country over the last few years. Our experiences through the Community Health Cell and the medico friend circle have convinced us that these trends and initiatives are developing in most parts of the country and Karnataka, which was our main focus, was no exception. In the years to come, this multi-dimensional response will probably grow as a generational response to the health needs of the large majority. Since health cannot exist in isolation, it is necessary that the community health movement becomes part of a larger social movement towards greater equity and justice. Equally important, is the need for such a movement to focus on the existing health care structure, health policy and health and medical education policy, to confront and challenge it to become a more "community health" oriented in its values and focus.

These challenges cannot be met, without networking of efforts. Hence networking and evolving a collective dimension in existing efforts must become a crucial phenomena in the years to come. There is no doubt that such networking and collectivity in efforts is already taking place. The medico friend circle, All India Drug Action Network, the Social Health Collective, Voluntary Health Association of India and the Asian Community Health Action Network are good examples of the phenomena. However, much more needs to be done. Networking requires, that the interaction between participating groups is frequent and diverse so that a common overall perspective emerges. Regional networking around issues and/or at district level are, therefore, rather important to sustain the collectivity.

Networking means, essentially, a coming together to share, reflect, associate and work together in mutually established action thrusts. The links established, need to be participatory and democratic and should transcend the constraints of group membership and institutional development. It is not uncommon for networks, to formalise into legal associations and institutionalise their efforts. Equally common, is the fact that networks often begin to focus on the needs of their membership, rather than the needs of the wider movement. A certain routinization and bureaucratization of action is also not uncommon.

The groups and initiatives in Karnataka with whom we have established some contacts in the last few years are expressions of a rich diversity. They differ widely in their focus of activity; their ideological inspiration; their understanding of the development process; their perceptions of the governments development efforts; their conceptions of their own role; their funding and their organisational ethos. This diversity has been noted even earlier in this report.

Our reflections with them, around the scope and dimensions of community health, which is experienced in our exploratory axioms, convince us that there is abroad consensus in understanding of community health action and, therefore, there is a real prospecti of 'health action' based networking. This networking will have to go beyond some of the existing efforts, in order to be able to tap and bring together the rich diversity of ongoing effort. Community health action initiators need to be invited to come together to share experiences and reflect on their action, in meetings without prefixed agendas or pre-conceived plans.

The ethos of the dialogue should be such that participants should be able to share their difficulties, problems and failures as much 3s their successes, strengths and positive experiences. The present "development ethos" in the country is rather geared to successes and "targetted objectives", and the links of funding and support to "success stories" is a great pressure preventing honest, critical, collective reflections on inadequacies of our efforts, which in the long run may be a great lacunae in the understanding of development dynamics participatory, non-threatening collective reflection rather than 'evaluation' could be the starting point for a rich learning experience.

A Networking effort in the long run will have to address itself to a large number of challenges that are required to be met, to support the emergence of a greater collective dimension in 'Community Health' action.

a) The first and most obvious is whether a collective dimension in effort is at all possible in the context of the rich diversity of existing initiatives and responses?

b) Can broad consensus and common perspectives emerge around some issues and action thrusts inspite of the recognition of differences of approach and situation analysis in other issues ?

c) Can 'Community Health Action' emerge in the context of a wider socio-economic-political-cultural process of change in a region or will it continue to reflect a more compartmentalised, medicalised response to overall health need?

d) Much resources in time, money, materials, training are being wasted by massive duplication of efforts in a spirit of competition and rivalry between initiatives sponsored by ideological divisions, funding agencies and personality conflicts. Can an ethos of collectivity be generated which can over-shadow these trends ?

e) Can a more interactive and participatory communication strategy be evolved through networking to allow :-

for a greater sharing of individual and group experience;

a greater transferance of community health perspectives in on-going development education efforts;

a greater translation·of existing documentation into link and regional languages to ensure a wider dissemination of ideas;

a greater dissemination of community health perspectives into mass education and conscientisation efforts.

f) Can networking also include an important dimension of dialogue with key Government Health Planners and policy makers to provide critical and relevant feed-back about the field realities of existing health care policies so that newer policies and alternative perspectives could be adopted by the existing system?

g) Though much of the alternative and innovative work we have been in touch with has emanated in the non-governmental "voluntary" sector, we see an important need in encouraging NGOs to see themselves <u>not as builders of a parallel health system</u> but as enablers and empowerers of communities especially its marginalised sections to make increasing demands on the existing health care structures so that they become more responsive to the real needs of the larger majority. Can such an "enabling" or "empowering" ethos be fostered through the networking ?

h) Can there be a greater collective interaction and utilisation of existing resources in a region in terms of training, documentation and communication support ?

i) Any regional networking will inevitably need to keep track of experiments, initiatives, innovative developments and collective process emerging in other regions of the country; How can a regional. network facilitate this ?

j) A lot of community health action effort is initiated in a somewhat adhoc and impulsive way. Often they are ideas imposed from the outside by Project Leaders responding to ideological compulsions, professional bias or funding agency suggestion. It may be possible to initiate a socio-epidemiological approach to problem solving and identification of priorities within the local context through a participatory process involving both the health team and the community. Such a skill development would greatly enhance the re-levance of community health action since it would ensure that action emerges out of a deeper under-standing of the social reality.

Could networking help to generate this sort of investigation and action-research support for ongoing initiatives?

k) It is important to recognise that 'health' is gradually becoming an important item on the agenda of people's science movements, trade unions and mass-based movements, outreach programmes of training and research institutions, adult and non-formal education programmes and so on.

Can the networking effort keep contact with these movements and understand the deeper issues and wider contexts in which they operate, apart from the health content of their interventions ?

1) Even though this may be a sweeping generalisation, it has been our experience that 'alternatives' emerging in· health and development circles suffer from a lack of inculturation efforts. Due to a purely secular analysis which is strongly western in its cultural assumptions, the cultural and religious influences on the community and our own cultural/social/historical experience are not adequately studied or considered while evolving alternative approaches. The negative attitude to traditional systems of medicines and their philosophical assumptions, "scientific content" and cultural links is a case in point. Similarly, little importance is given to protest elements in the religious and cultural history of the country which could strengthen the process orientation of existing movements. Can the networking effort look at this lacunae and evolve a critical study process?

The ICMR/ICSSR Health for all report has specifically noted that an alternative health policy should have a philosophical and cultural dimension and also that 'there is a need to give a national orientation to the health care system by the incorporation of the culture and traditions of the people, not chauvinistically but rationally'. Can the networking effort initiate a process to look·seriously at this dimension?

m) Demystification of medical and health concepts are an important but neglected area of action and in the context of evolving a 'community health' movement, this is rather crucial. Community health perspectives emerging in the country need to be communicated in simple, straight forward language to the lay to build up their participatory involvement. Without a conscious effort in this direction, it can like most other aspects of life become mystified, full of jargon and professionalised. People's control over the means and

processes which make health possible can be ensured only if they have access to medical and health knowledge. What can the collective or networking effort do in this direction ?

These are some of the important components and issues in an emerging movement which all of us involved in community health action need to address ourselves, to in our activities in the years to come.

With particular reference to the exploratory principles we have evolved in **our** reflections, a large range of documentation efforts is also needed. For this documentation, to represent the rich field experience in India, greater collective efforts to collate ideas and approaches will have to be made.

The range of dimensions that need further exploration and clarification are many, viz.,

what does participatory, non-hierarchical, decision making process mean at the community and health team levels? what are the dynamics of such a process ?

what are the components of an awareness building pedagogy? what are the skills, approaches and materials that have developed in the context of this approach ?

what are the elements in the existing medicalised model of health which represent

over-medicalisation
over-professionalisation
compartmentalisation

How are they being tackled by different initiatives?

what are the examples where existing health superstructure has become more "people oriented", more "community-oriented", more "socio-epidemiologically-oriented", more "democratic" or more "accountable" ?

what are the components of a medical pluralism in policy and health care options? what experiments have been undertaken by the existing community health care network in this dimension of policy ?

if health has to become an 'enabling' and 'empowering' process rather than mere provision of a package of services then what are the social processes it must confront and address itself to?

A new approach and a new understanding will throw up more of such questions and the search will have to go on.

In conclusion, if community health is

a new vision of health care
a new value orientation in health action
a new perspective of the future linked to a new vision of society

then a large range of serious questions, issues and challenges face all of us who wish to commit ourselves to a participation in the movement which is evolving.

What will be our response - as individuals and as a collective network ?

The meaning of 'Health for All' by 2000 AD will depend very much on this response!

DIMENSIONS OF COMMUNITY HEALTH

(A summary of principles derived from the reflection)

COMMUNITY HEALTH

is a process of enabling people
to exercise collectively **their** responsibility to
their own health
and,
To demand health as their right

THE COMMUNITY HEALTH APPROACH

involves the increasing of the individual,
family and community autonomy over health and
over the organizations, the means, the
opportunities, the knowledge and the
supportive structures that make health
possible

THE COMMUNITY HEALTH APPROACH

includes

an attempt to integrate health with
development activities including
education, agricultural extension and
income generation programmes;

an attempt to orient existing medical
programmes towards preventive, promotive
and rehabilitative actions;

a search for and experimentation with low-cost, effective, appropriate technolcgy in health care, health communications and recording systems

a recognition and involvement of local, indigenous, health resources like traditional healers, folk-medicine practitioners, traditional birth attendants (dais), non-allopathic systems of medicine, herbal medicines and time-tested home remedies;

a training and involvement of village-based health workers;

an initiation of greater community organisation through farmers, youth and women's clubs;

an increasing involvement and participation of the community, through formal and informal organisations and health committees, in decision making for health action including planning, financing, organising and evaluation of health actions;

a quest for generating greater community support in health action through cooperatives, health insurance and other schemes as well as tapping locally available labour, human skills and material resources;

an organisation of informal and non-formal demystifying and conscienting programmes of education for health.

THE COMMUNITY HEALTH APPROACH

is essentially a democratic, decentralised participatory, people-building and people empowering activity

and

recognises that this new value system must pervade the interaction between the community and the 'health action' initiators as well as within the team of 'health action' initiators themselves.

To enhance the 'community health' approach it is "therefore, necessary for 'health action' initiating teams to evolve a greater democratic, non-hierarchical, participatory, team-building and 'team empowering' ethos in their own relationships as individuals and members of a team.

THE COMMUNITY HEALTH APPROACH

recognises that in the present inequitous and stratified social system there is no 'community' in the real sense of the word and hence community health action will invariably mean, the increasing organisation, involvement and participation of the large sections of the community, who do not participate adequately in decision making at present i.e. the poor, the under-privileged, the marginalised

such attempts will invariably be opposed by 'status quo' forces and all those who draw greater advantage from the present situation.

A community health approach will recognise the presence of these conflicts of interests and the inevitable social tensions consequent to community health action but being committed to a 'community empowering' process it will support actions and struggles as they go beyond 'health' issues.

THE COMMUNITY HEALTH APPROACH

recognises that the large majority, the poor and the disadvantaged are not themselves 'one community' even though they are linked by their poverty and social situation, since they have internalised various social, cultural religious and political differences that divide society at large.

It, therefore, accepts that in terms of process, efforts to imbibe the concept and the spirit of community, to improve group dynamics and group inter-relationships are preliminary to evolving community actions of any sort.

Hence through all its component programmes and activities, the community building process will be promoted and enhanced.

recognises that the present over-medicalised health care system is characterised by certain features viz.,

hierarchical team functioning and non-participatory decision making;

water-tight division of responsibilities with over-emphasis on the role of doctors;

quest for specialisation and compartmentalisation of professional activities;

a pre-occupation with the understanding of human illness in terms of an organ-centredness and at intracellular, molecular levels, forgetting the whole 'being' in the process;

a clear distinction between 'providers' of the service and the 'users' of the service;

an over-emphasis of the 'physical' dimension of health and a disregard for the psychological, social, cultural, spiritual, ecological and political dimensions;

over-professionalisation which controls the spread of technical knowledge and skills to members of the health team and to the people at large;

'providing orientation of services and actions rather than the 'enabling' orientation;

an over-emphasis on drugs and technology leading to a complete disregard for non-drug therapy and skills;

a pre-occupation with the allopathic system of medicine ignoring the existence or utilisation of the culture and practices of the other systems of medicine and healing.

Community Health action initiators even though they most often emerge from these medicalised environments, do not see themselves as just extensions of this medicalised system.

They constantly confront these issues in· their approach and actions and try to evolve new attitudes, new skills and new approaches that are people and community oriented and place medicine, professional skills and technology in their right and limited context.

THE COMMUNITY HEALTH APPROACH

evolves action from the community outwards and upwards confronting the various components of the existing superstructure of health services which includes

the primary health centres, dispensaries, hospitals, teaching and research institutions;

the medical, nursing, paramedical and public health teams and professional training centres and associations

the health programmes and health institutions under government or non-governmental voluntary agency auspices.

IT CONFRONTS THE SUPERSTRUCTURE TO BECOME

More people oriented ie. sensitive to the realities of the life of the large majority of people - the poor and the underprivileged,

more 'community' oriented ie. understanding health in the context of the problems of the whole community and all its sections and not just as individual problems,

more 'socio-epidemiologically' oriented

ie. recognising the biological, socioeconomic, psychological, cultural, spiritual, political and ecological dimensions of health,

more 'democratic' ie. participatory in its growth, planning and decision-making processes,

more ،accountable' ie. increasing the sub-servience of medicine, technology, structures and professional actions, to the needs and hopes of the people, the patients, the consumers, the beneficiaries and the community which they seek to serve •

THE COMMUNITY HEALTH APPROACH

is therefore not just a speciality, a new professional discipline, a new 'technological fix' or a new package of actions

It is predominantly a new vision of 'health' and 'health care', a new attitude of mind, a new 'value orienation' in health action and a new perspective for the future linked to a new vision of society.

It must therefore, pervade existing health care systems, institutions, research efforts, training programmes, professional ethics and health planning exercises.

COMMUNITY HEALTH ACTION

is closely interwined with efforts to build an alternative socio-political-economic-cultural system in which health can become a reality for all people.

The 'community health approach' therefore recognises that the components of actions are means and not ends, and will therefore be flexible enough to reorient, reprioritise disband or change towards more relevant actions and directions as they evolve in the interactions at the community level.

d)

APPENDIX : : A

These reflections are based on an interaction with a wide range of projects, individuals and groups, institutions and initiatives all over India, who are involved with alternative approaches in health care and development. The interactions have taken place since 1975 but more specifically since 1982. They are listed out in order to express the rich diversity of ongoing efforts as well as to acknowledge that the written or shared experiences of most of them have helped in the evolution of these reflections.

1. Community Health and Development Projects

a) Action Research in Community Health (Mangrol), Gujarat.
b) Ahmedabad Study and Action Group (Ahmedabad), Gujarat.
c) Chandrabrathi Project (Tamluk), West Bengal.
d) Chetna Vikas (Gopuri), Maharashtra.
e) Child in need Institute (24 Parganas) West Bengal.
f) Comprehensive Health and Development Project (Jamkhed) Maharashtra.
g) Gandhigram Rural Training Centre (Ambathurai), Tamil Nadu.
h) Kishore Bharati (Hoshangabad), Madhya Pradesh.
i) Marianad Fisherman's Cooperative (near Trivandrum), Kerala.
j) MG DM Hospital Community Extension Programme (Kargazha), Kerala.
k) MERG Project (Tambaram), Tamilnadu.
l) Nilgiri Adivasi Welfare Association (Kotagiri), Tamilnadu.
m) Pallimangal Project Centres of Ramakrishna Mission (Kanarpukur, Jairanbati, Balideranganj), West Bengal.
n) Rural Unit for Health and Socail Affairs (Kavanur), Tamilnadu.
o) Sewa Mandir (Udaipur), Rajasthan.
p) Social Work Research Centre (Tilonia), Rajasthan.
q) Tapovan Community (Amravati), Maharashtra.
r) VIKAS Project (Ahmedabad), Gujarat.
s) Vivekananda Girijana Kalyana Kendra (BR Hills), Karnataka.
t) Voluntary Health Services (Adayar), Tamilnadu.

2. Health Projects linked to medical colleges

a. Projects of St John's Medical College (Mallur, Uttarahalli, Silvepura, Dommasandra, Bidraguppe, Yadavanahalli, Mugalur, Huskur), Bangalore, Karnataka.

b. Saklavara Community Mental Health Project, National Institute of Mental Health & Neuro Sciences, Bangalore, Karnataka.

c. Ballabgarh Rural Health Project and Urban Health Centres of All India Institute of Medical Sciences, New Delhi.

d. Raipur Rani Project of Post Graduate Institute, ·Chandigarh.

e. Rural Projects of Community Health and Development Department, Christian Medical College, Vellore, Tamilnadu.

f. Community Medicine Department of Mahatma Gandhi Institute of Medical Sciences, Wardha, Maharashtra.

3. Training, Coordinating and Resource Centres and initiatives in Health and Development

a. Asian Community Health Action Network (Madras), Tamilnadu.
b. Behaviourial Science Centre (Ahmedabad), Gujarat.
c. Catholic Hospital Association of India (New Delhi).
d. Christian Medical Association of India, Bangalore.
e. Centre for Science and Environment, New Delhi.
f. Federation of Voluntary Organisation in Rural Development, Karnataka (FEVORD-K).
g. Indian Social Institute, Bangalore, Karnataka.
h. Indian Social Institute, New Delhi.
i. Centre for Education and Development, Bombay.

j. Lokyan, New Delhi.
k. medico friend circle (Pune, Baroda, Mangrol, New Delhi, Bombay, Nipani, Wardha).
l. Science for the villages (Wardha), Maharashtra.
m. Safai Vidyalaya (Ahmedabad), Gujarat.
n. Seva Kendra (Calcutta), West Bengal.
o. SEARCH (Bangalore), Karnataka.
p. State Voluntary Health Associations (Karnataka, Tarnilnadu, Andhra and Gujarat).
q Vikram Sarabhai Centre for Science and Technology (Ahmedabad), Gujarat.
r. Voluntary Health Association of India (New Delhi).

4. Church related health centres and small rural hospitals and dispensaries in

Kalathipura, Kolar, Kalenhalli, Kollegal, Martahalli and Mandya in Karnataka.

Shilonda, Vaijrapur, Talasri, Amravati; Aurangabad in Maharashtra.

Jubaguda, Bhavanipatna and Berhampur in Orissa.

Zankhvav and Unai in Gujarat.

Purulia, Thakurnagar and slums of Calcutta in West Bengal.

Jagadhri in Haryana.

Omalur, Coonoor, Ootacamund, Kotagiri in Tamilnadu.

5.Initiatives in Karnataka

a. ASTRA, Indian Institute of Science, Bangalore.
b. Bandipur Project.
c. Centre for Nonformal & Continuing Education, Bangalore.
d. Arogya Vikasa, Bangalore and Shimoga.
e. Centre for Social Action, Bangalore.
f. Centre for Study of Religion & Society, Bangalore.
g. Centre for Informal Education and Development Studies, Bangalore.
h. Christa Sharan Development Project, Birur, Chikmagalur.
i. CORD, Coorg.
j. DEEDS, Hunsur, Mysore dt.
k. India Development Service, Ranebennur, Dharwad dt.
1. INGRID, Raichur.
m_w ICRA, Bangalore.
n. International Nurses Service Agency, Bangalore.
o. Karnataka Rajya Vigyan Parishad, Bangalore.
p. Janapada Seva Trust, Melkote.
q. Shubada, Mangalore.
r. Snehakunja, Hoonavar.
s. VEDS, Pavagada, Tumkur dt.
t. Vivekananda Girijana Kalyana Kendra, BR Hills.
u. Institute for Youth & Development, Bangalore.
v. Vikasana, Melkote.
w. ACRESAT and OTHERS.

6_w Apart from the above list, there are a large number of individuals from institutions and projects all over India and involved with various initiatives with whom we have had much discussion. These are too numerous to enumerate.

APPENDIX :: B

Over the years discussions with a large number of community based action initiators has taken place through a series of key meetings, workshops and seminars. Only the more significant ones are listed here. The focus and organisers are indicated :-

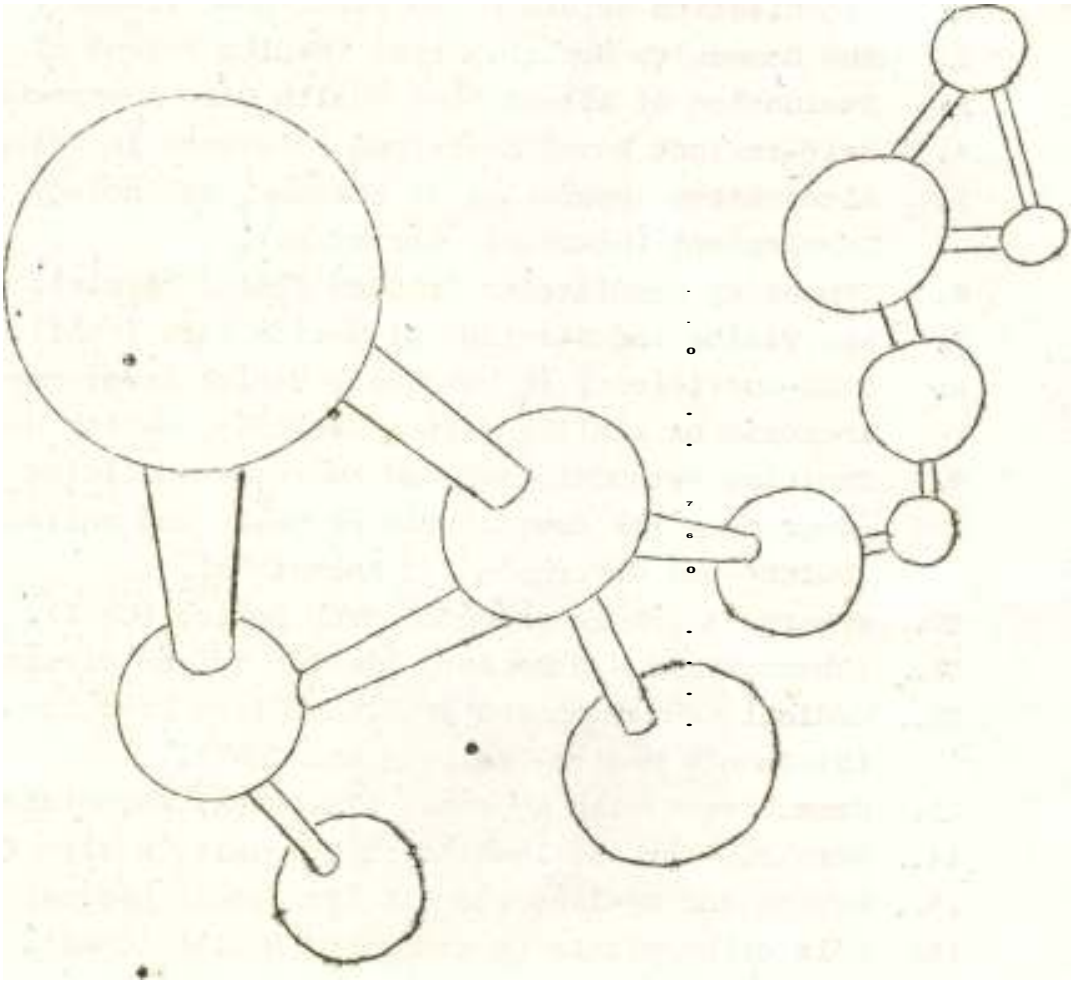
1. Organisation of urban and rural poor (ICSSR)~
2. The Community Health Worker (medico friend circle).
3. Evaluation of Alternative Health Care Approaches (ICMR).
4. Self-reliant Development and Relevance in Science (SYS).
5. Alternative approaches to Science, Technology and Development (Lokayan, Karnataka).
6. Community Paediatrics (medico friend circle).
7. New Vision and Strategy 0f Health Care (CHAI).
8. Self-sufficiency in Community Health Programmes - rhetoric or reality (Asian Community Health Network).
9. Training methodologies and Awareness building in programmes for development of women and children (UNICEF and Government of Karnataka).
10. Towards a people oriented drug policy (CHAI).
11. Tuberculosis and Society (medico friend circle).
12. Medical Education and Small Hospital Practice (St John's Medical College and CHAI).
13. Community Health Approach (FEVORD-K, Karnataka).
14. Participatory Evaluation in Community Health (I.S.I.)
15. Health and Healing for All (St John's Medical College).
16. Role of hospitals in community health (CHAI).
17. Issues in environmental health (medico friend circle).
18. Rural development (Consultative Committee, Government of Karnataka).

19. Health education in hospitals and Government -non-governmental agencies links in Health care (Voluntary Health Association, Karnataka).

20. Involving NGOs in health care (a UNICEF Consultancy).

21, Emerging Trends in women's movement in India (ECC).

22. Alternate development strategies (Citizens for Democracy and TNC).



APPENDIX :: C

This bibliography includes some of the key books, reports and bulletin articles on the new approaches in health care in India since the 1970s. It is arranged chronologically.

At the end, addresses of sources, from where they can be obtained have been listed out. The list includes project reports, overviews, critiques, reflections, study group reports, training manuals and other miscellaneous materials.

1972

1. Comprehensive Rural Health Project, Jamkhed

Rajnikant S Arole.
CONTACT 10, August 1972.
Christian Medical Commission, Geneva.

1975

2. Health Services and Medical Education - a programme for immediate action

Report on the Group on Medical Education and Support Manpower. Shrivastava Report, 1975.
Ministry of Health and Family Planning,
Government of India, New Delhi.

3. A Comprehensive Rural Health project in Jamkhed

Mabelle Arole and Rajnikant Arole in
Health by the People, (Ed) Kenneth W Newell,
World Health Organisation, Geneva.

4. The Ayurvedic System of Medicine in India

K N Udupa in
Health by the people, (Ed) Kenneth W Newell;
World Health Organisation, Geneva.

5. Pills against poverty - a study of the introduction of Western Medicine in a Tamil village

Djurfeldt G and Lindbergh S.
Oxford and IBH Publishers, New Delhi.
(Scandinavian Institute of Asian Studies;
Monograph Series no. 23).

1976

6. History and Evolution of Health Services in India

D Banerji
medico friend circle bulletin 1-3, January-March 1976.

7. Health Care in the Context of self-reliant Development

Samuel L Parmar

CONTACT 32, April 1976.
Christian Medical Commission, Geneva.

8. Alternative Approaches to Health Care

Report of a symposium - October 27-30, 1976, New Delhi.
Indian Council of Medical Research (monograph).

9. A treatise on community health - a textbook of preventive and social medicine

J E Park
Banarsidas Bhanot, 1976. (new edition, 1985)

1977

10. In search of diagnosis - analysis of present system of health care

Ed. Ashvin J Patel
medico friend circle
(reprinted by VHAI, New Delhi).

11. An alternate system of health care services in India - some proposals

(Ed) JP Naik
Indian Council of Social Sciences Researches (ICSSR)
Allied Publishers Private Limited, New Delhi & Bombay.

12. People' participation in Health Services

Imrana Qadeer
medico friend circle bulletin 23, November 1977.

1978

13. Manual for Community Health Worker

Ministry of Health and Family Welfare,
Government of India, New Delhi.

14. Health as a lever for another development

D Banerji
Development Dialogue, Vol. 1, pp. 19-25.

15. Realisation of an integrated health service programme in rural India

Eric R Ram
COITACT 44, April 1978 Christian Medical Commission.

16. Evaluation of Community Health Workers Scheme - a collaborative study

National Institute of Health and Family Welfare.
Technical Report Series no. 4, NIHFW, New Delhi.

17. Teaching vi

18. llage health workers - a guide to the process (a teaching kit in three parts)

Ruth Harnar, Anne Cummins.
Voluntary Health Association of India, New Delhi.

18. Manual for child nutrition in Rural India

Cecile De Sweemen, Nandita Sengupta, Sheila Takulia.
Rural Health Research Centre, Narangwal.
Voluntary Health Association of India, New Delhi.

1979

19. Moving closer to rural poor

Volken H, Gonsalves J and Kaithathara S.
Indian Social Institute, New Delhi.

20. Children in India : critical issues in human development

(Ed) A De Souza.
Manohar Publishers, New Delhi.

21. Health and Culture in a South Indian Villaqe
CME Mathew
Sterling, New Delhi.

22. Where there is no doctor - a village health care handbook

David Werner
Revised for India by C Sathyamala.
Voluntary Health Association of India, New Delhi.
(Reprinted in 1986).

23. Manual for Health Worker (female)

Volume I and II.
-Ministry of Health and Family Welfare,
Government of India, New Delhi.

24. Manual ,for Health Worker (Mqle)

Volume I and II.
Ministry of Health and Family Welfare,
Government of India, New Delhi.

1980

25. Evaluation of primary health care programmes

National Conference Proceedings, April 1980, New Delhi.
Indian Council of Medical Research, New Delhi.

26. Manual for Health Assistants (Male and Female)

Ministry of Health and Family Welfare.
Government of India, New Delhi.

27. Community Health Workers : some aspects of the experience at National level

Rishikesh Maru,
medico friend circle bulletin 51, March 1980.

28. Primary Health Care

Luis Barreto
medico friend circle bulletin, 55, July 1980.

29. People's participation in Development - Approaches to Non-formal Education

(Ed) Wdlter Fernandes
Indian Social Institute, New Delhi.

30. Community Health to Build up people's leadership the Berhampur experience

S Kaithathara and Mariam DC
in People's Participation in Development
(Ed) Walter Fernandes, Indian Social Institute.

31. Community Health as a tool for people's development

R S Arole in
People's participation in Development
(Ed) Walter Fernandes
Indian Social Institute, New Delhi •

32. Training Methodology

Primary Health Centre Training Guides - I
Ministry of Health and Family Welfare,
Government of India, New Delhi.

33. Training of Community Health Volunteers

Primary Health Centre Training Guides - II
Ministry of Health and Family Welfare,
Government of India, New Delhi.

34. Training of Dais

Primary Health Centre Training Guides - III
Ministry of Health and Family Welfare,
Government of India, New Delhi.

35. Training of Health Assistants and Health Workers

Primary Health Centre Training Guides - IV.
Ministry of Health and Family Welfare,
Government of India, New Delhi.

36. Handbook for the delivery of care to mothers and children in a community development block

Dhillon, Dasgupta, Krishna Menon, Shah.

Ministry of Health and Family Welfare.
Government of India, New Delhi
(Oxford University Press).

37. Plan for a village health programmes using VHWs

Patricia F Wakeham
Voluntary Health Association o
f India, New Delhi.

1981

38. Health for all - an alternative strategy

Indian Council of SOcial Sciences Research/Indian Council of Medical Research Study Group/Indian Institute of Education, Pune.

39. Appropriate Technology for Primary Health Care

Proceedings of a National Workshop, April 1981. (New Delhi); Indian Council of Medical Research.

40. People's participation: and economic self-reliance in community health

Abhay Bang
medico friend circle bulletin, 64, April 1981.

41. Health for All : a reaffirmation

N H Antia
E
conomic and Political Weekly, August 15, 1981.

42. Changing Health Beliefs and practices in rural Tamilnadu

CME Mathew and V Benjamin.
Indian Social Institute, Monograph series no. 1;
ISI, New Delhi.

1982

43. National Health Policy - a statement

Ministry of Health and Family Welfare;
Government of India, New Delhi.
(reprinted by CHAI, New Delhi).

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Centre for Social Medicine & Community Health,
J Nehru Univerwity, New Delhi.

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Malini Karkal
Economic and Political Weekly, February 13, 1982.

46. The ParadoK of Kerala

Pran Chopra
World Health Forum, Vol. 3, No.1, pp. 74-77.

47. Health Care which way to go ? - an examination of issues and alternatives

(Ed) Abhay Bang and Ashvin J Patel
medico friend circle
(reprinted by VHAI, New Delhi, 1985).

48. Ayurvedic Medicine and Primary Health Care

Rex Fendall
World Health Forum, Vol. 3, No.1, pp. 90-94.

49. Learning from the rural poor - experiences of MOTT

Volkan H, Kumar A and Kaithathara S.

Indian Social Institute, New Delhi. pp 114

50. The Vadu Budruk Project

Banoo J Coyaji
World Health Forum, Vol. 3, No.4, pp. 387-390.

51. Health for all an alternate strategy - a note on current tasks

Ashok Subramanian
medico friend circle bulletin, 79, July 1982.

52. Community Health

Hellberg. (VHAI, New Delhi)

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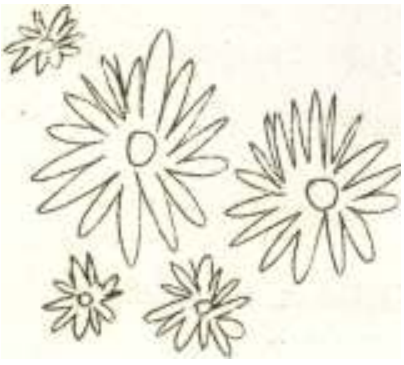

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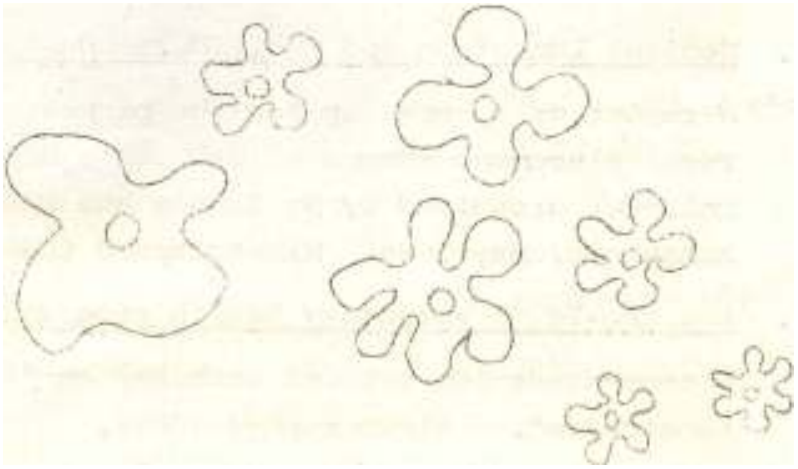

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Presented at the annual Convention of the CHAI in November 1984 on the theme "Towards a people oriented drug policy". The production was by Janadhare (people's stream) group in Bangalore. The CHC was a technical collaborator.

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An audio-visual presentation prepared for the CHAI Convention (see no. 12 for details) November 1984. Produced by Centre for Non-formal and Continuing Education, Bangalore.
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APPENDIX ADDED TO THE DOCUMENT WHEN IT WAS TURNED INTO A MICROSOFT WORD FILE, DECEMBER 2008: DRAFT VERSION OF METHODOLOGY SECTION

THE PROCESS OF REFLECTION ..
A METHODOLOGICAL OVERVIEW

It has been our growing conviction that not-with-standing the relevance of micro-level field experience in initiating community relevant health programmes, there is a great need to take an over-view and evolve some macro-level generalisations, and framework for further action research.

This macro-level perspective formation from the creative responses of a large generation of health care activists, and programme initiators is all the more important because of certain unhealthy trends in which many 'ideas and approaches' emerging from this grassroots experience have been adopted by the existing or promoted by the enthusiasts themselves.

Equally problematic is the fact that many of the overviews attempted by the well-meaning researchers have tended to study this "evolving process" by the well-established "project mentality" of the existing health practice research. This has mean that in their attempts for 'objectivity' and 'measurable goals, targets and indicators' researchers have tended to remain aloof from the whole process, thereby deriving their 'model generation', based on overviews from project reports and in the process, much of the existing understanding is rather 'interventionist' and focussed on evolving technical 'packages', or 'fixes', 'selective' or 'comprehensive' thereby missing the dynamics of the 'social change' process in the bargain.

Most, if not all, these initiatives arise from a desire among the 'initiators' to respond to a social need which being unmet by our existing approaches to meet them.

Very few were 'health practice researchers' per se, and where they were, this was not the primary objective of their intervention. Hence they neither used 'neat, well planned health practice approaches' in their planning, organisation, recording, documentation or evaluation dimensions of their work, nor did they impose 'measurable goals' on themselves. This means that much of the retrospective attempts to thrust ‘parameters' and impose 'measurable' objectives on these initiatives, as are evident by the 'research methods', employed to study them today, are rather invalid if not unfair.

Secondly, though much of these initiatives get reported the purpose of reporting are seldom 'critical evaluation’ of the evolving process but more the exigencies of putting together the basic components of actions and achievements as feedback to 'funders’, ‘sponsors' or ‘supportive groups'. Due to time constraints, these reports are most often rather sketchy, stressing 'action' ‘successes' and 'achievements' rather than describing in detail the 'processes initiated' to generate and sustain action including the failures and the changes of approach that these failures generated. Sometimes this objective of looking from both these experiences does get addressed in internal team reflections and meetings - but seldom expressed in great detail in project reports. Outside researchers have to be able to provide very 'non-threatening’ situations for these dimensions to surface.

Our experience of initiating health care programmes in seven rural situations, during the medical college years had convinced us of the futility of the search for ‘replicable models'. Experience had taught us that what succeeds in one area, will not necessarily succeed in another area since the very process of success was intimately connected to a creative interaction and understanding of a 'local social reality' and since this ‘social reality' varied from place to place, village to village, community to community different actions would

emerge though the processes initiated to determine the nature of the action may be somewhat similar. Our own personal experience sensitised us to the great need for a rich diversity of approaches and action. We understood the difference between 'project' and 'process', and hence we were keen in our preliminary efforts to concentrate on a reflection of the latter.

We, therefore, decided to evolve this 'process over-view' from these diverse experiences by evolving an exploratory, tentative, alternative methodology. The process of informal study which we initiated in 1982, (six months of which were spent visiting health and development projects) and the 30 months in 1984-86 (when we evolved the informal Karnataka based study - reflection - action experiment in community health) could be described as 'an informal discussion technique with the 'researchers' participating with the 'activist' or 'health team' in common reflection and sometimes even planning for action.

The process of study was not a formal one in the academic sense- i.e. fixed objectives, clearly defined research protocols, tested questionaires, formal interviews and formal recording and statistical analysis of data. This decision was purposive even though we were well aware that in 'traditional academic circles' this non-formal methodology would be·frowned upon as inadequate, non-objective and perhaps even invalid.

This evolution of an informal process of study does not, in any way, mean that we reject the need for well-formulated epidemiological, sociological and health practice research on these initiatives. The attempt was to emphasise that many of the variables of such a study go beyond the usual parameters used in present day medical research and many of these variables are neither easily definable nor quantifiable.

A dynamic interaction with 'health workers' and 'communities' evolving a process which involves a paradigm shift from 'medicine' to 'health' and from 'providing' to 'enabling' needs the evolution of new study methodologies. Therefore even to identify the issues and the variables required to be studied further by 'planned studies' an exploratory informal method is required to begin with.

We spent as much time as possible with individuals and groups interacting, sharing experiences and ideas, planning initiatives together. In this process, ideas, perspectives, approaches, understanding was mutually challenged and confronted. In addition, we learn from our own field observations and many 'process reports' we discovered in the process of study.

We firmly believed that this participatory approach; this learning by mutual sharing and questioning; this critical analysis together in a non-threatening dialogue situation would lead to some indepth perceptions of community health action as an eyolving process in the community. These perceptions could easily be missed by more neatly classified, 'objectified', compartmentalized, 'microscopic issue' based research efforts.

Most people whom we met since 1982 were free to share their difficulties, misgivings, failures, anxieties just as much as their perceived achievements, as we sat and reflected together. They were not put in an 'object relation ship'. We were perceived as partners in a learning process not 'evaluators' or 'research experts' looking at the process from outside. Our own field level experiences in the medical college years and the 'informal approach', provided the background for the 'non-threatening' reflections and we were

particularly heartened by the frankness with which so called 'failures' could be analysed by this approach.

The fact that health practice research and health care evaluation studies particularly at a community level find such little coverage in the volumes of disease-oriented research reports that emanate from our research and teaching institutions bears testimony to both the lack of interest among researchers to community based processes, as well as to the inadequacies of existing and established skills of research. The exploratory meetings organised by the Indian Council of Medical Research **in** 1976 and 1980 to look at alternative health care approaches were welcome steps in this direction, but, this is still a very neglected area and, the challenges of 'study' continue to daunt those of us who are interested in the process.

Our attempts were just a beginning.