COMMUNITY HEALTH

In Search of Alternate Processes

Report of a
Study-Reflection-Action-Experiment
by
Community Health Cell
Bangalore

First printed in 1987
Republished in 2011

CELEBRATING 20 YEARS OF SOCHARA
1991-2011

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The Community Health Cell team in 1987 consisted of:
Ravi Narayan
Thelma Narayan
K Gopinathan
Krishna Chakravarthy

Centre for Non-formal and Continuing Education
'Ashirvad'
30, St. Marks road, Bangalore -560001

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Ravi Narayan
Deepak Kumaraswamy
Lavanya Devdas
Mathew Alex
Victor Fernandes
Thelma Narayan

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1987 edition

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

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Many Thanks

FOREWORD

It gives us immense pleasure to publish the second edition of the Community Health Cell (CHC) book titled '*Community Health - In Search of Alternate Processes*' on the occasion of the 20th anniversary of SOCHARA. The first edition contained an analysis built on praxis, based on what today may be termed a 'Grounded Theory' method, to evolve an alternative approach to understanding and practicing community health. The Community Health Cell (CHC) was the seed from which SOCHARA grew. The teams have always seen themselves as part of a much wider and deeper movement towards equity in health and life in all its fullness.

It has been a long, fruitful and challenging journey since the four co-initiators of CHC embarked on our "Search" for meaning and for a deeper understanding of community health in 1984. At that time we already had over 20 person years of experience together in a department of community medicine in one of the best medical colleges in the country. We had a lot of support, freedom, and space within the college for our work. However something was missing!

During 1986-87, thirty months after the study - reflection - action experiment, we heeded to the advice of our wise council and got down to writing our reflections. The alternative approach to community health that emerged became known as the 'social paradigm of health' and was rooted in a framework of rights and responsibilities. The book with its first edition in 1987 became known as the 'Red Book' because of its red cover, with no reference to work known by the same name! The approach, to us, was a pathway towards greater social justice in health. While using an analytical societal framework, it kept persons and communities at the centre.

The alternative approach to community health has provided a robust and resilient framework for the diverse involvements of the Community Health Cell team, SOCHARA and the Centre for Public Health and Equity as they all evolved later over time. The approach has been used in a variety of community based health initiatives addressing public health problems and in community health teaching learning programs. It has also been used in research work. This has included a study of the community orientation and social relevance of undergraduate medical education; a golden jubilee evaluation of the Catholic Hospital Association of India (as a result of which it was renamed the Catholic Health Association of India); a doctoral study of health policy process and implementation; a study of externally aided projects, among others. This understanding led us to the need for broad based networking and alliance building for health and to a proactive involvement in the *Jan Swasthya Abhiyan* and the Global People's Health Movement

Shorter papers based on the Red Book were published several times. Two such early papers in the Indian journal 'Social Action' are included in this edition. Many peers responded to the ideas and axioms with alternative perspectives. Some of these are also included in this compendium.

The 'Health for All' movement has grown and gained in strength, over the last decade, in India and globally. PHM and WHO have drawn attention to the underlying structural determinants of health. Very recently the 'World Conference on Social Determinants of Health' in Rio de Janeiro, Brazil, organized by WHO with a slogan 'All for Equity' issued a consensus 'Rio Political Declaration on Social Determinants of Health' dated 21st October 2011. There were reportedly around 120 countries present who pledged action on health determinants through better governance for health and development, participation in policy making and implementation, reorientation of the health sector towards reducing health inequities and measurement to increase accountability. The bar has been raised. There were gaps however when it came to addressing issues of global trade, finance, militarization and their adverse health impacts. A declaration by public interest civil society organizations and social movements was developed by PHM and several networks on 18th October 2011 and widely circulated. People around the world are ready to participate in and contribute to action that is ethical and just.

Readers will find a resonance between early ideas in the Red Report and the recent declarations, and a trace a common thread across the manifestos of several Indian networks from the 1970's onwards cited in the report. Ideas, alliances and action have also evolved much further over the decades. Scholar activists in health and sustainable development would benefit from reading the detailed references from the rich diversity of community health and development work in the country from the 1970's and 80's – often a forgotten resource.

We hope readers find this document of use in their own personal journeys and collective endeavors. We are sure you will add your own reflections and energy and take the work forward.

Thelma Narayan
Secretary
SOCHARA
Bengaluru

31st October 2011

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The Red Book

The Inspiration

"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 organize the poor and under-privileged groups so that they are able to fight for their basic rights; and (iii) 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.....

These are our tasks and it needs millions of young men and women, both within and without the health sector, to work for them. If a mass movement for this purpose can be organized and the people rededicate themselves to the realization of these national goals, the country will be able to keep its tryst with destiny at least by AD 2000, if not earlier".

Source:

'HEALTH FOR ALL - AN ALTERNATIVE STRATEGY' Report of a study group set up jointly by the Indian Council of Social Sciences Research and the Indian Council of Medical Research, 1981.

INTRODUCTION 1

This reflection is an attempt to draw upon some of the rich experience in Community Health 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 traveled 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 organizational 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.

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 experimental 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. The reflections are divided between community health action in India and the evolving movement dimensions

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.

The appendices highlight:

i. The sample of people, groups and situations with whom we have been in contact (Appendix A and 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” with 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 Gopinathan
Krishna Chakravarthy

HEALTH CARE IN INDIA: A SITUATION ANALYSIS 2

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 (Box-A).

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 realization 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.

Box A

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 undeserved want."

Constitution of India, 1950.

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 organize 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.

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 (1981) 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 B and C)** are typical examples of this introspective and critical self evaluation in Government sponsored efforts.

Box B

A critique of the Indian Health Model (1974)

"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 professionalization 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-professionalization 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 ".

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

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. No 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 the dissatisfaction and the felt need for an alternative approach as voiced by the official health system and Government experts as well.

Box C

A Framework for a new Indian Health Model, 1981

"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. For example, the ashrama concept of stages in life, non-consumerist attitudes, sense of individual and community responsibility, yoga, simplicity and self-discipline as the core of a life-style.

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.

Source: 'HEALTH FOR ALL - AN ALTERNATIVE STRATEGY'
Report of a study group set up jointly by the Indian Council of Social Sciences Research and the Indian Council of Medical Research (ICSSR & ICMR), 1981.

Equally significant in the Indian situation, is that this critical and reflective upsurge was not just a response to the Primary Health Care declarations linked to 'Alma Ata' but was a process, which had begun even earlier.

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 F)** and 'offered a forum for debate and dialogue to share experiences and experiments' and for 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'** (ICMR, 1981).

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

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 **(See Box D)**.

The Voluntary Health Association of India (VHAI) which began in the early seventies as the Coordinating Agency for Health Planning was a more formal attempt to bring together this

Box D

The ACHAN Vision (1982)

"The Asian Community Health Action Network (ACHAN) 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".

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

growing commitment to alternative and community approaches to hea1th 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 (**See Box G**).

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) have both begun to reflect this changing trend in policies and programme directions (**See Boxes E and H**). 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 attempt to formulate the postulates of a new theory and a new framework within which the 'evolving health care' framework could be placed (**See Box I**).

In much of this literature and in 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.

Box E

The Catholic Hospital Association of India (CHAI) Manifesto (1983)

"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."

Source: Policy statement of the Catholic Hospital Association of India (CHAI), 1983.

Box F

The medico friends circle (mfc) manifesto 1984

mfc

"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."

Source: medico friend circle, Perspective and Activities, 1984.

Box G

The Voluntary Health Association of India (VHAI) VISION (1984)

"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."

Source: Introductory pamphlet Voluntary Health Association of India (VHAI).

Box H

The Christian Medical Association of India (CMAI) VISION (1986)

"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."

Source: Christian Medical Association of India, Policy Statement, 1986.

Box I

The Centre for Social Medicine and Community Health, Jawaharlal Nehru University (CSMCH-JNU) Vision (1986)

"Health service development is thus:

- *A socio-cultural process*
- *A political process; and*
- *A technological 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."

Source: D. Banerji, 1986.

Public health is
"*the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals*"
(1920, C.E.A. Winslow)

THE PROCESS OF REFLECTION: A METHODOLOGICAL OVERVIEW

3

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.

Background

It has been our growing conviction that not-withstanding 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 number of a 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 system or promoted by the enthusiasts themselves.

Equally problematic is the fact that many of the overviews attempted by well-meaning researchers have tended to study this "evolving process" by the well-established "project mentality" of the existing health practice research methods. This has meant that in their attempts at '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 focused 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 remains unmet by our existing approaches. 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 many of these initiatives get reported, the purpose of reporting is seldom a 'critical evaluation' of the evolving process, but rather 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 learning 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.

Past Experiences

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'. Since this 'social reality' varied from place to place, village to village, and 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.

The Objective

The objective 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 and empowering process in the community, and orthodox research strategies were felt to be inadequate.

Methodology

We, therefore, decided to evolve this 'process overview' 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 heath action initiators in a common reflective exploration of their past experiences as well as their ongoing experiences and future action plans.'

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

Assumptions

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 marginalized 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.

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 were based on team and community feedback. 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 also 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.

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

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

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 factors 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 them can be initiated.

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.

Process

The process of study was not a formal one in the academic sense- i.e. there were no fixed objectives, clearly defined research protocols, tested questionnaires, 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.

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 reflecting 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.

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 in-depth perceptions of community health action as an evolving process in the community.

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

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. 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.

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. These perceptions could easily be missed by more neatly classified, 'objectified', compartmentalized, 'microscopic issue' based research efforts.

In addition, we learnt from our own field observations and many 'process reports' we discovered in the process of study.

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.

Health Practice: Continuing Lacunae

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 bears 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**.

While preparing this revised version of the book we discovered two drafts of the methodology chapter- one slightly more detailed than the other. These were integrated into one chapter for this edition of the book.

Community health is :
"*enabling and empowering people to take care of their own health which includes conscientisation and political action*"
- Community Health Cell, 1987

COMMUNITY HEALTH IN INDIA

4

The community health cell team moved away from an institutional base located in a medical college in 1984 in search of an approach to addressing the root causes of ill health that went beyond medicine. An alternative approach to community health evolved, based on their own field experiences and through an overview of community health and development initiatives in the country. After a study of background challenges and evolving responses, an alternate approach emerged. This was embedded within a value base and went beyond dichotomies and polarisations such as between community medicine and community health.

The "checklist" became a reference point for later initiatives by the team and by others interested in this approach. The subsequent narrative has been written in the order given in the checklist.

A check list

Background challenges

Health and social justice
Health action as awareness building and organization
Medicalization of health
Hospital based value systems
Commercialization of medicine

The evolving responses

The Health For All study group
Community health project initiators
Differences among project initiators
Commonness among project initiators

Approaches in community health

Integrating health with development
Preventive, promotive, and rehabilitative orientation
Appropriate technology
Utilization of local health resources
Village based health cadre
Community participation
Community organization
Financial self sufficiency
Education for Health
Conscientization and political action

Values in community health

A democratic, participatory, community process
A democratic, participatory, team work
A social analysis built on local reality
Health action as means not ends

Beyond the dichotomy

Community Medicine and Community Health

The continuing challenge

Community health approach and the existing medicalised systems

Background Challenges

Health and social justice

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 healthpossible. 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.

Health action as awareness building and organization

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.

Medicalization of health

For too long the terms '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.

Hospital based value systems

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 iatrogenesis. 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.

Commercialization of medicine

The commercialisation of “medicine" and "health" and its conversion to a commodity to be promoted, advertised and sold with a profit motive are 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 phenomenon of commercialisation 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 with its 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 in spite 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. More specifically in the Indian situation and in Karnataka State 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 parent's ability to pay for the seat.

The Evolving Responses

The Health For All study group

What is most heartening, however, is the fact that the 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 All' 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.”

(2) “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” (ICSSR & ICMR,1981).

Community health project initiators

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 each of 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.

Differences among project initiators

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 widely in the following ways with different characteristics:

- Individual or project focus
- Ideological background
- Understanding of the development process in the country at national, state and regional levels
- Perceptions of government developmental efforts
- Conceptions of their own role in the development process
- Funding
- Understanding of others involved in a similar process
- Understanding of training, research and networking needs
- Perceptions of their own future

Commonness among project initiators

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 and 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 also 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 as 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.

Approaches in community health

Broadly speaking the approaches commonly evolved included many of the following:

Integrating health with development

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.

Preventive, promotive, and rehabilitative orientation

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 prevent 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.

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, demystified and more within the operational capabilities of local people and health workers. These included improved *dai* (Traditional Birth Attendants) kits; nutrition mixes prepared from locally available foods; indigenous Mother and Child Health 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:

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 adaptation to '*nachna*' (song and dance improvisations) was a common feature.

Recording and evaluation techniques-- Many projects have evolved simple methods of recording, quantifying and keeping track of health activities or materials and 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.

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.

Village based health cadre

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. This 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 fishing communities 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 tea plantations, health workers called link workers had emerged as local union leaders. Such situations were not at all unusual.

Community participation

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 prerequisite conditions are essential.

i) Firstly the involvement of all sections of the community. 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 'democratic 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 participation is a variable.

Community organization

The qualitative difference from the above approach is only of emphasis. Many projects have themselves initiated 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 organizations around issues and common actions are themselves prerequisites for community health actions.

Financial self- sufficiency

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 linked 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 mean local resources - material, structural and human - that can be harnessed to support health actions. These have included grains for nutritional programmes, accommodation for clinics and programmes, basic supportive services by volunteers, grain banks, voluntary labour, building materials and so on.

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 dont'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, the health of their own families and their community, share the same vision.

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 recognize 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 provision of a water supply has often become such a rallying point.

Values in community health

Do all these approaches taken together make up an alternative 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 institutionalized effort providing a mix of community based services.

These were:

a) A democratic, participatory community process

Community health action had to be essentially a democratic, participatory, people and community building and empowering process. This value - system had to be gradually internalized 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, 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

a) Respect for each member's skills and potentials, appreciation of each member's expectations and personality.

b) Greater understanding through mutual, non threatening feedback on work and relationships.

c) Growing dialogue among members of positive and negative experiences and feelings, doubts, insecurities and plans for future.

d) Confronting entrenched social divisions like professional/non-professional, medical/non-medical, technical/non technical, intellectual/manual, masculine / feminine, expert/generalist and so on.

e) Common sharing of work reward and recognition, and rationalising of economic support and use of facilities.

c) A social analysis built on 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 iniquitous and unjust social system, aimed at increasing the participation and organisation of the large majority - the poor in the village will be 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 actions as means not ends

If health projects, health struggles, and 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 development. This would also prevent institutionalisation and bureaucratisation of the process.

Beyond the Dichotomy

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, Oral Rehydration Therapy(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. In addition there were some other features which needed to be reflected upon. These included:

- Water-tight division of responsibilities.
- Compartmentalization of health, development and educational activities.
- Over professionalization.
- Clear distinction between 'providers' and 'users'.
- Quest for efficiency and cost effectiveness over-riding process building needs.
- Preoccupation with targets and even a degree of profit orientation.

These 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

- Frank team evaluation.
- Participatory evaluation by the community, especially the poor.
- Willingness to reflect and critically analyse experience in the context of a social analysis.

The continuing challenge

Community health approach and the existing medicalised systems

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 counterproductive 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 care 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:

- Hospitals, dispensaries, specialist centres, health centres under government and non-government voluntary agencies and private initiatives.
- Medical, nursing and paramedical education and training centres.
- Specialised research centres, the professional medical and nursing associations and the regulatory councils and committees.
- Doctors, nurses, paramedical and health auxiliaries.

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

More 'people' oriented

That is sensitive to the realities of life of the large majority of people the poor and underprivileged.

More 'community' oriented

That understands health in its community sense and not just as the problem of individuals.

More socio-epidemiologically oriented understanding of health

In its holistic sense which involves the biological, social, economic, cultural, political and ecological dimensions.

More democratic oriented

Participatory and democratic in its growth, planning and decision making process

More accountable

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 reorientation 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.

Community health

"*increases individual, family and community autonomy over health and over the organisations, means, opportunities, knowledge and supportive structures that make health possible*"

- Community Health Cell, 1987

THE MOVEMENT DIMENSION

5

Dialectics of the movement

Alternative approach to health versus alternative politics

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 J)**.

BOX J

The mfc debate

"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-founded euphoria- the second to inactive cynicism towards the burning health problems of the people."

Source: Health Care -Which Way to Go? mfc anthology, 1985.

Trends in Health Movements in India

Positive "trends"

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:

Government policy reflections

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

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

"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 health training manuals are themselves a phenomenal process of demystification of health.

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.

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 all over the country. School health programmes have begun to increasingly focus on "education for health" programmes directed towards school children and teachers. Science education experiments (for example "*Kishore Bharati* and *Eklavya*" experiments in Madhya Pradesh) have also introduced health aspects in the innovative curricula developed by them.

Health on the agenda of science 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.

Health linked to 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.)

Health on the agenda of mass organizations

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

Health orientation of coordinating groups and networks

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 state level 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 health 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 (See Boxes E and H).

Health care issue networks

In medical and 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.

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:

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.

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 goals of community health. Most of these projects are characterised by a lack of understanding of people's 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.

Inadequate networking of efforts and divisions among them

'Community health catalysts and action/project initiators are not adequatelynetworking 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 divisive trends.

Development circles in India have been divided by ideological divisions intovarious 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 inclusive networking.

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.

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 collective thinking and action has prevented the movement from spreading as much as it needs to, considering the issues and gigantic efforts required.

Status-quo forces

The ability of the existing status-quo forces dominated by the 'haves' over the have-nots and their ability to internalise and co-opt 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 underestimated. 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 many 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.

Conclusion

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 6

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.

The importance of networking

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 routineness 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 government's 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 broad consensus in understanding of community health action and, therefore, there is a real prospect 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 as their successes, strengths and positive experiences. The present "development ethos" in the country is rather geared to successes and "targeted 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.

The challenges in networking

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.

Collective dimension

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?

Consensus building

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

Compartmentalised or integrated?

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?

Reducing duplication

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?

Interactive communication

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 transference 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.

Dialogue

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?

Community empowerment

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 not as builders of a parallel health system but as

facilitators who enable and empower communities, especially its marginalized 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?

Sharing of resources

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

Regional networking

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?

Socio-epidemiological approach to priority setting

A lot of community health action effort is initiated in a somewhat ad hoc 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 relevance of community health action since it would ensure that action emerges out of a deeper understanding of the social reality.

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

Links with other social movements

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.

The challenge of enculturation

Even though this may be a sweeping generalization it has been our experience that 'alternatives' emerging in· health and development circles suffer from a lack of enculturation 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 lacuna 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?

Demystification of health

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

Documentation of community health experience

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-professionalization
  - compartmentalization
- 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.

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 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!

AXIOMS OF COMMUNITY HEALTH

7

A summary of axioms derived from the reflection

1. **Rights and responsibilities**

   Community Health is a process of enabling people, to exercise collectively their responsibility, to their own health and to demand health as their right.

2. **Autonomy over health**

   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.

3. **Integration of health and development activities**

   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 technology 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.

4. Building decentralized democracy at community and team level

The community health approach

- Essentially a democratic, decentralized participatory, people-building and people empowering activity.
- 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.
- Enhances 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.

5. Building equity and empowering community beyond social conflicts

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 marginalizedsuch 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 recognize 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.

6. Promoting and enhancing the sense of community

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.

7. Confronting the biomedical model with new attitudes skills and approaches

The community health approach 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 compartmentalization 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.

8. Confronting the existing super structure of medical/ health care to be more people and community oriented.

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:

- Primary health centres, dispensaries, hospitals, teaching and research institutions.
- Medical, nursing, paramedical and public health teams and professional training centres and associations.
- Health programmes and health institutions under government or non-governmental voluntary agency auspices.

It confronts the superstructure to become:

- **More people oriented** who are sensitive to the realities of the life of the large majority of people - the poor and the underprivileged.
- **More 'community' oriented** 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 subservience 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.

9. A new vision of health and health care and not a professional package of actions

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 orientation' 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.

10. An effort to build a system in which Health For All can become a reality

Community Health Action is closely intertwined 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, reprioritize, disband or change towards more relevant actions and directions as they evolve in the interactions at the community level.

Community health is
"*a preventive, promotive and rehabilitative orientation to health action*"
- Community Health Cell, 1987

APPENDICES

APPENDIX - A

List of individuals, groups, projects and initiatives who have inspired these reflections

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), Tamil Nadu
l) Nilgiri Adivasi Welfare Association (Kotagiri), Tamil Nadu
m) Pallimangal Project Centres of Ramakrishna Mission (Kanarpukur, Jairanbati, Balideranganj), West Bengal

n) Rural Unit for Health and Social Affairs (Kavanur), Tamil Nadu
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), Tamil Nadu

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 and 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), Tamil Nadu

b) Behavioural 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) Lokayan, 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, Tamil Nadu, 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 the following places :

a) Kalathipura, Kolar, Kalenhalli, Kollegal, Martahalli and Mandya in Karnataka

b) Shilonda, Vaijrapur, Talasri, Amravati; Aurangabad in Maharashtra

c) Jubaguda, Bhavanipatna and Berhampur in Orissa

d) Zankhvav and Unai in Gujarat

e) Purulia, Thakurnagar and slums of Calcutta in West Bengal

f) Jagadhri in Haryana

g) Omalur, Coonoor, Ootacamund, Kotagiri in Tamil Nadu

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 district

k) India Development Service, Ranebennur, Dharwad district

l) INGRID, Raichur

m) 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 district

t) Vivekananda Girijana Kalyana Kendra, BR Hills

u) Institute for Youth & Development, Bangalore

v) Vikasana, Melkote

w) ACRESAT and OTHERS

6. 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.

Community health is
"*a search and experimentation with low-cost, effective and appropriate technology for health*"
- Community Health Cell, 1987

APPENDIX - B

Workshops and seminars attended during the period of action reflection

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 or theme of the discussion and organisers are:

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 Pediatrics (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.)

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Community health is
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APPENDIX - C

Books, reports and bulletins consulted during the action reflection phase (1984-87)

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

Later in the report the addresses of sources from where the books/ reports can be obtained are made available. This list includes project reports, overviews, critiques, reflections, study group reports, training manuals and other miscellaneous materials since 1972.

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   Nirman Bhavan, New Delhi 110 001.
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4. **Publications Department**
   Indian Council of Medical Research, Ansari Nagar, New Delhi 110 016
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   Hosur Road, Bangalore 560 029, Karnataka.
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   PB No. 2126, 157/6, Staff Road, Secunderabad 500 003, Andhra Pradesh.
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    Parishad Bhavan, Trivandrum 695 037, Kerala.
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    Ullor, Trivandrum 695 015, Kerala.
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19. **Centre for Science and Environment (CSE)**
    807 Vishal Bhavan, 95 Nehru place, New Delhi 110 019.
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APPENDIX - D

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APPENDIX - E

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   medico friend circle bulletin pp. 97-98, January-February 1984.

3. **Summary of Curriculum Recommendations in Medical Education (1946-'81)**
   Typed Report, distributed on request and announced in mfc Bulletin pp. 97-98, January-February 1984.

4. **A School Health Programme - a Suggested Process for Evolving a Relevant Scheme, 1984**
   For Deena Seva Sangha, a voluntary organization in Bangalore which used this document and consultative support to establish a school health program covering 3000 urban poor children which continues till date.

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17. **The Challenge of Bhopal**
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22. **The Crisis of Medicine - What the Nurses Can Do?**
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PART – II

Reflections on Community Health

Reprinted from SOCIAL ACTION- 1985

Community health as the quest for an alternative

-Ravi Narayan (Convener, Medico Friends' Circle, and
is based in CHC, Bangalore.)

**(Narayan R, Community health as the quest for an alternative,
Social Action, 35(2), 1985, 254-266)**

> ***The health worker must decide whether to join the labourer and peasant in a common struggle for radical social change. Or whether, in the charitable and therefore "safe" posture, to stand above them, distributing the largesse of health services, "alternative" or otherwise (Zurbrigg 1984: 190).***

Ill health in the ultimate analysis is a direct product of an unjust socio-political system which results in poverty and inequality of resources and opportunities. 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 illness or disease are but a symptom. This seldom takes place in practice, for many reasons, not take the least of which is the confusing of 'health' with 'medicine' and the emphasis on health care being a 'providing process' rather than an 'enabling process'.

This emphasis has its historical roots in the 'medicalisation' of health that we have witnessed over the last many decades. If health has to mean what the World Health Organisation defined it i.e.- as a state of complete physical, mental and social well being and not merely the absence of disease or disability' then activities and services with health as their goal must be much more' than the prescribing of medicines, much more than the diagnosis of illness using sophisticated technology in order to' prescribe more medicines. Health activities must include preventive, promotive and rehabilitative activities, health education and de-mystification of medicine, popularisation of health producing activities and attitudes, programmes to strengthen the people's traditions of self-care, attempts to increase the individual's autonomy over his own body and finally awareness building and an organisation of people and communities to get the means, the opportunities and the supportive structures that make health possible.

Medicalisation of health

What we see' around us today, however, leaves little doubt that health has come to be used as synonymous with medicine and health care as synonymous with doctors, drugs and

hospitals. This attitude is fostered by the established conspiracy between the medical profession, the pharmaceutical industry and the growing medical technology industry which converts 'health' into a commodity and promotes, advertises and sells it in the pursuit of a profit motive. The signs of this growing conspiracy are seen by the following trends in our society:

- Phenomenal increase in hospitals and dispensaries.
- Increasing commercialisation of practice and the recent entry of the corporate sector into what was traditionally the cottage industry of private practice.
- Unbridled growth of the pharmaceutical industry (we produce over 30,000 formulations in this country when the Hathi Committee recommends that 116 drugs is all that we need to run our health services).
- Mushrooming of capitation-fees-taking medical colleges.
- Well established doctor-drug-producer axis which exploits people through the promotion of an abundance of drugs.
- The continuing political rhetoric of more doctors, more hospitals, more medical colleges and more specialists means more health (an oft-repeated slogan heard at the foundation stone laying ceremonies of our medical institutions and at the inaugural arid valedictory functions of professional medical conferences).
- The increasing evidence of excessive and unnecessary laboratory investigation and equally unnecessary surgery.
- And so on. All this unashamedly in the name of the people's health.

No wonder the ICSSR·ICMR report (1981: 179) warns that

"There is always a dangerous turning point at which the over-production of drugs and doctors creates a vested interest in the continuance or expansion of ill health. It is not generally recognized that we are dangerously close to this explosive point."

An anti-health value system

Through these trends not only does health become mistaken with medicine but institutions and teams internalise a value system which becomes counter-productive to health itself. Enough has been written on· the characteristics of this value system which include among others a dependency creation, compartmentalisation and an organ-centeredness, a hierarchical decision making, a, mystification and professionalisation, an encouragement of consumerism iatrogenesis both clinical and social and ultimately a dehumanization, all of which are patently anti-health. Medicine rather than generating health begins to generate ill health and the ultimate vicious circle is established-ill health-medicines-more ill health-more medicines.

Notwithstanding the establishment of a vast network of institutions (service, educational and research); the reduction in mortality rates, the increase in life expectancy at birth, the control of small pox, cholera, plague and malaria and the gigantic expansion of the maternal and child health services especially family planning (probably our only achievement), the disparities and weaknesses of our health system are even greater. The lCSSR-ICMR report (*ibid*: 81-84) lists these' out as:

- "A health care system which has no roots in the culture and traditions of the people and relies almost exclusively on the imported western model.
- A service based on a curative approach in urban hospitals, a bias which has not changed in spite of the establishment of Primary Health Centres (PHC) and rural dispensaries.
- A service which benefits mainly the upper and middle classes and fails to reach the bulk of the poor, especially rural poor; -a health delivery system devoid of any participatory element and hence increasing the dependency of the people.
- A service whose costs are exorbitant.
- The failure to integrate health with overall development.
- Little dent made on the massive problems of malnutrition and environmental sanitation.
- Woefully high rates of mortality among women and children.
- No 'programme of health education worth the name.
- Health itself having a very low priority in the planning process and getting an investment about half that of education which itself is given a step-motherly treatment."

All this led the ICSSR-ICMR expert committee (*ibid*: 84) to categorically state that

> ***'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 or 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, is a strong pointer to the futility and wastefulness of continuing the same policies.'***

The quest for alternatives

Though this assessment of the situation is slowly becoming accepted in some of the higher decision and planning levels in the country today, the social disparities and the health needs of the masses have all along challenged and stimulated individuals-doctors, nurses and others-to search for alternatives which not only are more suited to the lives and needs of the large majority of the people but which are also more committed to health promoting activities and attitudes. Starting mostly from the early seventies a growing number of health care projects have developed in the country which may loosely be grouped under the title of alternative health care projects or community health care projects. Most if not all were rural based projects concentrating on illness care initially, but moving on gradually to activities and programmes much beyond illness care. For most of the decade, these experiments nearly always developed independently of each other though in the eighties they have inspired similar attempts elsewhere. There has also been a growing networking through which perspectives gained, lessons learnt and new ideas evolved are shared. The focus of study of each of these has been to see them as innovative models, created by highly motivated charismatic 'health' leaders and consisting of good ideas worthy of emulation. On the contrary, it would be more realistic to see them as a generic response of socially sensitive individuals reacting creatively to local realities. The 'project' mentality has also often overshadowed the recognition of 'process' in these efforts.

The components of 'alternatives'

Much has been written on many of them and hence giving a detailed list of sources would suffice (see ICMR 1976; Naik 1977; ICSSR- ICMR198I). What is more important, however, is to identify the broad components of health care emerging in these alternatives.

1. An attempt to integrate health with development activities

Recognising ill health as the product of poor nutrition, poor housing and poor environment, many health projects have gradually, got involved with agricultural

extension programmes, water supply and irrigation programmes, housing and sanitation schemes, income generation schemes and basic education including non-formal and adult education programmes. Similarly, many rural development projects which had some of the above components have added a health dimension to their activities.

2. Preventive and promotive orientation

Many of these health projects have moved beyond the medicalised concepts of health symbolised by the distribution of drugs to activities-individual and group-that prevent illnesses and promote health. Immunisation programmes, maternal and child health care, environmental sanitation, nutritional supplementation and nutrition education and school health programmes are the commonest among them. A strong component of health education is a characteristic of most of them. This education has in many cases been de-mystifying and de-professionalising thus increasing both the individual's and the communities' autonomy over health activities.

3. Search for an appropriate technology

Many projects have involved medical care and health technologies that are more appropriate to the health needs of the very poor (ICMR 1981: 85-86). The emphasis is not only on it being low cost but also on it being more culturally acceptable, de-mystifying and more within the operational capabilities of local people and health workers. The range of appropriate technology varies from dai kits to nutrition mixes produced from locally available foods, an indigenous MCH calendar, a locally manufactured lower limb prosthesis, bangles and tapes to measure nutritional status of children, low cost sanitation options, home based oral re-hydration solutions, herbal medicines and home remedies from the backyard or kitchen. Many of these have been adaptations of ideas developed outside the country and many have been recognition of the usefulness of ideas that are already part of the local culture.

Two additional areas of technological appropriateness which have been experimented with in many of these projects are:

(a) **Communication:** Attempts have been made to use low cost media alternatives like flash cards and flip charts and also to adapt and involve local folk media and traditional cultural forms of communication like puppetry, ballads, kathas, street theatre and song and dance (nachna) particularly in tribal areas.

(b) **Recording/Evaluation techniques:** Many projects have evolved simple methods of recording, quantifying and keeping track of health activities or resources utilized by the health workers. These are geared to the capacities of the local people (if they are patient retained) or to the capacities of local health workers. Many are geared to get over the constraint of illiteracy.

4. Promotion and utilisation of local resources

Local health resources include local family based traditions of health and self-care as well as traditional systems of medicine. Many health projects have created positive relationship with local dai or birth attendants, traditional healers, folk medicine practitioners, and practitioners of the indigenous or traditional systems of medicine. This relationship has very often gone beyond a mere association to a sharing of knowledge and skills and an adaptation or acceptance of some of the medical and health practices by the projects themselves. Promotion of herbal medicines and home remedies is an important aspect of many of these projects.

5. Training of village based health cadres

Training of local representatives of the village in basic health care activities, minor ailment treatment, and recognition of illnesses needing higher levels of care, nutrition, environmental sanitation, communicable disease control, mental health and so on has been probably the most characteristic feature of most of these projects. The selection methodology, the training methodology, the expected skills and scope of training have varied from project to project but the most important result of such a trend has been the conscious de-mystification of health issues and the creation of better informed village based individuals who are available to help the people in their times of crisis. Depending on the orientation of the trainers themselves such village based health workers need not necessarily be 'lackeys of the existing health services' but can well be and have often become 'liberators of their people' (Werner 1980). In many projects once health workers have been trained to understand, plan and decide on health matters, certain leadership qualities are generated so that gradually issues wider than health are tackled as well. Only recently I heard about a group of women health workers in a fishing community who organised the people to protest against the local bus system which refused to allow women to carry their baskets of fish in the bus to the market. In some plantations women health workers called link workers have recently emerged as local union leaders. Such situations are not at all unusual.

6. Increasing community participation

In addition to training village level health workers, many of these projects have attempted to involve villagers in the planning and decision making processes through the organisation of local village health committees consisting of formal and informal leaders. Many have involved local youth groups, mahila mandals, teachers, religious leaders and farmers, associations and co-operatives in health work. This is a very important trend but has often become an expression of rhetoric rather than real

participation. Two pre-requisites are essential if this 'community participation' has to be a genuine process of enabling people to take responsibilities for their own health services.

(i) Firstly, the involvement of all sections of the community. In the stratified set up of the village with certain groups always dominating and exploiting certain other groups, this must often mean a more purposeful and even exclusive involvement of the more disadvantaged and oppressed sections of the village .

(ii) Secondly, the openness of the team to learn from the people and their own experience of life. This means a dialogue on more equal terms where the people are involved in all aspects of planning and decision making and not just expected to participate in programmes organised by the 'health team'.

7. Initiating community organisation

The qualitative difference from No.6 above is only one of emphasis. Many projects have themselves initiated or catalysed the development of youth clubs, mahila mandals, farmers' associations and co-operatives recognising the need for local organisations to participate and sustain health activities. It is, therefore, not just involving the existing organisations in the community if there are already some, but seeing this step as a pre-requisite and hence being involved in their initiation and their growth.

8. A quest for financial self-sufficiency

Many projects have concentrated on the dimension of the financial participation of the community. These projects have concentrated on generating local finances to run and support some or all of the health activities. The experiments have included health insurance schemes, adding health functions to dairy and other co-operatives, graded payment of services according to family income and so on. Experience has, however, cautioned that an exclusive pursuit of this objective can often result in the exclusion of the very section of the community which needs the health services the most (Bang 1981).

9. Education/or health

Many projects have introduced health issues in their ongoing adult education and non-formal education programmes. This process does not only help to further de-mystify the health issue but has often served as the starting point for individual or group action. As people discover the causes of the illness they experience, and identify the roots of it within their own social situation, they are then prepared to do something. School health programmes where teachers and high school students are oriented to do something about their own health, that of their families and their community, share the same vision.

10. Conscientisation and political action

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

Community health is not community medicine

To summarise then, the state of the art of alternatives in health care in the country includes health integrated with development activity; a preventive and promotive orientation; a search for appropriate technology; promotion and utilisation of local health resources including herbal medicines and traditional systems of medicine; training of village based health cadres; promoting community participation and community organisation; a quest for economic self-sufficiency; and a commitment to conscientisation and socio-political change processes.

Does this constitute **COMMUNITY HEALTH?** A personal quest to discover an answer to this question took my wife and me around parts of the country in 1982, visiting many community health and development projects. We spoke to doctors, health workers, development activists and others about field level realities, about the 'successes and failures of micro-level projects, the strengths, weaknesses opportunities and threats of grass root health action, about the problems of team work, about personal motivation-ideological, religious or otherwise-about the emerging networks and about the future.

One of the most important insights we got from this rich feedback was the difference between 'community health' and 'community medicine' and this was more than a matter of semantics. We understood for the first title that all these alternative health trend setters, though often labelled as 'community health projects' were not all 'community health orientated'. Most often they were extensions of the hospital system in organisation method of functioning, team work and hence should rightly be labelled as community 'medicine' projects. True to their medical roots, many of these projects for instance continued to distribute not only drugs but vitamins, vaccines and food with the same dependence creating mentality. Their teams were hierarchical and in the absence of participatory decision making even within the teams, the claims of community participation seemed hollow. The water tight division of responsibilities, the compartmentalisation of health, development and educational activities, the professionalisation, the clear distinction between the 'providers' and the 'users', the quest for efficiency and cost effectiveness, the pre-occupation with targets all belied their overall commitment to health as a community building process.

Consciously or unconsciously they had internalized the value system of the hospital and even though on a superficial overview they appeared to be different from hospital medicine, a deeper evaluation of the projects showed that they were just community-based extension of a medicalised form of health. Was this because most if not all the project initiators had a professional medical or nursing background and, therefore, this ingrained professionalism, superiority, sense of inborn leadership and 'know all' attitude was difficult to discard?

Due to this orientation, therefore, many projects we saw had built up 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 government health projects except that they were more efficient, more, organised and probably more cost-effective, but no less irrelevant.

Towards a new value system

On the other hand, there was a small but growing number of project interventions that had teams committed to the process of socio-political change, identifying their health activities as collaborative efforts in the overall process. They were identifiable by their commitment to a real democratic, decentralized involvement of people in decision-making, commitment to de-mystification and awareness building through non-formal group methodologies, a commitment to work through and support people's own organisations, a concentration on the human element of the effort not on the structural or material, a clear understanding of their role as catalysts not 'service providers' or project organisers, a commitment to process not projects and a commitment to trying to internalise most of these attitudes and value systems within their own team's functioning.

An equally important development raising some cause for optimism was that even in the so called community medicine projects mentioned earlier, this change of value system was beginning to take place encouraged by frank team evaluation and openness to feedback from the people.

What then is community health?

Based on this overview, therefore, it would be not out of place to attempt a definition of what community health should be. Community health has been defined as 'a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right' (CHAI 1983). This definition could be extended further by adding that the community health process would involve increasing the people and communities own autonomy over their own health and over the organisations that can prevent ill health and promote health. The process would include the concepts of present day Primary Health Care-minor ailment treatment, village level workers' training, appropriate health technology, promotion of herbal medicine and home remedies, nutrition and environmental

sanitation, community participation and organisation-but would essentially be a democratic, participatory community building process.

This would invariably increase local tensions since any process aimed at increasing the participation and the organisation of the under-privileged and poor (which has to be part of any movement toward greater social justice) will be opposed by the status quo factors and exploiting sections of the community. Rooted in the people and committed to a process of health building through the people's own actions and struggles, all those committed to community health would support and participate in the process even as it goes beyond health issues. Projects, structures, health activities would then be means to an end-not the end itself. Such projects would then be willing to even disband programmes if they became counterproductive to the wider struggle or abandon them in favour of, more relevant approaches.

Is community health possible?

Are there signs of such an alternative evolving in the country? The trend is not conscious but implicit in many developments in recent years which are possibly creating the right social milieu for such an evolution. The delay has been due to a double failure-a failure of community health projects to see themselves as part of a larger socio-political change process in society and the failure of political activists, mass organisations and people's movement to recognise the value and true meaning of health. Yet probably a beginning is being made.

Bang and Patel (1981) have described this as a conflict between two schools of thought:

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 utilisation of non professionals and appropriate technology in health care. Another school is equally confident that the only real cause of ill health problems of the people is the present economic system and nothing can be and should be done to solve these health problems unless the present economic-political system changes by revolution. The first leads to ill-founded euphoria(the second) to inactive cynicism towards the burning health problems of the people.

Positive trends

Firstly, there is a growing army of villagers and lay workers who have been trained as health workers both by governmental and non-governmental voluntary agencies. Whatever the quality or orientation of training, taken in the overall, a phenomenal process of demystification of health problems has already been initiated.

Secondly, there are a growing number of individuals - development or political activists -

who are beginning to recognise the non medical dimensions of health and are including it in their action programmes;

Thirdly, there is a growing body of health knowledge which has become part of the syllabi of adult education and non-formal education in the country. Science education experiments have also introduced health aspects into the innovative curricula developed by them.

Fourthly, people-oriented science movements like the *Kerala Sastra Sahitya Parishad*, the *Lok Vignyan Sanghatana* (Maharashtra) and many other smaller forums are actively taking up health issues in their awareness building programmes, in their jathas and their exhibitions.

Fifthly, there are a series of evolving people's movements around forest issues, environmental issues, other social issues which have 'health of people' as an intrinsic component though not always well recognised. Sixthly, there is an evolving interest in the trade union movement, the women's movement and other mass movements about the importance of health issues and the need to include them as components of the wider struggles. Seventhly, even within the medical and nursing, professional and institutional networks there is a growing sensitivity to broader issues of social change and not to see them as a narrow technical or professional enterprise.

Finally, even expert documents on health in the country are beginning to echo this challenge. The ICSSR-ICMR (1981: 94) report clearly states that the conditions essential for success of the 'health for all' goal is 'to reduce poverty, inequality and to spread education; to organise the poor and the underprivileged groups so that they are able to assert themselves; to move away from the counter-productive, consumerist western model of health care and to replace it by the alternative based in the community.'

Negative factors

However, there is no cause for unbounded optimism. The trends favouring the evolution of the community health alternative are definitely there but the trends opposing and most often neutralising the gains made are equally there and probably stronger.

Medicalisation, professionalisation and the consumerist orientation of health care is increasing and is symptomatic of the overall situation in the country. Many so called health projects are mushrooming all over the place goaded by foreign funding agencies vying with each other to invest in the alternative; or by industrial houses as part of the rural development oriented income tax benefits; or by professionals interested in involvement for prestige, status and power and for many other objectives counter to the spirit of community health. This band wagon nature of the growth of 'alternative health care' out of context of social analysis, understanding of people's needs and insensitive to social change process is going to be rather counter-productive.

A lack of adequate networking among the committed community health catalysts to share perspectives, support each other, evolve a common understanding of a highly complex situation is a serious lacuna.

Finally, the ability of the existing exploitative socio-political system, the bureaucracy, the health planners and the decision makers to internalise the ideas and experiments in jargon and rhetoric but defeating the spirit of the process is phenomenal and rather confusing.

To sum up then, the evolving Community Health approach is an attempt to bridge the 'ill-founded euphoria of the alternative health care deliverers' and the inactive cynicism of socio-political activists about the role of health care and to bring the two groups together, if Possible, in a common endeavour. All committed community health activists have to seriously face up to this challenge.

Are there efforts bringing this about?

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Towards a people oriented health care system

Ravi Narayan (Coordinator of Community Health Cell, Bangalore)

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> ***"A people-oriented alternative health care system cannot be just a new package of actions, or a new technology fix. It has to be a new vision of health care, a new attitude of mind, a new value orientation in health action intertwined closely with efforts to build an alternative socio-political-economic-cultural system in which health can become a reality for all people."***

It has been the field experience of many that the existing health -care system in India does not meet the needs of the large majority of, the people in the country. There are many reasons for this situation.

Firstly, the present model based on the 'western institutional model' of health care is too costly and efforts to duplicate it have meant that we can develop much less of it with our constraints on resources.

Secondly, the present model relies too heavily on expensively trained doctors and nurses and other para professional workers, who by the very nature and culture of their training are the least likely to work in disadvantaged areas, be they rural, urban slums, or tribal regions where most of the people reside. Hence there is a continued shortage of human power in situations which need them the most.

Thirdly, the system is too closely linked to a rapidly growing medical industry of drugs, equipment, technology which, because of its preoccupation with growth and profits, has developed a vested interest in 'the abundance of ill health' and in the medicalisation of health itself; the proliferation of drugs, capitation fees:'-medical colleges, high technology, private diagnostic centres, corporate sector hospitals are all indications, of this trend.

Fourthly, the system, having developed in a different historical and socio-cultural milieu, is cut off from the health culture of the people. It looks upon traditional healers and birth attendants, herbal and home remedies, indigenous systems of medicines and their practitioners and the folk medical culture of the people, as superstitious remnants of an earlier era, waiting to be replaced by the so-called 'rational scientific western system'.

Fifthly, the system looks at health in a very myopic way, concentrating on the physical and biological dimensions, paying lip service to the mental/psychological dimension and mostly ignoring the social, cultural, political, economic and ecological dimensions. The focus is on 'diseases' and 'syndromes' rather than on the way of life or social processes in the community that cause ill health. The system also has a built-in prejudice of looking at problems in an individualistic sense rather than analyzing them in a community and collective context.

Sixthly, the system is highly professionalised and mystified with its knowledge being compartmentalised in specialities and fully under the control of professionals. There is a built-in resistance to transfer of knowledge and skills down the line within the hierarchy of the health team itself.

Seventhly, the medical system undermines the autonomy of individuals, groups and communities by not increasing the common knowledge of health and by promoting an 'economy of created needs'. In addition, the planners of the system thrust top-down, vertical package of services, be they curative, preventive or promotive in nature, on the community.

Finally, the people who use the system are seen primarily as beneficiaries and consumers rather than as participants of a joint effort (by professionals and patients) to build health.

When such a 'health system' with the built-in contradictions outlined above is transplanted and developed in an inequitous social system such as ours, in which class, caste, money and power determine accessibility, availability and affordability of services, then it is not surprising that the large majority of the people who are either marginalised or disadvantaged, live below the poverty line-dalit or tribal groups-are left out of it. Not having control over the means, opportunities, knowledge, organisations and supportive services that make health possible, the large majority of the people do not utilise or participate in such a system. It is in this sense that the existing system is not people-oriented. What then is an alternative?

Towards an alternative: The Search

Since the late 1960s a large number of initiatives and projects have emerged outside the governmental system by individuals and groups keen to adapt 'orthodox health care' to our very different social realities. Doctors, nurses, health and development activists, social workers and others pioneered micro-level community-based projects that gradually moved beyond medical care to a host of activities and programmes that were geared to making health care more relevant to people's needs. These individuals and groups, in fact this whole 'movement' if it can be called such, is marked by its diversity in ideology, background social analysis and perception of the developmental process, funding, conceptions of their individual roles and their knowledge of medicine/health itself. However there were many common perceptions as well engendered by the situation in India:

- All of them were aware of the inadequate reach of the existing services, so they reached out their efforts to more peripheral areas.
- All of them moved beyond the 'orthodoxy' of pill distribution by doctors and nurses to a wide range of health actions in which para-medicals, health auxiliaries and community based health workers were involved.
- In all these projects much of the health action was invariably planned at the community level involving existing leadership and community organisations of the village and most sections of the people.
- Invariably most of them added preventive and promotive dimensions to their health work and some went further on to integrate health with developmental programmes focusing on agriculture, income generation, water supply and formal and non-formal education.
- However, since each of them were creatively responding to the special situation and issues relevant to their area be it a caste village, a tribal region or an urban slum, they also developed and explored other components of health action.

Towards an Alternative: The Evolving Perspectives

Some of us have been spending the last few years informally studying these experiences, programmes and approaches, trying to understand their dynamics and trying to build a new perspective, emerging from the 'collectivity' of the experience and basing it on the successes and failures of these, numerous, micro-level health action projects. Our study reflections have led to the identification of the following 'action' components of the emerging alternative.

Integrating health action with developmental, welfare and educational activities: some examples

Banwasi Seva Ashram (Govindpur, Uttar Pradesh) had a health and family planning programme which is integrated with its other programmes which Include' agricultural extension, dairy, village industries, education, gram kosh (revolving village fund) and social justice programmes.

Rural Unit for Health & Social Affairs - RUHSA Project (Kavanur, Tamil Nadu) has developed a comprehensive health and family welfare project along with adult education, vocational training, community organisation, income generation, agricultural development and agro-support services.

Vivekananda Girijana Kalyana Kendra (VGKK) Project (B.R. Hills, Karnataka) evolved a programme of health care along with programmes of community organisation,

education, cottage industries, vocational training and adult education for the Soliga tribals of that region.

Streehitakarini (Bombay, Maharashtra) working in the slums of Bombay included among its activities maternal and child health and family welfare, non-formal education, female literacy programme, income generation programmes, crèches for under fives and small savings schemes.

Integrating curative with preventive, promotive and rehabilitative activities in health action: some examples

The Voluntary Health Services Project (Adyar, Tamil Nadu) evolved the mini-health centre scheme which included maternity services, child welfare, nutrition, family welfare, minor ailment treatment, communicable disease control and health records and data system.

AWARE (Telengana, Andhra Pradesh) has a health programme which includes maternal and child health and nutrition, health education, environmental sanitation, disease control and a floating health centre catering to 300 Villages along the banks of the Godavari.

Rangbelia Health Project (24 Parganas, West Bengal) has a maternal and child health care programme along with minor ailment treatment, and programmes for family welfare, housing, safe drinking water, sanitation, communicable disease control and health education.

Though most projects developed a 'health package' not very different from the Primary Health Centre package of the Government of India, the main difference was that, in these projects there was activity in all the components and they were not pre-occupied with the Family Planning component as the government health centres are doing today. There was also a qualitative difference in the type of services;

Experimentation and development of low-cost appropriate technology

- Many projects evolved simple kits for traditional birth attendants to ensure that they were able to conduct hygienic home deliveries.
- Many projects evolved simple, locally produced health education materials using local ideas and art skills. Others evolved simple record keeping materials that could be used even by illiterate village workers using simple diagrams and signs.
- The promotion and incorporation of herbal and home remedies was a common response.

- Preparation of local food mixes and home-based oral rehydration solutions are additional examples of this search .for 'technological appropriateness'.

Recognition, promotion and utilisation of local health resources; some examples

Miraj Project (Maharashtra) trained indigenous dais, .village health aides and established liaison youth untrained practitioners of Ayurvedic medicine, bone setters and registered medical practitioners without formal training working in the area'.

Vivekananda Girijana Kalyana Kendra -VGKK (BR Hills, Karnataka) worked not only with *dais* but explored the use of traditional herbal medicines as well.

Tilonia Project (Rajasthan) involved indigenous medical practitioners and dais in implementing their programme along with village health workers.

Deenabandhu Project (Tamil Nadu) incorporated the use of herbal remedies, acupressure and massage in their health care programme and have been one of the enthusiastic proponents of this dimension.

Training of village based health cadres:

Jamkhed Project (Maharashtra) pioneered the training of village health workers-local, illiterate, middle aged women, who became the front-liners of their programmes which included, maternal and child health, nutrition, immunisation, family welfare services, control of communicable diseases, safe water and health education.

The Rehbar-I-Sehat Prozramme (Korbhalwal, Jammu and Kashmir) trained teachers of village schools as primary care guides

Local workers were trained in most projects and they took several interesting names for example:

"Swasthya Mithras" (Banawasi Sewa Ashram, UP)

Link Workers (Comprehensive Labour Welfare Scheme, UPASI, Coonoor)

Lay first aiders (Voluntary Health Services , Adyar, Tamil Nadu)

Community Health Volunteers (SEWA-Rural, Gujarat)

"Gram Swasthikas" (Indo-Dutch project, Somajiguda, Andhra Pradesh)

Family Care Volunteers (RUHSA, Tamil Nadu)

Organising and involving community organisations like *Mahila Mandals* and Farmers' Associations

Child-in-Need Institute (Daulatpur, West Bengal) organised its maternal and child health programmes and balwadis by involving *Mahila Mandals* (women's associations) in the slums and villages of Calcutta.

Kottar Community Health Project (Kottar, Tamil Nadu) initiated the whole health programme in conjunction with the evolution of *Mahila Mandrams* (women's organisations) which have taken gradual charge through an ongoing programme of decentralization. Over a hundred registered village women's organizations pay and support over two hundred village health guides and animators.

Jamkhed (Maharashtra) evolved and involved young farmers' clubs in the planning and organisation of services;

Bodokhoni Project (Orissa) evolved its programmes of health, adult education, grain bank, savings scheme, goat rearing, non-formal school for children etc. with the participation of *Gramya Sangha* (men's organisation) and *Mahila Sangha* (women's organisation).

Community participation in decision making

Most of the projects involved existing and or newly evolved community organizations or representative health/development committees in their organization and planning exercises. The village health committee was an important component.

The ongoing process was difficult since involving all sections of the community, especially the marginalized elements, was not easily possible. Also project staff had to learn to treat community members as equals and learn from their local culture and experience and not impose ideas from outside. Different projects have evolved this dimension to different extents depending on their ability to handle the above two problems.

While many of them have involved the community at various levels of the planning cycle, decisions about funding and evaluation are two dimensions still not generally decentralized.

Tapping local financial, manpower and other resources

The Mallur Dairy Cooperative (Karnataka) supported its health project through health cess on production of milk, generating adequate resources to pay for the health team and most of the health care supplies. Over the years the cooperative established a health endowment scheme which paid for the basic services.

The - Raigarh Ambikapur Health Association - RAHA Projects (Madhya Pradesh) developed a medical insurance scheme which provided medical cover through a network of three base hospitals and 47 rural health centers.

The Kartar Project (Tamil Nadu) built up a local contribution from the beneficiaries to support village health guides scheme. Other forms of local support apart from direct payment for services included health savings scheme, festival donations, grain banks, accommodation for clinics and programmes, voluntary labour and building materials, services by volunteers, village health fund and so on.

Would these eight action components' taken together constitute a People-oriented Health Care System?

Many alternative health care enthusiasts and activists would have us think so? The ICMR organized two meetings on alternative health care approaches, to identify new perspectives from the Indian experience. The list of components that emerged in these meetings were not dissimilar.

The 'Social Process' Dimension

Our study reflections show however that these are important components of the alternative people-oriented health care system but are basically in the category of technical and managerial innovations. There is another whole set of issues and dimensions which can be called 'social process' components which help the above approach to become more people-oriented. Often these issues are neglected or ill understood by health action initiators so that even though the goal of the initiated process is to build a health system with the participation of all, this objective gets somewhat derailed in the ongoing process. To understand these process components, one has to first understand some important characteristics of our social reality as well as of the health care system that is existing and dominant.

An unequal society

Firstly in the present inequitous and stratified social system there is no community in the real sense of the word. The community is divided by factors of caste, class, religion, land ownership, power, education and status: Even the so-called 'community of the poor' has internalised these divisions. The 'haves' consisting of the landed, rich, educated, upper caste groups dominate decision making processes and invariably participate, utilise and monopolies any services-health or otherwise or development in the community. The poor do not participate at all or marginally in the process. Building a people oriented health system in such a situation would invariably require two added components:

(I) Increasing the organisation, involvement and participation of large sections of the community who do not participate adequately in any development process today. Such attempts will invariably be opposed by the 'status quo' forces and all who draw greater advantage from the present system.

(II) Efforts to imbibe and improve the concept and spirit of community aid to improve group dynamics and group 'inter relationships by enhancing the collective dimension of action and the cooperative spirit.

New value system

Secondly the existing health care system is over medicalised and characterized by certain values which are inherent components of the organizational ethos as well as of the professional and paraprofessional teams working in them. These values described in the beginning reflect our social system and have been internalised even by those who set out to build a more people-oriented system. Therefore, health action initiators have to constantly:

(I) Confront these Values in their action and approaches and try and evolve new attitudes, skills and approaches that are more "people and community-oriented and place medicine, professional skills and technology in their right and limited context.

(II) They need to empower the people to counter these trends in the health superstructure to make it more democratic, accountable and relevant to people's life.

If we wish to build a health system with the partnership of all, people including the illiterate and dispossessed, then health team members need to have experienced some features of this new ethos in their own team functioning itself. Building democratic, decentralised, participatory and non-hierarchical decision-making processes within the health team become as important as introducing these elements in the interaction between the health team and the people.

Learning from local knowledge

Thirdly, there is need to recognise that there are numerous cross-cultural conflicts inherent in transplanting a western medical model on a non-western culture and hence exploring integration of medical traditions and cultures in a spirit of dialogue is very important. This means often; more than involving the local dai or healer in the health programme. It means learning from their knowledge and experience and cross fertilising it with what is already known in the more dominant and rational medicine. In this process, however, one should also not allow a sense of romanticism about traditional or indigenous systems of medicine making us uncritical of some of their inherent values which may be similar to those of the dominant allopathic system. The relevance to the life of the poor must be an important criterion in the dialogue and integration process. It also means looking at the dominant western model with a more critical I focus rejecting all that is non-science and or anti-people in it.

Understanding societal processes

Finally, a people-oriented health system would help the people to understand and appreciate the deeper links that ill health has with societal processes so that health action could move towards wider social issues and movements to enable people to demand health as -their right as well as to increase their autonomy-both individual and collective-over health and organisations, means, opportunities, skills, 'knowledge and supportive structures that make health possible. A people-oriented health system would therefore have a strong dimension of empowerment.

Is this social process dimension and value orientation in Health Action being taken seriously today?

Our study-reflections show that this awareness is gradually evolving as serious groups and committed project initiators subject their action to a critical evaluation in the context of an ongoing social analysis. For example,

The Deenabandu project (Tamil Nadu) reports 2 emerging policy changes in their project which symbolize the recognizes of these dimensions

(I) A shift of the programme focus from its initial focus on total community – rich and the poor like to a focus on target group of powerless- the landless and the *dalit*.

(II) Introduction of comprehensive account of the nature of poverty and its relationship between ill health, the unjust distribution of the land, oppression in the name of religion and other factors in women village health worker training programme to instill in their\ mind the class nature of illness.

Action Research in Community Health & Developmetn (ARCH Mangrol (Gujarat) records its experience of working among the marginalised poor in the eastern belt of Gujarat and the movement of their efforts from health of women and poor children to organizing the poor tribal villages to challenge the unjust rehabilitation programme for the villagers losing their home lands due to narmada dam project.

The Bodokhoni Project (Ganjam Orissa) records the journey of its health animators in helping the people to move from magical understanding of their problems to a critical one so that they can strike at the root cause. Diarrhoea is not only treated with ORT but the villagers marched to the block the development office to demand as well as a right of the citizens of India and then when materials and resources a were made available, dug collectively their own well as a symbol of their unity and mutual concern.

Community Health Programme (Pachod Maharashtra) records its effort in efforts in participatory management, which implies a redistribution of power to take decisions and is convinced that this process can increase effective community reflection and increase the demand on health services.

Miraj Project (Maharashtra) records that due to its efforts in training all health workers in various religions and castes together and with taking their meals together, the age old caste systems is breaking down and the Dai's from the dalits are called upon by the upper caste Hindu women to conduct deliveries.

The Medico-Friends Circle – a national network of doctors and health activists stands for the demystification of medicine, democratic decentralised team functioning, active community participation, medical practice built on humane values, and equality and firmly opposes the negative unhealthy values of our society which include glorification of money and power, division of labour into manual and intellectual workers, domination of men over women, urban over rural, foreign over Indian.

The Community Health Training Team of the Catholic Hospital Association of India (Secunderabad) defines community health as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right'. Thus it goes beyond mere distribution of medicines, prevention of sickness and income generating programmes. Its training programmes for middle level workers are therefore based on this perspective.

The 'Mandwa Project' (Maharashtra) recounts that its experiment of training semi-literate village women as health workers was opposed by local powerful rich leaders and the government health personnel since they, demonstrated results superior to those of the professionals, demystified health and reduced people's dependency. This resulted 1n loss of practice in the private sector, created surveillance and brought accountability in a normally unaccountable public sector. The powerful leaders were fearful of an alternative power structure developing through the project.

All these examples taken together show that this social process dimension is beginning to be taken seriously by many groups and there is a move away from developing isolated models to locating the initiative in a local socio-political cultural context.

It must be recognized at this stage that most of the health-action initiators in the NGO/Voluntary sector do not set out in their exploration of an alternative health care process after a thorough societal analysis or a critical analysis of the political economy of existing health and health care services. Much of the innovation and creativity is therefore of an ad hoc nature, action and ideas evolving by trial and error. There are, on the other hand, a lot of aberrations as well due to this initial lack of understanding of 'health in society'. This aberration manifests itself in many ways.

(I) A gradual conversion from focus on the poor and indigent to a preferential option for the well-to·do and paying patient.

(II) A promotion of a distribution service and not the evolution of an enabling empowering service.

(III) Increase in size, bureaucracy, compartmentalisation, over professionalisation and hierarchical decision-making cut off from the lives of the poor.

(IV) A preoccupation with targets and records, numbers, efficiency and cost effectiveness rather than a focus on indices of equity, Participation, quality of services and health abilities of the local people.

This is inevitable when health action is not located in a wider socio-political-economic-cultural analysis of society and is a great danger faced by and those who begin this exploration today. Moreover, all those who begin this search today invariably emerge out of the educational and health system which are themselves not geared to a people's orientation. Therefore an attitudinal change and a value re-orientation become pre-requisites though not always easy.

Conclusion

This short exploration highlights some of the action dimensions of the search for a people-oriented health system in India. It also highlights some of the social process dimensions that need to be recognized by health action initiators to ensure that the project/process that evolves through their effort does not lose its people-orientation somewhere along the way.

The examples given are a small selection from the wealth of experience and reflections emerging in the country in the last two decades. The main plea of this paper is that the quest for a people oriented health system must not become a quest for a new package of actions or a new technology fix.

It has to be a new vision, a new attitude of mind and a new value-orientation in health action intertwined closely with efforts to build an alternative socio-political-economic-cultural 'system in which health can become a reality for all people.

A MOVEMENT NOT A PROJECT
A MEANS NOT AN END

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A Continuing Dialogue :

Key responses to the Red Book

The red book was mimeographed and circulated in 1987 to all the contacts of CHC with whom we had interacted during the early years. The community health reflections in the red book were seen as a collective, consensus building exercise and tried to bring together the diverse and plural experiences of a large group of community health innovators and action initiators in 1980's. Some of them sent interesting and thought provoking responses to the reflections and these helped us in CHC to look at new dimensions, reconsider our positions and continue to grow in our collective understanding of community health.

From time to time, we also published shorter articles and reflections in various journals and bulletins drawing from the reflections in the original red book but reorganizing them according to the requirements of the publication. These additional publications, when reviewed chronologically will reflect a growing and evolving understanding of community health. In this revised publication we are including five substantial responses from well known people and institutions and reproducing two publications from social action in 1985 and 1989, to symbolize this continuing dialogue and the constant evolution of our understanding of community health.

(Another, larger publication on Community Health: an alternative paradigm, is also being produced during this jubilee year which will bring together all aspects of our experience and understanding of community health from 1984- to the present).

SOME KEY RESPONSES

Community health: The political dimension!

I do agree with your definition of Community Health. It does take in all the socio- political and strictly, the health aspects into consideration.

A few ideas that may need further elaboration:

a) The reasons why community health turned out to become community medicine is the class character of the voluntary groups which have undertaken community medicine initiatives. An analysis of this could perhaps make things more clear as to why they really cannot work towards community health.

b) What the ruling class in India and the Government itself want is at the most community medicine and not community health.

c) Hence, all that will be allowed by the powers that be of our society to take place is community medicine; and any effort towards community health will be frowned upon and looked at with suspicion because then, the implications of community health, especially the economic and political will become more clear.

d) A dependent capitalist society such as India cannot and therefore will not work towards real community health programmes.

e) The realization of community health takes place as part of the realization of a socialistic society.

f) Hence, any medical person/group working towards community health must work as much towards a socialist order.

g) Hence, just as socialism is brought about through a political process, so also, community health can be the result also of a political process only. However, it does not exclude experiments and other efforts at a technical level so long as these efforts would be part of an on-going political process for socialism.

Kindly take them for what they are, since I really do not know how much of the explicitly political dimension can be brought into an article that is quite technical health wise.

Stan Lourdusamy, *Social scientist, Director-Indian Social Institute, Bangalore-Karnataka, 15th Oct 1985.*

From providing to enabling!

It is a candid analysis of what goes on today in the name of community health in the country and is certainly both stimulating and provocative.

As you very rightly point out, a good majority of the present day efforts to take the message of 'health and wholeness' to the community, are only extensions of the medicalisation effort, I would say, arising mostly out of ignorance about basic concepts of community health and what its avowed goals are, and which serve to perpetuate all the ills of medicalisation of health. Here the activities are confined to patient care and that too in a casual manner. Team leadership, even in the so called, successful experiments is often left in the hands of a junior doctor, ill motivated as a rule (often conditioned by the prevailing attitudes among the elders). This endeavour is highly reoriented in its scope even in terms of so called medical care, the services hardly reach the poor as more often than not, it is beyond their purchasing capacity. The danger of this approach is that the programmes, ultimately become the monopoly and the exclusive preserve of the elite and defeating its very purpose.

How many of this peripheral outreach projects are planned on the basis of a situation analysis or community diagnosis? Is there an epidemiological basis for planning?

The 'providers' role is glamorous! One is elevated on a pedestal from where he doles out graces to the deprived. I am afraid, community health is increasingly becoming a fashion and a fad of the elite. In some instances, it is an inconvenient yet unavoidable appendage, in certain others it serves a camouflage to hide the ugliness of the past sins- of omission and commission.

The 'enabling' role is never visualized as it involves serious effort of working with the people and which has lot of connotations. The 'activists' role of the health worker should be seen, after all, as part of the awareness building efforts and which to all intents and purposes is the staple of community health. The sequential steps would then be, creating awareness about community's own needs and in depth understanding of the factors that stand in their way of progress, and how perhaps they can join together in overcoming the forces of repression. This is the inalienable role of the health worker, as someone who enables those who have been age-old victims of oppression to liberate themselves.

Community health as seen from this perspective projects an image of powerful dynamism and growth, nurtured by all the contemporary, progressive forces of political thought and opinion. And that is what 'public health' is meant to be: to serve as powerful instrument transforming the lives of common people and changing itself in the process. The one possible way to narrow down the dichotomy between the alternative health care approach enthusiasts and socio-political activists is to make socio-epidemiological foundation, the basis of all their community health efforts!

Dr. George Joseph, *Former Professor of Community Medicine, AIIMS- New Delhi, Executive Director- Healing Ministry, Church of South India, Chennai, Tamil Nadu.*
8th Oct 1985)

The scientific spirit of community health

I have read your article on Community Health. It is well written and balanced article, but something about this argument 'What is Community Health (CH)?' has always – at least since 1979, bothered me, which I still find difficult to articulate adequately. Your clear summary of 'What is Community Health? towards the end of the article is quite comprehensive and concise. Community health is about, above all a definite constellation of values, it is a value frame work, but in my opinion still a few important values are missing in this way of formulation of community health. Very indirectly I have tried to tackle this problem in the paper we prepared for Calcutta meet (1983). This is to do with scientific temper of the whole enterprise of community health. It is not certainly technological service system/structures, but then it is not also merely community building. Community health tackles some very hard health problem that causes effects which are all pervading and have to be clearly, adequately understood to solve them. The way community health concept is being formulated in the dissent circles tend to not only over emphasize values (community) part but almost exclude the scientific part. The word 'Scientific' or 'Science' even has assumed certain connotation and get associated too strongly with establishment. I think we should fight this tendency. There are reasons and sound reasons for that for this type of reaction, but they are not reason to turn away from scientific spirit. In fact I hold that 'scientific spirit' value and other values of community health which we uphold intergenerate one another. No question of two being incompatible. Indeed one without another is not really possible, not at any rate beyond certain point. I think mfc at least should be much more alive to important lacunae in the problem posing of community health.

Dr.Anil Patel, *Director, Sarvangeen Gram Vikas Mandal, Prayas, Rajpilpla, Gujarat.*

More focus on praxis and practical realities

I went through your paper- "Community Health as the quest for an alternative". I must accept that it is well written, and I feel it could happen so because it reflects what you saw during your "make friends' tour"

About the components of 'alternatives', every word is an expression of what one witnesses in various health projects. 'Alternatives' are desired goals. What is achievable in practice needs to be discussed more in depth say for example,

a. Village health worker- lackey or liberator

b. Whether youth groups/mahila mandals/farmers associations / cooperatives in health work – do they represent interest of the 'people'? Will it be possible / How far it has been possible in a situation where conflict of interests lie?

c. Self reliance in health

d. Scope of community participation around health issues.

e. What are the observable linking threads between "ill founded euphoria of the alternative health care deliverers" and the in active cynicism of socio-political activist about the role of health care and to bring the two groups together?

From the analysis of what has been observed, a rough outline of a role of medical professional in a given social structure needs to be spelled out. This can be split up further into what is the goal and how far the practical attempts have succeeded.

Somewhere it needs to be mentioned that it is the vision of the field worker which is important, because it decides the process, and that the enormous tide of the materialistic civilization washes out the majority of young people.

Dr. Ullas Jajoo, *Department of Medicine, MGIMS, Sevagram Wardha, Maharashtra,*
26th Aug 1985.

Beyond conflicting paradigms

I like the theme. It is very appropriate time to touch this issue you have dealt with the theme in a balanced way so as a whole the paper is good. Following are my suggestions.

1. You begin with Zurbrigg's quotation which suggests that there is a dichotomy between health and political work. In the later part of the paper you try to show that the gap is closing between the two positions. It is confusing to begin with a quotation which does not go along with your position. You may use that quotation later on as an example of the School (of thought) which believes only in political action and considers health as totally a political action.

2. Paragraph one in the Red Book is also internally contradictory: if in the ultimate analysis, an unjust society alone is the cause of ill health, then associate an ill health is wastage of time because it is merely a symptom.

3. The word conspiracy is misleading. It is a popular leftist expression but it creates a false impression as if all the capitalist persons sit together to plan a conscious conspiracy. What really happens is that in the pursuit of individual gains, the forces align with each other in the natural process of marketisation.

4. I personally feel that is would give better flow and direct start to the article if you begin with the 'quest for alternatives' omitting the first three pages of the text. They are unnecessary and confuse as to what is your main issue and argument. Then on, the flow is very good. In your comments on community medicine projects rather than community health, you may use David Werner's description of projects with 'people' in centre vs. projects with medical technology on management in the centre.

5. The points in 'positive trends' are very good and you should elaborate and illustrate here with examples and descriptions. Those who are not in touch with this part of circles may not know or understand what you are indicating at.

6. In spite of these positive trends, it remains a fact that many staunch Marxists take a position that more health work of whatever culture and values is a wastage of time or even reactionary. For example, Zurbrigg in whole of Rakku's story. Many health technologists totally forget and think appropriate technology is the panacea. It may be a useful exercise to list their respective positions and conflicting paradigms in the form of tables and then to show how reality is not just two poles.

I believe you have hit a very vital theme and it will be a great value to further develop this theme.

***Dr. Abhay Bang**, Gopuri, Wardha, Maharashtra-28th Sept 1985.*

The Society for Community Health Awareness, Research and Action (SOCHARA) is a professional resource group in community health and public health, rooted in civil society. It has spearheaded community health action; innovative training; networking; and policy action research in community health and public health since its inception in January 1984. the Community Health Cell (CHC) is the functional unit of Society for Community Health Awareness, Research and Action (SOCHARA), which is a registered Society. (see website www.sochara.org).

The objectives of SOCHARA are:

- To create awareness regarding the principles and practice of community health among all people involved and interested in health and related sectors.
- To promote and support community health action through voluntary as well as governmental initiatives.
- To undertake research in community health policy issues, particularly in areas of :
  - Community health care strategies
  - Health personnel training strategies
  - Integration of medical and health systems
- To evolve educational strategies that will enhance the knowledge, skill and attitudes of persons involved in community health and development.
- To dialogue and participate with health planners, decision-makers and implementers to enable the formulation and implementation of community oriented health policies.
- To establish a library, documentation and interactive information centre in community health.

"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".

" 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 more "community health" oriented in its values and focus".

Society for Community Health Awareness, Research and Action
359, 1st Main, 1st Block, Koramangala, Bangalore - 560034.
Tel.: +91-80-25531518 / 25525372 / 25630934
Email: chc@sochara.org Web: www.sochara.org