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COMMUNITY HEALTH : :

the search for an alternative process

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

PROJECT PROPOSAL

Centre for Non-formal & Continuing Education
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30 st marks road Bangalore 560 001

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3. Some thoughts on the future

3.1 Critical questions
3.2 A documentation cell
3.3 A communication and continuing education cell
3.4 An Action research cell
3.5 Networking
3.6 Summary of Needs

4. Towards an Action Research Cell

4.1 Features of the cell including type of research, team structure, funding and base.

5. In Conclusion
5.1 Publication of the C H C Report
5.2 Phase II of the process

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REPORT OF THE COMMUNITY HEALTH CELL ::
JANUARY 1984 TO JUNE 1986

1. THE PROCESS

The Community Health Cell was an informal study-reflection-action experiment, embarked upon by a small team in January 1984 and a continuation of a process that had begun some years ago.

The main objective was to gradually interact with all the groups involved in Community Health Action in Karnataka including individuals, health project teams, networks, coordination groups, documentation and education efforts, training centres and build up an overview of Community Health as a process. As health practice researchers committed to a 'community and epidemiological' orientation, we hoped to study the situation by taking a macro-level overview of what was either a series of micro-level experiences of social reality, or ideologically confined perspectives emerging through some networking efforts. By so doing, we hoped, to actively participate in what we had perceived from our earlier experiences, to be a meaningful and evolving process in the country since the seventies.

1.1 Evolving Guidelines for the experiment

Our efforts were tentative and cautious. We were keen to remain small and uninstitutionalised; so, we managed to get support for our team of four to function from an informal Cell in Koramangala for an initial period for two years.

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A small team, we felt, would have adequate flexibility to relate to such a process. It would also allow us to experiment with more democratic participatory, non-hierarchical functioning, in keeping with our own 'health' objective.

We decided to limit our main focus of efforts to Karnataka, geographically, to allow for closer interactions with individuals and groups with whom our work would bring us in contact. Even Karnataka proved too large finally.

We decided not to structure our efforts too much. Some technical and overall operational guidelines were drawn up and used as reference points in our interventions. The guidelines as they evolved were :-

a. We would meet and discuss any ideas for health action with anyone who approached us;
b. We would select those initiatives which we thought had an element of social analysis and were open to review/ reflection and work more closely with them;
c. We would provide all of them with whatever supportive information/documentation that we had access to;
d. Often there were demands, to be resource persons in initiatives that were mainly ad-hoc actions/events within a project or institutional contex (eg) ad-hoc camps, ad-hoc training programmes, ad-hoc celebration of events. We generally referred them away to other resource centres, since in our new order of priorities, we had to be selective.
e. We were open to association with any individual/group/ project or initiative which was keen to reflect and analyse the existing health system and evolve more meaningful approaches that were more relevant for the poor and the under-privileged in society. Not-withstanding the divisions that exist - political, social and, religious in developmental circles - in India we adopted a more open-issue-based approach in keeping with the perspectives of the medico-friend-circle of which we were a part.

Another conviction from which arose this approach was our earlier experience that whatever the ideological background the attitudes to health as a process, among most groups involved with development in India, is severely medical in its orientation. The Doctor-Drug-Hospital model is a common fixed perception and the awareness that health could be an awareness building process, an organisational effort, a struggle for health as a right, had yet to become a common perception.

f. Since we were sensitive to the fact that health efforts needed healthy team functioning, we associated mostly with groups who were more democratic and participatory in their decision making processes and efforts. In terms of larger meetings too, we participated in those efforts that were sensitive to the idea of building perspectives in a participatory way.

It must be stated that in all our interactions we were not neutral in our perspectives of health. We did encourage and emphasise perceptions like :-

a. health efforts going beyond medicalised, curative and preventive efforts, beyond drugs, hospitals, dispensaries and medical professionals.

b. health problems and health efforts being seen in their wider socio-economic-political, cultural and ecological context.

c. health as a process of awareness building and community organisation and not merely institutional/project building or provision of services.

d. health process/approaches to be evolved through greater sharing of field experiences by activities and all those involved including 'demystified' professionals and sensitive academicians. Only then would more socio-culturally relevant approaches emerge. This would then, wean us away from the existing initiatives - transplants of the Western model.

1.2 INVOLVEMENT WITH m.f.c. AT NATIONAL LEVEL

Very early in our planning efforts there was a request by our m.f.c. colleagues, that our team, which was to be based in Bangalore, should shoulder the organisational responsibilities of the circle. This is a rotating responsibility - a feature of the collective functioning of the circle.

After some hesitation we agreed to this additional responsibility, which included among other things, the bringing out of a monthly bulletin and organising annual and mid-annual discussion on health issues. We decided that in addition to our focussed efforts in Karnataka, this added responsibility would give us an opportunity to meet, communicate and interact with a wider group of people all over India, searching for more relevant options in health care.

1.3 CATALYST ROLE

We decided that our interventions would primarily be that of a catalyst or animator. We decided to actively associate with ongoing meetings and dialogues organised by other groups and resource centres, networking efforts, training efforts and support individual initiatives as well. We did not call any meetings of our own nor initiate a project of our own. The idea was to understand the existing situation and to support encourage ongoing initiatives without creating one more centre, one more project.

1.4 WISE COUNSEL

A small nucleus of three senior persons were identified with whom we regularly shared our plans and communicated our ideas. They were not a governing council, but a wise counsel, mainly listening, encouraging, raising questions, sometimes confronting as we went along.

A network of associates/colleagues which included many m.f.c. core group members, was a wider group with whom we discussed issues/communicated and kept in touch with, during these years.

2. THE INITIATIVES

In the thirty months since we embarked on this experiment we were involved in many meetings, sharing sessions, discussions, travels, field observations, reflections, planning sessions and actions. To list these out chronologically would serve only an administrative purpose. We, however, share here a variety of interactions to give you a feel of the thought provoking process we went through.

2.1 Reflections on a new vision of health and health care and evolving of a strategy of reorienting/training members of a hospital association towards this vision. Apart from the initial reflection in May 1983 there were concurrent and annual sessions where the evolving process and training inputs were constantly evaluated with the community health team of this hospital association.

2.2 Reflections with graduates of St John's who had participated in the rural placement scheme. During these sessions we reflected on the relevance of their work experience in small rural hospitals. Problems of policies and practice in these

peripheral institutions were also identified. It was hoped, that the former would be relevant feedback to the faculty of the college and the latter, feedback to the coordinating hospital association, so that further collective reflections to identify solutions could be initiated

2.3 Reflections with field level activists of a large number of voluntary organisations from different parts of Karnataka on the scope of Community Health. All of them were members of a coordinating federation of voluntary organisations.

Over the two years we also got opportunities to meet individuals and team members from these projects separately to discuss their perceptions of health.

2.4 A sequel to this, though not directly linked, was the regular participation with many members of this Federation, on a Consultative Committee on Rural Development, formed by the Government of Karnataka, to establish a dialogue between secretaries of Government departments and representatives of non-governmental voluntary agencies. This idea was initiated by the Planning Commission and this dialogue process is evidently going to be greatly enhanced in the Seventh Five Year Plan period.

2.5 Reflections on "Community Health" with varied groups such as :-

i. Participants of an Apprenticeship course in "development";

ii. Secretaries of state-level Voluntary Health Associations;

iii. Diocesan level Health Coordinators;

iv. Members of training teams of Community Health and Family Planning Department of a Coordinating Church medical agency;

v. Participants of a course in community organisation and development;

vi. Members of a project evaluation team of a coordinating agency;

vii. Participants of a Regional Consultation organised by coordinating health associations and social service societies;

viii. Formators of religious training institutions in Bangalore;

ix. Teachers of a women's college planning a social awareness and sensitisation programme;

x. Participants of an intensive training in self-renewal;

xi. Participants of a National Seminar for Youth Leaders;

xii. Participating youth leaders and youth groups in a consultation on Youth and the struggle for justice and peace;

xiii. field officers of a funding agency;

xiv. Foreign medical students on an exchange programme.

2.6 Workshop on evolving "A More People-oriented Drug Policy" for members of a Hospital Association as part of their annual convention in Bangalore. This effort involved a series of reflections and group discussions on drug policy and rational therapeutic issues for :-

a. a thirty member team of facilitators-doctors, and health activists;

b. an audio-visual resource team, who produced a slide/cassette show on the theme;

c. a group of religious brothers, who wrote relevant liturgy on the theme;

d. a street theatre group, who evolved a short skit on the theme;

e. background papers and a special issue of the journal of the association on the theme apart from participating in the entire proceedings of the workshop;

f. some short-term studies on use/misuse of drugs in small hospitals and health centres;

It may seem surprising that so much effort should be spent by a team interested in Community Health - on the issue of drug policy and rational therapeutics. It is our firm conviction that with the strangle-hold that "drugs and prescribing" seem to have on the thought processes of existing professionals and administration of Medical Care institutions and even in the expectations of lay consumers - drug issues, can be levers to confront and challenge the existing highly medicalised system and stimulate social analysis and some movement towards relevance.

2.7 A series of reflections on different components of community health or associated dimensions in the planning process.

a. Health Education
b. Governmental - non-governmental links in health care
c. School as a focus of health action
d. Crisis in Medicine and the new vision of health care
e. Analysis of the existing health system
f. Crisis in medicine and search for an alternative process
g. Alternatives in Medical Education
h. Community Diagnosis.

2.8 A few additional interactions (not possible to group with the earlier categories) were :-

a. the colloquium on 'Health and Healing for all' organised by St. John's Medical College, Bangalore;

b. A workshop on Training methodologies and awareness building in programme for the Development of Women and Children in rural areas organised by UNICEF and Government of Karnataka;

c. Evaluations and planning session organised by the Centre for Nonformal and Continuing Education, Bangalore.

d. Mental Health course for community health team of CHAI and associates;

e. Refresher course in community health for Franciscan Brothers Trained in Community Health;

f. Participatory evaluation of community health projects organised by Indian Social Institute, New Delhi.

g. Seminar on Research priorities in occupational health organised by Regional Occupational Health Centre, Bangalore; NIOH, Ahmedabad and ICMR.

2.9 The medico-friend-circle organisational work, led to a series of initiatives that widened our understanding of some wider aspects of Health Policy and Health Care.

a. the Bulletin responsibility helped us to focus on a series of issues like Medical Education, Child Health, Cost of Health Care, Environmental Health, the nuclear epidemic, dams and their effects on health, Workers Health, Pesticides and Health, Nutritional and Health, and the Bhopal disaster.

b. a series of group reflections on Medical Education (Hoshangabad); Tuberculosis (Wardha); Tuberculosis and Society (Bangalore); Bhopal intervention and evaluation of role of m-f-c (Patiala) and environmental health - a case study of pesticides (Khandala) gave us opportunities to look at other related issues with this growing community health perspective.

2.10 The Bhopal Disaster, one of the worst industrial and environmental accidents in history, became another focus of study and action. At the request of many voluntary agencies and action groups working in Bhopal, the medico friend circle decided to send a team of researchers to conduct an epidemiological and socio-medical survey and later a survey of pregnancy outcome. The rich learning experience included :-

understanding the disaster and the local situation after the disaster;

assessing existing relief and rehabilitation efforts;

evolving and supporting a plan of study;

understanding the findings and their implications;

evolving a communication strategy on health issues including ideas emanating from research efforts;

lobbying for relief and rehabilitation actions and relevant type of research;

interacting with other scientists and the ICMR and the medical establishment of Bhopal;

trying to get voluntary agencies and action groups to work together on health issues;

evaluating mfc's interventions; publishing reports, communicating results and basically supporting attempts to understand the problem and identify action in a people-oriented sense.

Bhopal and post-disaster events and follow-up have been a real life, case study - an open university - of the strengths and weaknesses of various initiatives by Government, professionals, non-governmental voluntary agencies and action groups in the context of such a devastating tragedy.

The most important learning experience, however, was the need for process-oriented, socially sensistive, community based epidemiological research for backing ongoing efforts by non-governmental voluntary agencies and action groups. This would greatly support the demand for relevant health care policies and interventions. These studies will not only help in lobbying with decision makers but also in the use of the legal system to stimulate social change. More important is the support it will give to health and development activists, in basing their actions, initiatives and movements on a sound and analytical information base. A key learning experience of Bhopal which must be stated is the inability of voluntary agencies, health and development action groups and those committed to the people to work together in solidarity. The disconcerting experience in Bhopal - of mutual suspicion and distrust, highlight once again an important problem in the Indian development scene. The dynamics of such networking are still to be well understood but in part they were due to ideological and personality conflicts.

2.11 Some reflections and action with the environmental groups and other citizens' groups, who have evolved especially as a sequel to Bhopal, were also interesting. In Bangalore, we have been in touch Parisara - one of the local, environment action collectives that formed up, post-Bhopal. The contact has meant attending discussions, meetings, protest marches and assisting in some nascent plans for research. The groups supporting the peoples' movement around the Harihar Polyfibre plant pollution of Tungabhadra river in Karnataka has also sought various types of informational/study support for their work. So also the rallying

groups around the controversial social forestry and eucalyptus issues. Whatever the other arguments, that need to be considered, to decide on relevant action there is a growing realisation that one of the effects of environmental mismanagement is an increasing threat to the health of people and therefore a need for community health action.

2.12 Drug policy issues and rational therapeutics has remained an area where our role was primarily catalytic even though there has been increasing interest on the matter in Karnataka. Starting with the group discussion - on a people oriented drug policy - the Bangladesh Experience (led by Dr Zafarullah Chowdhry of GK Project, Bangladesh) at the beginning of our experiment, we continued our role by planning special bulletin issues of the Bulletin of Sciences (Science Circle, Bangalore); medico friend circle bulletin (November 1984 and December 1985); Medical Service (November 1984; CHAI Journal), and a resource file on Bangladesh experience (in coordination with ISI Bangalore and Science Circle).

Many meetings of an evolving Karnataka Drug Action Forum consisting of doctors, health worker, development activists, consumer groups have taken place but the process is still nascent.

2.13 Women's Health issues in the context of the overall emerging trends in Women's Movements in India also became a new and additional focus of the cell. We have been involved with the Bangalore based womens' groups in discussions regarding women's health and the adverse effects especially on the poor women of the present health and development model. MFC & other womens' groups have been active in the campaign, regarding injectible contraceptives, and are now going to focus on Family planning programmes and policies in India at the next annual meet.

2.14 Planning, analysing and technically supporting studies undertaken by many of our associates was another mode of mutually supportive reflection. These included the study of Community Health Programmes involving village Health Workers (Oxfam, Vanaja Ramaprasad); Study of drug use/misuse in small rural hospitals (CHAI, GD Ravindran); The Bhopal based studies (m.f.c); Survey of Health Institutions (CHAI); and Health Survey of a Karnataka District (Tumkur group).

2.15 An adhoc assignment which added to the evolving perspectives was a two week brain storming session with UNICEF on an action plan for governmental/ non-governmental assistance in India for 1985-89 in September 1985.

2.16 A few miscellaneous events were :-

a. meetings to discuss the WHO Document on the Government/Non-government collaboration in Health care;
b. A meeting with Oxfam campaign unit - researchers on drugs, pesticides, deforestation and dams;
c. meetings with a newly formed foundation, to critique their idea of individual enterpreneurship, in health and development and the need to shift focus to collectivity and teamwork;
d. discussion on approaches to Community Health with representatives of several funding agencies.

2.17 INDIVIDUAL INTERACTIONS

Whereas in paras 2.1-16 we have highlighted the important groups reflections/action and study, another very important and probably most worthwhile dimension of this experiment was the time spent by us with many individuals listening to their experiences, sharing their plans and hopes, and providing them with information and technical support. We often challenged some of their perspectives in a spirit of solidarity and shared some of our own field experiences, observations and tentative conclusions. This was probably the most satifying and meaningful part of the whole experiment.

Too often, in the packed schedule of a busy medical college department, we were not able, in the past, to give adequate time to all those who would like to share an idea in health, plan an initiative or a project, reflect on their experience or just share the positive and negative experiences of field involvement.

The Community Health Cell was kept very busy with this dimension of work, apart from the initiatives mentioned earlier. Many of the field level activists, who contacted us, were often from outside Bangalore and were constrained for time. Hence we tried to be very flexible and followed an open-house policy though this did make the routine of the Cell rather hectic and somewhat exhausting. In later months as a practical requirement to conserve our energies for greater depth work and to improve the quality of our support we were forced to adopt a slightly more selective policy. The individuals who visited the cell shared their experiences and ideas but very often the supportive response

from us included :-

a. guidance, technical support and references for the various components of Community Health Work - planning/executing health surveys, evolving training programmes for village health workers, planning a community health programme, evaluation/ reorienting methodologies, under 5-care issues and so on.

b. Rural placement/project placement support for all those contemplating long-term, short-term assignments in Community Health/rural hospitals/ peripheral institutions.

c. Supportive planning of study tour, or electives, by young medicos, interns, non-medical students, post graduates.

d. Guidance to post graduate students doing field oriented project work for their theses.

e. Alumni of St Johns' - both doctors and Community Health workers, who would like to discuss their current field projects/rural experience and assess their own initiatives.

f. A whole range of m.f.c. members and bulletin subscribers requesting information/ideas/ reference.

g. Foreign visitors doing elective studies and action/reflection in India - among other this even included an acupuncturist from London interested in the role of acupuncture in Community Health Work.

h. Colleagues/associates and friends in health and development work sharing ideas/experiences from time to time.

i. Informal support to ex-colleagues from St Johns' in their current interests and initiatives.

just to give an idea, in a year, there were at least about 150 such contacts, and many came more than once to continue the informal discussions.

2.18 TEAM DEVELOPMENT

The various inhouse activities of the team of our Cell apart from those already described included sessions, reference work, correspondence, basic secretarial work, basic office assistance, reporting, communications, work at the press and so on. We ensured that the team also got sometime to learn/appreciate/understand various dimensions of the experiment.

This was done through informal discussions on each of the interventions, pre- and post-event. Also by some planned sessions to discuss relationships, job satisfaction, decision making and other aspects related to the working ethos of the cell. These greatly helped to evolve an increasing participatory decision making process in the Cell. (Refer CHC-III for further details).

The team members also attended short courses and ad hoc training sessions as part of ongoing staff development and enrichment. These included diverse topics such as low cost communication media like puppetry and posters; a basic course in mental health; scriptural inspiration for liberation and freedom; scientific advances and practical problems in Natural Family Planning; group sessions in self-analysis and self-actualisation. Individual team members made their own choice of courses.

2.19 Community Health - A collective perspective

In August 1985 at the request of the ISI a short paper on Community Health as a quest for an alternative was prepared putting together some key issues identified in our study-reflection. This was included in the special issue of Social Action on the theme - 'The Health System in India'. Later it was added to a collection of experiments with participation and non-formal education focus, and included in the book 'Development with people'.

This preliminary article was circulated to twenty five colleagues and associates to elicit critical reactions and comments, and evolve a collective perspective.

2.20 Review and Evaluation

From February 1986 - we began to review the work of the past 26 months and wrote a report to highlight the main initiatives and learning experiences and plan more concretely, for the continuation of such an effort.

This report was sent to the three members of our wise-council in March for an indepth review and comments.

A two day meeting was organised in April 1986 when this draft report was discussed in detail and the critical comments as well as other observations of the wise council was considered. From this crucial meeting a short term plan for a 18-month staff training phase and some long term perspective plans emerged which were initiated from June 1986.

3. Some thoughts on the Future

3.1 Critical questions

The 'Community health cell' was an informal study-reflection action experiment - evolved as a tentative strategy to understand an ongoing process in development. It was not intended that this strategy should automatically grow into a more formalised or institutional initiative. Therefore from the very beginning it was decided that a mid-course reflective-evaluation would be organised after about two years to take stock of the experience and plan future directions.

During this experiment we came accross many people and initiatives working for Community Health at grass root level and many other individuals and initiatives supporting this process through training, planning, evaluation, networking, communications and research. A process of action and a process of support was already present and evolving. The main questions however - were. What were the additional supports that this ongoing process needed ? what were the lacunae of the existing supportive systems ? what were the actions that needed further strengthening ? What could be the role of a team like ours, in the future ?

3.2 A documentation Cell

Inspite of the many adhoc, ongoing initiatives in documentation, we still perceived an urgent need for a comprehensive, specifically Community Health focussed documentation cell.

a. Keeping track of materials

Such a Cell would need to keep track of health related publications, bulletins, newsletters, occasional papers, research studies and government non-government agencies reports arising out of the rich ongoing experience in the country.

It would be crucial to establish close links with initiatives such as Voluntary Health Association of India, (New Delhi) Centre for Education and Documentation (Bombay), Centre for Science and Environment (New Delhi) and the Indian Social Institutes (New Delhi and Bangalore) to keep track of documentation efforts. Locally in Karnataka, a close link with documentation centres in Bangalore, and Libraries of research institutions, university departments, directorate of health services and medical colleges should be established.

These national and local links would be aimed at ensuring access to available materials and documentation/collation efforts with the minimum of duplication.

b) Materials in Regional Language

Much of the materials especially in the non-governmental Sector is still predominantly in English and this is a sad commentary of the distance of the existing communication efforts from ~~with~~ the people. A major thrust of the documentation cell should therefore be

1) identification of all available materials in Kannada, Tamil, Telugu, Malayalam and Marathi - the main language groups in Karnataka.

11) Facilitation of translating key documents and reports into Kannada - to begin with to ensure that collective reflections can be stimulated at levels more firmly based in the community.

C) Distribution of Documents

Facilities for cyclostyling and Xeroxing key documents at low cost for all those interested in the process of Community Health is also an important need. Stocking of key publications and handouts produced by other organisations in Karnataka and India, for distribution and sale could also be a key function but this needs some planning and basic infrastructural support.

3.3 A Communication and Continuing Education Cell

The ongoing process can be further supported by a concerted communication strategy which must be directed at atleast three levels:-

a) Lay - Awareness Building

The level of lay people - rural or urban with whom the ideas, issues and perspectives in Community Health need to be shared to initiate a participatory dialogue as well as a crucial process of demystification of medical and health matters.

Ongoing initiatives such as the Karnataka Rajya Vigyan Parishat, non-formal education and adult education efforts of voluntary agencies and government organisations, science education programmes organised by voluntary agencies, and various extension education efforts by workers in the health and other sectors of development could be partners in such efforts.

b) A continuing education - to team members of health action projects and initiatives, as well as to the staff of the government primary health centres is another crucial venture.

While the former has to be a new venture organised by a networking effort of existing Community Health training organisations in Bangalore, the latter will have to be a process initiated with the directorate of health services as a pilot scheme in possibly one district.

Two crucial contributions, that NGO's involved in Community Health can play in this pedagogical intervention is 1) the facilitation of a more appropriate, group sensitive, participatory, problem solving pedagogy that they have gained experience in 11) the facilitation of an understanding of health beyond the purely physical, technological and organisational, dimensions that characterise the present educational efforts.

The absence of both these factors at present make the so called 'Health Education' efforts of both government and non-governmental agencies ineffective and somewhat counter productive. This continuing education effort would have to be supported by audio-visual skills as well pedagogical skills oriented to distance learning.

c) A communication of Community Health - issues ideas and perspectives to key decision makers in the state - politicians, administrators, technocrats and leaders of trade unions and pressure groups to ensure that 'Community Health' is brought into the focus of 'development debate' in the system. This would also ensure that decision makers begin to see 'Community Health' in its broader perspective and not in its severely myopic medicine- doctor - hospital - medical college perspective that is popular at present.

3.4 An Action Research Cell

A large amount of present day community health action is adhoc. The issues identified are important but the methods employed to determine justification for action are often 'emotional' rather than on a collection, organisation and critical interpretation of data on the local problem or social reality. There are times when issues get referred for legal action or are parts of representations or demands to the governmental agencies for action. At these times particularly it would be a great help to an evolving action programme or initiative that well researched and well documented facts are available to them to support their efforts. There is therefore an urgent need to make available such expertise and back up efforts with socio-epidemiological field investigations. In many ways this would actually be a sort of 'counter-expertise' available to the community since research efforts by many of the existing in-system institutions are coloured by certain unchallenged assumptions about social reality as well as operate under controls which make information inaccessible to the people.

There is therefore a need for an interdisciplinary team which has the basic skills, creative flexibility in approach and the social sensitivity to tackle the challenges of grass-root level investigation. The research endeavours initiated or supported by this team must not be super imposed upon existing action programmes but must be adequately participatory and accessible so that 'health action initiators' as well as representatives of the community can appreciate the problem solving approaches ie, socio-medical-epidemiological investigation.

Not only would the problem solving methodology and ethos, thereby become part of grass-roots organisations but the researches, would also be continously challenged in their efforts to collect and interpret data and to ensure that certain assumptions of present day research design and methodologies do not go unchallenged.

A wide range of issues can be studied by such a team. These would be identified by existing organisations or even by the research team members during their grass-roots contacts or team reflections.

From the experience of the Community Health Cell many issues were already beginning to emerge.

i) Health and nutrition effects of development policies such as present agricultural policy, social forestry etc.

ii) Accessibility and availability of existing health services both governmental and non-governmental to different sections of the community.

iii) The health culture of the community and its attitude, utilization and perceptions of the various, modern and traditional alternatives available to it.

iv) Health effects of environmental pollution caused by industrial effluents particularly along water courses affecting villages down-stream.

v) Health of occupational groups and marginalised sections of existing rural communities.

vi) Studies of participatory and problem solving pedagogical innovation in training programme and non-formal education efforts of existing voluntary agency initiatives

The possibilities are enormous.

3.5 NETWORKING

There is a great need for networking among a whole range of existing efforts so that some or most of the above needs can be met by supportive initiatives.

The networking should involve :

a. Grassroots - health and development action groups;
b. Health projects especially under voluntary agencies' auspices;
c. Training, communication and coordinating agencies, associations and initiatives;
d. Non-formal education, adult education and science education experiments;
e. Socially sensitive 'academics' and 'professionals' in the health related sectors;
f. Socially sensitive elements among planners and decision-makers;
g. Health oriented elements among pressure groups such as Trade Unions and issue-raising movements such as the environmental and women's movements.
h. Socially sensitive elements in society and their organisations who can promote health perspectives - journalists, teachers, lawyers and so on.

It is important to clarify that networking need not mean coordination in any 'big-brother' or organisational sense. We basically feel that networking should imply a coming together to dialogue, share information, and experience, discuss issues and evolve common perspectives and all the existing forums should be made use of to the maximum extent possible. As and when common action initiatives emerge, these too could be supported by ongoing available organisational frameworks rather than seeing the need for a distinctly new and identifiable networking organisation, in every case.

3.6 In summary then the Community Health Cell's study-reflection-action experiment has led to the development of certain broad perspectives on Community Health which are described in great detail in a separate publication to be brought out by the Centre for Non-formal and Continuing Education, Bangalore.

In addition the study reflection has led to the identification of the following basic initiatives required to support the emerging and on going process of Community Health in the State:

(a) Documentation
(b) Communication and Continuing Education
(c) Action research
(d) Networking

Our assessment of the situation in Karnataka has led us to conclude that initiatives (a), (b) and (d) can be evolved and encouraged by bringing together a large number of individuals and ongoing projects already involved in supporting action. By strengthening existing initiatives and evolving a greater collective dimension among them, it is possible to increase the availability and accessibility of these supports to a larger number of group active at the community level. These supports would include skill training, planning and evaluation, group building efforts, audio-visual communication and so on. The collective dialogue and discussion initiated would also help in focusing ongoing initiatives in more crucial dimensions and directions.

4. TOWARDS AN ACTION RESEARCH CELL

The CHC team has decided that the development of an action research cell which has both the skills and creative flexibility to meet the challenges of field level investigation will be the primary focus of our efforts from June 1986.

4.1 The skills of such a research team will be primarily geared to sociological/epidemiological field investigations. Other skills and technical facilities required to back up epidemiological enquiry can be tapped from a large number of existing organisations with which loose but effective linkages can be established. The Cell will bring together researchers who value and appreciate involvement in field based investigations, and have the social skills and attitudes to work with people in the community, most often focussed on the more marginalised sections, in what can often be difficult field conditions. This pro-people ethos and a social sensitivity are crucial to such a Cell, if it aims to go beyond the traditions of existing medical research institutions and support in a participatory way, ongoing community health action. Various possibilities will have to be considered in terms of a long term viability of such an action research cell.

(a) Type of Research

Whether research undertaken will be primarily at the request of ongoing projects and initiatives or will the research cell have long term research interests of its own? Probably a mix of both these types of research projects will have to be considered.

(b) Structure of Team

What will be the basic structure of a nuclear or core team? How will other resource persons interested in specific projects or problems be involved in research efforts even though they may be based in formal institutions and other projects. Flexibility in the concept of participation and support will be a crucial requirement.

(c) Funding

What funds can be tapped to support action research efforts? As an overall policy it seems that efforts to tap governmental funds like those from the Department of Science and Technology, ICMR, ICAR, ICSSR, Karnataka State Council of Science and Technology have to be made. Private trusts and research foundations and grant-in-aid to NGOs from government departments of health, education, rural development and social welfare will also have to be considered.

Foreign funding agencies supporting health and development initiatives in India could be tapped for certain specific supports such as books and publications but this should be with caution and only if it possible to get it without the existing charitable, paternalistic, project projecting and project imposing relationship. Some agencies value a more participatory relationship and could be considered. Small individual based support systems will also have to be considered since funding could also be a consciousness raising exercise as well as a symbolic participation. Ultimately an aware, socially sensitive supporter is better than an ad hoc charitable donor.

Whatever the source of funding a strong emphasis on simplicity, low cost efforts, non-duplicating and non-waste strategies, resource reuse value systems will be constantly encouraged.

(d) Base of operations

The CHC team believes that it may not be absolutely necessary or inevitable to formalise this initiative by registering an independent organi ation in the future though this may have to be considered if no other alternatives emerge in the next 18 months.

It may be possible to relocate this initiative in a larger, ongoing health oriented initiative, research institution, teaching department, educational institution or coordinating organisation. However, a creative autonomy and a participatory governance will be pre-requisites to ensure that some crucial features of the search and some aspects of a new work ethos can continue to be experimented with as part of the action research.

We do have certain misgivings of relocating in a larger venture, primarily around the following questions:

(i) Can institutions/projects built on existing value systems/modes of functioning appreciate, support or nurture the sort of creative flexibility such an initiative requires?

(ii) Can governance mean a participation in a process of discovery rather than a control or an authorization in the traditional sense?

(iii) Will institutional needs and objectives and the fears of precedence, over-ride the exigencies of an evolving, exploratory process?

(iv) Can institutions/projects committed to a 'medical model' and concentrating on 'provision of services' support a paradigm shift in efforts toward a 'health model' and an 'enabling' orientation.

Notwithstanding our misgivings we are still convinced that a serious effort should be made to locate our efforts in the context of an existing ongoing initiative rather than launching off on yet another centre.

5. IN CONCLUSION...

The Community Health Cell (CHC) was an informal study--reflection--action experiment in Karnataka State which began in Bangalore in January 1984. The main objective of this experiment was to understand the dynamics of Community Health action and to get an overall perspective of the sitution in Karnataka. As a basic methodlogy, a small team (three of whom were previously members of staff of a department of Community Medicine in a medical college in Bangalore) participated in reflections and supportive actions with a large number of health projects and development initiatives organised by non-governmental voluntary agencies in Karnataka. It was hypothesised that with the 'researchers' and the 'activists' participating in commong reflection and action a more comprehensive understanding of the community health process would emerge. During the ensuing months the CHC team also shouldered the organisational responsibilities of the medico friend circle, an all India voluntary network of doctors and health activists trying to evolve health care policies and medical education policies, more relevant to the Indian context.

The experiment was concluded in June 1986. The study reflections are being published in a report entitled Community Health--the Search for a Process. The CHC team als also identified the needs for a documentation effort, a communication and continuing education effort and a networking effort to support and sustain the ongoing 'Community Health' process emerging in Karnataka. These, however, did not necessarily need a distinctly independent effort but could very well

be brought about by strengthening existing initiatives, training centres, coordinating groups and encouraging a greater collective dimension in their efforts.

A crucial but unmet need was action research primarily socio-epidemiological to support the ongoing health initiatives and the evolving issue-based movements in the community.

The CHC team has, therefore, decided that the initiation of an action research cell, which will promote a wider appreciation of socio-epidemiological perspectives in problem solving in health, health care and community health action, will become the focus of its future activities.

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5.1 Publication of Report

As part of a process to initiate a collective response to the study--reflections of the CHC team a cyclostyled report entitled 'Community Health--the Search for a Process' will be brought out by the Centre for Non-formal and Continuing Education in Bangalore in 1987. This report will include:

(i) a background note on certain important developments in India in the years 1972-1986 to place the reflection in the right context;

(ii) A short note on methodological issues;

(iii) The reflection on Community Health in India;

(iv) The principles of Community Health arising from this reflection;

(v) A series of important tasks for the future; and

some appendices to highlight the sample of interactions from which these reflections are derived as well as reading and reference lists.

This will be sent to our colleggues and associates in Karnataka and other parts of India to generate responses that will help to sharpen the focus of our future efforts. The report will also be available to all who are interested as a modest, reference document on Community Health in India.

5.2 Phase II of Process

The CHC team has now moved into Phase II which is an eighteen month planning, training and staff development phase. June 1986--December 1987. During these 18 months members of the team will pursue

courses to equip themselves for future action research.

During this phase many aspects of the study--reflection will be documented and some critical reflection and approaches on possible future areas of action research will be generated.

Ideas arising out of the study-reflection will be shared with colleagues and associates and various dimensions of future action will be discussed. Explorations for future base, financial support, core team and research perspectives and methodology will also be undertaken.

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