ROLE OF VOLUNTARY ORGANISATIONS IN HEALTH AND HEALTH CARE SERVICES

CHAI study team, Community Health Cell, Bangalore.*

15th April, 1993.

The Policy Delphi Method of research was utilised as a component of the larger CHAI Golden Jubilee Evaluation Study. Forty-nine persons participated as panelists. They come from diverse backgrounds such as sociology, theology, different branches of medicine, nursing, community health, communication, law, education, development etc. The interaction between the panelists and the facilitators was by mail, using questionnaires and other information sheets.

In the first round of the method an open question was put to the panelists regarding the role of voluntary organisations in India, with respect to health and health care during the next fifteen years. Thirty-seven panelists (75.5%) responded. A summary of the different ideas that emerged is given below. This particular question was not taken for the next round which focussed particularly on the role of CHAI. Therefore, no prioritization or rating of the ideas/issues has been done. For the purpose of this note similar ideas have been put together in broad groupings. Most of the roles identified are already being played to greater or lesser extents by different volags or NGO's in the country. Given the breader contextual issues (raised in the earlier notes) in which health work is situated, it would be important to reflect as to what could or should be the areas of priority during the next: fifteen vears. Arriving at some clarity about this would help in the planning of work, development of skills, utilisation of time and other resources etc.

The four broad areas covered, concerning role of volags are:

- 1) Primrity groups for focus of health related work.
- 2) Varying types of intervention.
- 3) Methods of work,
- 4) Methods for spread of ideas.

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Paper prepared for a meeting organised by CHAI of Community Health Trainers in June 1993 at Bangalore. It is an analysis of Question: Three of the 1st round of Policy Delphi method of Research.

I. Priority groups for focus of health related work by volags:

1.1 Need to focus on and support the poor and marginalised:

- * Special focus on the rural and tribal poor and on urban poor living in slums. There is a need to identify neglected groups among the population, especially those that depend for their livelihood on the fragile eco-system. Strategies of work intervention need to be evolved.
- * There is a need for a preferential option in the provision of health care for marginalised groups, weaker sections and neglected areas of the country. These groups are largely ignored by the elite institutions involved in health care. There is a need for extension work and increased health care services in inaccessible rural areas. The market orientation of health care should be resisted and efforts made to give good quality care at low prices for the masses.
- * Volags could function as spokespersons for the poor and work to influence government policies in their favour.
- * There is also need to ensure that systems of social security for the poor are effectively implemented.
- * While working towards greater justice for the poor, volags should also work towards overcoming the difficulties faced by the poor as a result of the new economic policy. There is scope for involvement in development work that will enhance the capacity of the poor.

1.2 Need to care for special groups:

Those groups mentioned specially were:

- a) Girl Children and women there is need for education and special health care to counter the anti-girl child bias in our society. Education and advocacy towards empowerment of women is required. The health status, infant mortality and population growth, not to mention the economic status of a community changes in a positive direction when women are educated and have a significant say in the matter of social decisions etc.
- b) Tribal groups.
- c) Patients suffering from AIDS and leprosy.

II. Varying types of intervention by volags:

- 2.1 Provision of services secondary and tertiary prevention:

 Examples given were as follows:
 - * Mobile clinics in endemic areas for diseases like leprosy, filaria etc.
 - * Half-way hospitals closer to the community with facilities for surgery etc, so that chronic diseases can be tackled at the community level.
 - * Services for the physically and mentally handicapped and the aged.
 - * Rehabilitation and supportive services.
 - * Counselling services.
 - * Treatment centres for alcoholics and drug dependants.
 - * Hospices.

2.2 Promotion of preventive and promotive health services: The following specific areas were highlighted:

- * Focus on all preventive andpromotive health work, including mental health.
- * Propagation of healthy food habits, diets and exercise for a better quality of life.
- * Nutritional programmes to deal with netritional deficiency diseases.
- * Prevention of communicable diseases.
 - * Effective implementation of the principles and components of primary health care through appropriate strategies for the attainment of Health For All.

2.3 Promotion of community health and development:

* There is need to work towards community health rather than institutionalised health care, to focus on general health rather than on specialised health needs. There is need for greater stress towards building community based health care. Rural health centres need to have a community health orientation.

- * Community health care programmes for marginalised communities with their participation, is liberative. Liberation of people takes place when communities of people take their lives into their own hands.
- * People should be empowered to do things for themselves by making them realise their self worth and by a building of self-confidence. Thus people can be helped to be makers of their own quality of life.
- * Health problems should be tackled within the family, the community and locally as far as possible.
- * People should be helped to prevent illness and promote health through their own organisations.
- * Health programmes should also be developed in the context of socio-economic development and its impact on health. For instance, initiating and linking up with programmes that are indirectly related to health, for example, supply of pure (safe) drinking water, nutrition programmes etc.
- *There is also need to provide and to pressurise government to provide for basic health needs and clean water to all.

2.4 Promotion of newer dimensions of health work/health care:

The newer dimensions mentioned included the following:

- *The wholistic approach to health in which proper priorities are given to spiritual, moral, medical, social, economic and environmental factors. Evolving and promoting the wholistic approach by bringing together practitioners and researchers of various indigenous health systems.
- *Use of non-drug therapies.
- *Promotion of positive health and natural methods of health care.
- *People should be enabled to rediscover experience, knowledge, skills and practices within their communities and give a scientific basis wherever possible to strengthen what is wholistic and healthy.
- *Promotion of an enthusiasm among people to build their own health system in which they are the primary planners and the real implementors. The authentic result of their health care will be founded on their innate sense of community traditions, simplicity of life style and self-reliance.

* Demystification of health, so that people can use what is available, accessible and acceptable to them.
* Developing natural resources in the field of medicine.
* Facilitation of consumer movements.
2.5 Premotion of a rational/scientific approach to health care planning:
* Need for re-assessment, re-prientation and rejuvenation of the considerable voluntary health sector in India. This system is

relatively large in India, but on the whole deteriorating, inappropriate and wasted.

* To make a constant (continuing) analysis of society and the

health system so as to bring about policy changes in the restructuring of health services.
 * Provision of cheaper and people's need oriented health care by

net expanding hospitals into specialised units.* Developing a system where a few hospitals in each region could

make sophisticated techniques available at reasonable prices.

- * To establish a liaison network with appropriate leaders at ...
 different levels to menitor preventive action.
- * To establish a network of epidemiological research centres to forewarn various diseases.
- * Need to develop regionalised health services. To work out a proper divergent type of referral system wherein specialists from larger institutions move out to smaller institutions and provide specialised services.
- * Need to develop methods for simplification and rapid diagnosis of common diseases.
- * The management of health care institutions need to be professicnalised using scientific methods.
- * To work towards legislation that protects and promotes good health, e.g., prevention of pollution, provision of safe drinking water, etc.
- * To challenge strategies being followed for "Health For All" like the G.O.B.I. package (growth monitoring, oral rehydration, breast feeding and immunization) and the targetted Universal Immunisation Programme.

- * Influencing policies using scientific evidence and through building up public opinion.
- * To promote/develop innovative, appropriate, feasible and costeffective programmes in health care, education of health proressionals/personnel, and in development.
- * To involve para-professionals and non-professionals in health .

2.6 Responding to emerging health problems and newer health issues:

- * Since Government is likely to focus primarily on public health care, volags (NGO's) should be the initiators of newer responses/services for emerging health problems.
- * The problem of AIDS prevention and control, care of AIDS patients, including running hospices for them, is one such new problem.
- * Environmental health issues are also emerging as being important.
- * Health effects of industrialist/consumerist expansion.
 - * The present system could be challenged by involvement in issues like the production of essential drugs, campaigning against unnecessary and harmful drugs and chemicals, challenging practices of multinational drug companies and hospital corporations and the misuse of advertising. There is a need for de-medicalisation of society and demystification of the health profession.

2.7 Promotion of indigenous and alternative systems of medicine:

- * To help rediscover health systems/health practices that are indigenous and effective, because they are related to the life situation, culture and ambience in which people live.
- * To educate and demonstrate to people the efficacy of herbal medicine and to instill confidence in them that basic health can be within their control in normal circumstances.
- * To judiciously use alternative systems of medicine so as to provide the best possible health care in different areas and situations.

2.8 To uphold and promote higher ideals in health care:

- * To keep alive role idealism, humaneness and a holistic approach in health care. These are the essential 'leaven 'to counteract and challenge the proliferation of mechanistic, commercialised and depersonalised medical/health care.
- * Volags should resist the temptations of competing with private commercially oriented health institutions which are primarily concerning with making profits rather than serving the poor.
- * The voluntary health sector should resist the temptation of going in for expensive diagnostic and monitoring equipment, which have been shown to have had no positive impact on the health status of the Indian people.
- * To ensure a fair and even generous deal to all personnel working in volag institutions.
- * To fight for honesty and lack of corruption in public systems and to ensure the delivery of services.
- * To be vigilant against malpractices and to mobilise public opinion against such anti-social activities.

2.9 To develop innovative programmes/approaches:

- * There is a need to build on the assets of volags, namely their willingness to serve in difficult areas and ability to innovate, by converting their limited resources at strategic intervention points.
- * By providing services where there are none and documenting experiences and information that are thus generated, another important purpose of policy critique will be made possible. There is a need for volags to provide critical comments on health policy and advocate changes found necessary by the data generated above.
- * To develop innovative methods for the health rupee to go farther.
- * To start innovative insurance schemes for the poor to increase their access to existing health services.
- * To develop motivational strategies to facilitate government health workers to provide health services.

- * To develop close interaction with the State so that entire Blocks/Primary Health Centres/specified areas are handed over to volags, with the funding. The concept of Primary Health Care to be used for health work.
- * To develop viable, affordable and effective models of health care in order to enable the poorer section of the population to afford and have access to health care and participate in its sustenance.
- * To bring successful innovations to the attention of the health system for dissemination and adoption.
- * All resources among NGO's could be combined to establish regional centres for production of generic drugs, manufacture of hospital beds, equipment, bandages etc. Sheltered workshops and vocational training centres run by NGO's could be utilised to provide infrastructure etc. There is a guaranteed market both for drugs and equipment in NGO/Church hospitals, provided quality, quantity and price requirements can be mat. This would help in cost reduction, employment creation and production.
- * There is a need for reorganisation of medical education to provide more socially sensitive doctors, with attitudes that will respect the role and leadership of experts of other disciplines and give importance to the team concept. There is also a need to develop relevant models for the education and training of health workers.
- * There is a need to find suitable ways of combining the excellent ideas of the basic philosophy of VHAI (1978), ACHAN (1981), CHAI (1983) and CMAI (1986).

III. Methods of intervention/involvement in health work:

There is an overlap between some of the issues raised below. There are a wide range of suggestions, some of which may appear contradictory and represent differing approaches.

3.1 Health activism and community organisation:

- * Promotion of genuine people's movements.
- * Volags should support activists in the field.
- * Support to people's movements, organisations and associations, so as to bring pressure on the government to work andto be accountable. Organising people and mobilisation of public opinion to put pressure on the system for a more just provision of services and for a revision of government priorities so as to emphasise the health of the poor.

201 201 100 京鄉 图 2004 vbude le cereare e deverde veclondest es * Need for awareness building, education and organisation of people in communities to critically understand their situation of the state the second of the second of the second nummer of the state of the stat garding health and healthy communities. To enable people to organise themselves to provide their own health services and to develop life styles within a self-reliant mode, that is to take health back from the 'technocrats'. * Campaigning towards bringing in legislation to ensure accountability and transparency in the functioning of government (and its health systems). a of Conscientising and anganising consumers against unhealthy ephasticeo. Bringing about a change in societal attitudes rets ogazding vo resomerism, aprofiteering mand cultural alienation, - * * Working towards community participation in health care policy * Mobilisation of people as volunteers in the neighbourhood to take care of the health aspects of that area. ii) Networking: syldashilagewallour de isacemblugedevipa * To develop working relationships and an effective network with activists and other groups involved in issue raising/lobbying/ advocacy work in the field of health, education, agriculture, technology and science. This is for mutual support, encouragement and solidarity. iii) Co-ordination: * Co-ordination of programmesfor health care (between volags) to avoid duplication and to help bring about better utilisation roffservices. o eved ment to vnem . . for includive include the var * Inter-sectoral and intra-sectoral coordination of services. iv) Collaboration: Ad ividera was less than and the comment in a section of *To work as partners with each other and with government towards achievement of Health For All. *To collaborate with government in improving the level of efficiency and quality of services at governmental hospitals and health centres.

v) Liaison:

* To be a link and bridge the gap between the community/public and the health authorities of the government sector to improve understanding, explain constraints etc. This liaison would help people to get access to 'government facilities' using a constructive, non-threatening approach. Thus people will not have to suffer when a volag/NGO withdraws.

vi) Research and Evaluation:

- * To promote research, documentation and evaluation by volags.
- * To undertake research to identify emerging health issues and to develop new solutions.
- * To develop appropriate technology through a process of study and research to deal with various health problems.
- * To promote study/analysis of social and health problems, particularly the social aspects of health.
- * To enduct operational research and undertake studies to pin-
- * To help in generation of national data about health changes occuring at the community level.
- * To study alternative systems of medicine and their effects. To promote systems besearch in the efficacy of integrated medicine.
- * Research and evaluation of engoing projects. Voluntary hospitals in general are required to do a lot of self analysis and re-examination of their role. Many of them have outlived their objectives and are not clear about their philosophy, objectives and goals in the context of current changes and developments. There is a need to re-examine their service effectiveness, cost effectiveness and quality of service.

VI. Methods for spread of ideas:

Advocacy/Lobbying:

Advocacy can be at two levels, namely:

- a) by networking at the macro-level for health and social justice,
- b) by education, organisation and development to help communities get better health care and services from the government.

This is cost effective and has widespread effect.

* Volags should lobby as an active group to influence the social, economic and political policies of the government, which may have direct and indirect effects on health and health care services.

* Among several areas it was suggested that advocacy for respect-

- * Among several areas it was suggested that advocacy for respecting human life needs to be taken up.
- * A strong lobby needs to be built to regulate the standard of operation of health services.
- * Need for a labby group to influence governmental and voluntary organisations to maintain the capacity and quality of the medical profession.
- * There is a need for information diffusion with greater media coverage to highlight health and social problems.

4.2 Creating critical awareness/education :

- * Voluntary agencies need to create a deep and critical awareness among people at the grass-root level about the real economic, political and social situation prevalent in the whole country. Once awareness has been created people must be helped to organise themselves to demand their rights with regards to health housing and education. Because in any system, changes will never come through people at the top or even at the middle, but at the bottom.
- * Volags could facilitate the interiorisation of the value of education, knowledge and larning for liberation from exploitation and deprivation.
- * Needs for education regarding the rights of people, without causing harm to the community and which helps with preserving the good value rased traditions that exist.
- * Need for awareness building among the public about the deficiencies and exploitative nature of the health system prevailing in our country.
- * Since, according to WHO, 80 per cent of illnesses in developing countries are preventable, the voluntary health sector should a concentrate on health education at the village level.
- * Dissemination of health knowledge and expertise and the process of leraning to the deprived sections of society through the media.
- * Need for an emphasis on the promotion of health and the ways and means of achieving it, through education.

- * Need to focus on the social aspects of health, in education.
- * Physical and mental health education with focus on teaching of traditional health care methods like yoga, meditation etc.
- * Teaching of self-help, health care methods.
- * Awareness building regarding sanitation.
- * Education to present AIDS and addictions.
- * Education to maintain a correct and healthy attitude to the medical profession, both among the public and among medical people.
- * Introducting effective machinery for health education.
- "Literacy along with health care programmes."
- Adult education in rural and tribal areas with health components.
 - * Public education for information sharing and action.
 - * Increasing the use of mass media for health education.

4.3 Training:

- * Need for training at the grass-root level and in the mornal sector.
- * To evolve training programmes to equipmural women with health and medical expertise, so that they can disseminate health information among the people.
- * To enlist motivated and appropriately trained bands of committed health workers at all levels, that is to train various cadres of para-medical personnel in health care.
- * Greater need for non-physician, health personnel development with emphasis on proper health management.
- * Need to improve the communication skills of health workers.
- * Need for formal and non-formal training of resource personnel for holistic health promotion.
- * Preparation of appropriate teaching aids.

There are over four hundred voluntary organisations working for health in the country. This does not include the mere informal health related work done by interested groups and people. The contribution of the voluntary sector is substantial not only in number but also in nature and type f work, which is often pioneering, creative and committed. A very wide range of roles, functions and methods of work have been outlined by Delohi panelists as being necessary and relevant for the future. Several of these ideas are already being done by various groups. Inclusion of these ideas into the training modules and programmes of those involved in community health training may, be redevant. Again, some groups may have already introduced these ideas into their training programmes. Sharing of methods would be beneficial:

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- 02. GOOD NETWORK OF CONTACTS (AT ALL LEVELS) AND STRONG CREDIBILITY WITH THEM
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- 09. FINANCIAL TRANSPARENCY / ACCOUNTS NOT MANIPULATED

- · Responsive to emerging concerns
- perspectives based on Indian Experience
- Promotion of Baloonist approach / Equity / Empowerment
- Secular; total freedom in work; Planning well

WEAKNESSES

- 01. SHORTAGE OF TECHNICAL PERSONNEL / SECOND LINE TEAM
- 02. EXCESSIVE BURDEN / WORK LOAD AND CHANCES OF BURN OUT ON FEW TEAM MEMBERS
- 03. PROBLEM OF TIME MANAGEMENT BECAUSE OF OPEN ENDED CATALYST APPROACH ("MORE THAN WE CAN CHEW")
- 04. TOO MUCH CATALYST ROLE MAY MAKE US UNWILLING TO TAKE ON RESPONSIBILITY FULLY
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- Conflicts between humaneness and professional functioning
- Individual roles overlap
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- · Need to build AV section further

OPPORTUNITIES

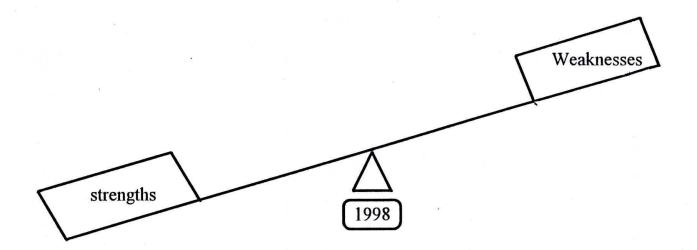
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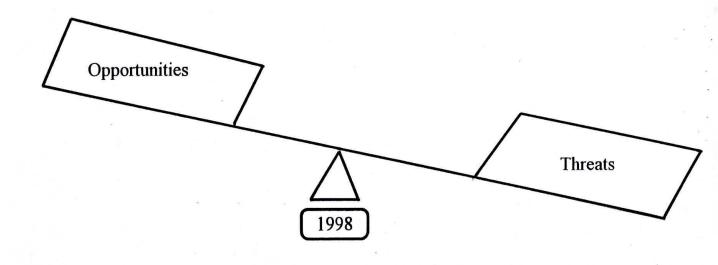
- With decentralization, opportunity to create greater awareness towards community health among policy and decision makers
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- 01. DIFFICULTY IN GETTING SECOND LINE LEADERSHIP, WITH SECURITY NEEDS OVERSHADOWING CREATIVITY NEEDS
- 02. POSSIBLE DANGER OF EMPHASIZING THAT OUR APPROACH IS THE BEST APPROACH
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- 04. FLEXIBILITY OF WORKING CONDITIONS EXPLOITED EVEN BY FULL TIME AND PART TIME STAFF
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- Financial sustainability still low
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- Tradition of flexi-management often used by team members to make personal needs to overshadow CHC needs
- Too much individualism. Reduced space for others to think. All good things can be misused





CHC REVIEW MEETING

3rd/ 4th April, 1998

CRITIQUES / REFLECTIONS / SUGGESTIONS

(Please note down any positive or negative comments, questions, suggestions that you have after the presentations on 3rd April and after reading the 14 year overview report. Time will be provided for the reviewers and others as well to share these on 4th April - Session $V:9.30 \ a.m.$ to 12.30 noon)

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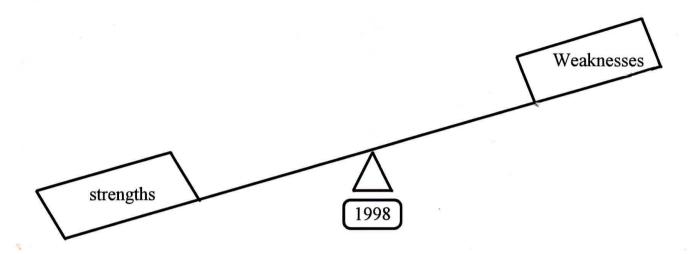
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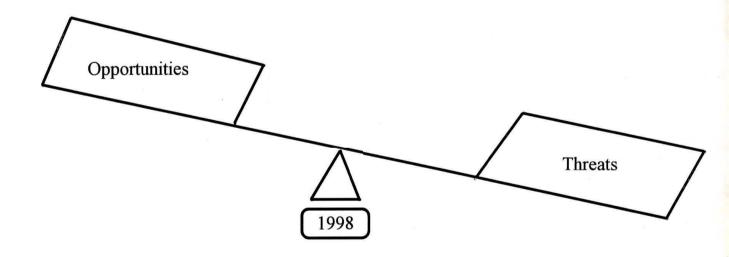
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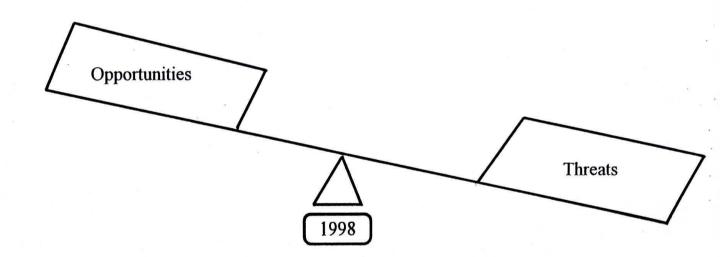
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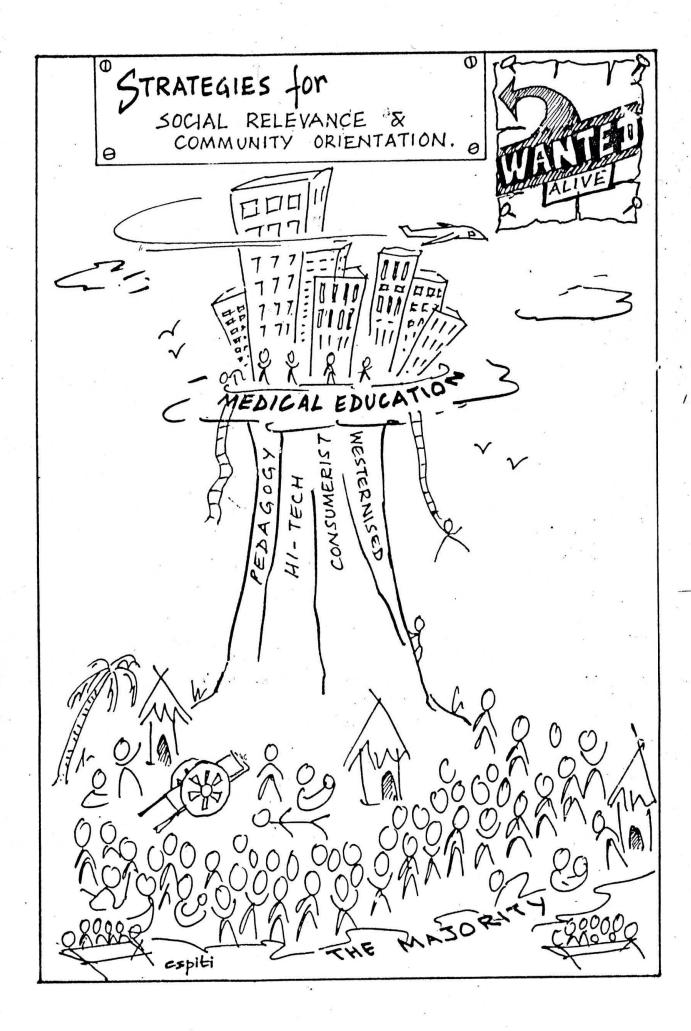
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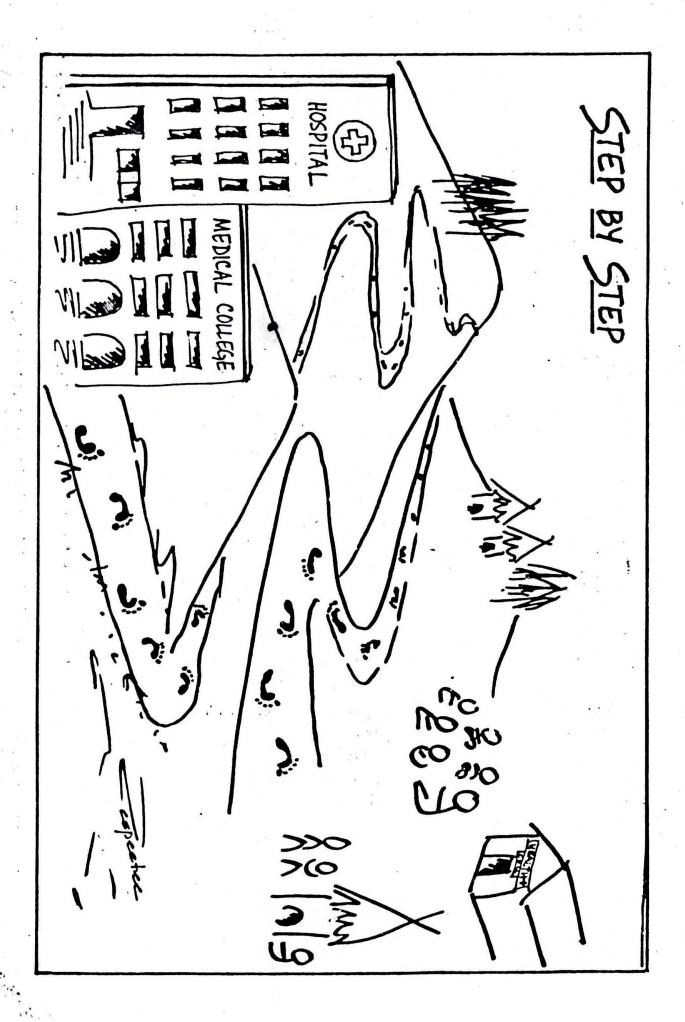
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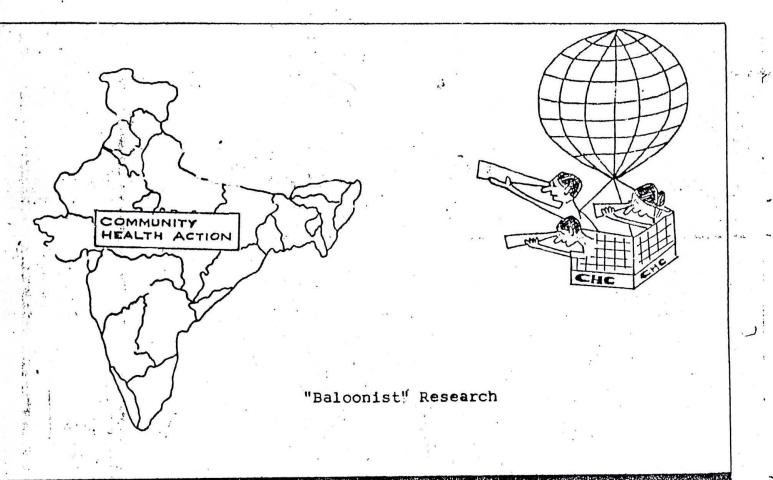


- Reduce:
- ✓ poverty,
- √ inequality and
- ✓ spread education
- Organise poor and underprivileged to :
- √ fight for their basic rights
- *Move away from*:
- ✓ Counter-productive and
- ✓ Consumerist
 Western Model of Health
 Care
- Replace with
- Alternative based in the community.

ಭಾರತ भारत NDIA RN/TH'S 1982 TRIP (BHARAT DARSHA) VIBITING mfc core group SIMC. Dockers and C.HWs Health and Perelopment Projecto Coordinating Agencies in Health.









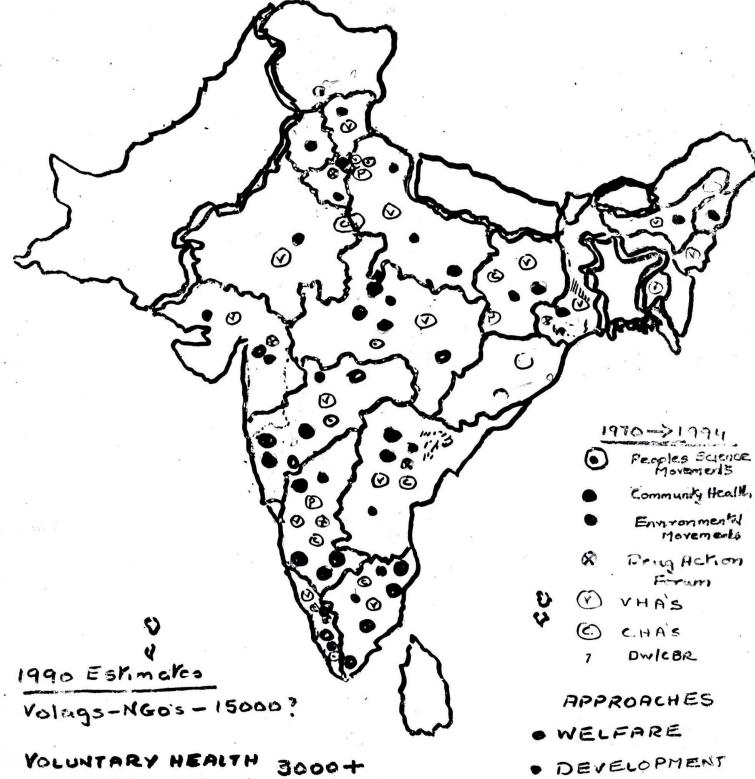
Participatory Reflection

magi

COM MUNITY HEALTH

(An overview)
VOLUNTARY HEALTH
SECTOR
(1980)





VOLUNTARY HEALTH 3000+

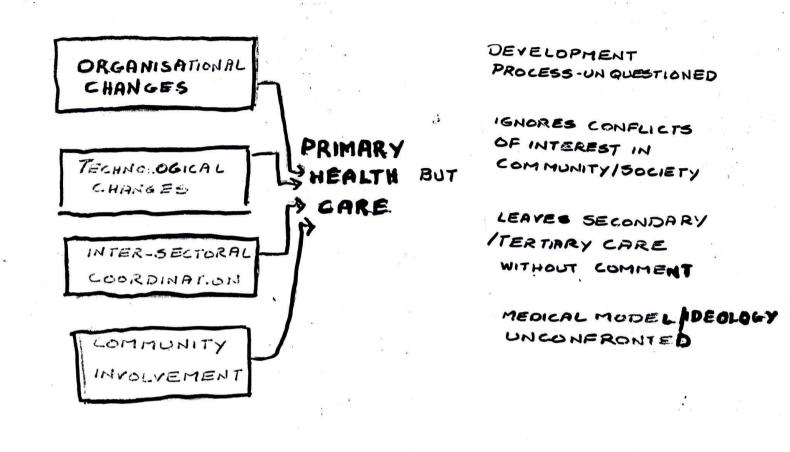
ASSOCIATION

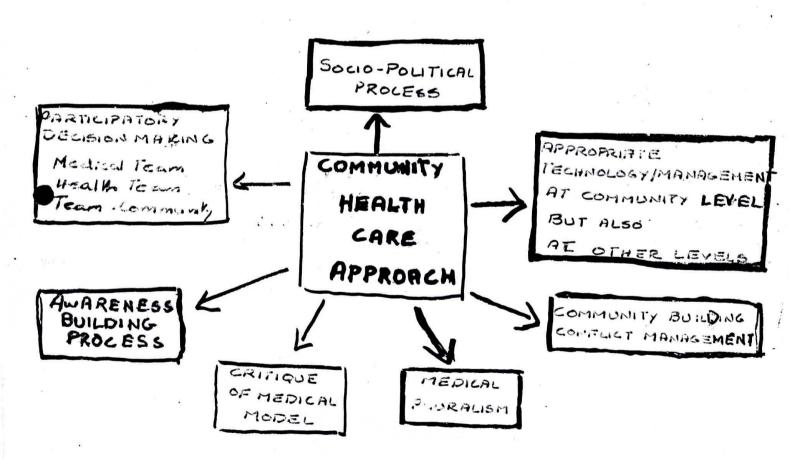
CATHOLIC HOSPITAL (HEALTH) 2000+

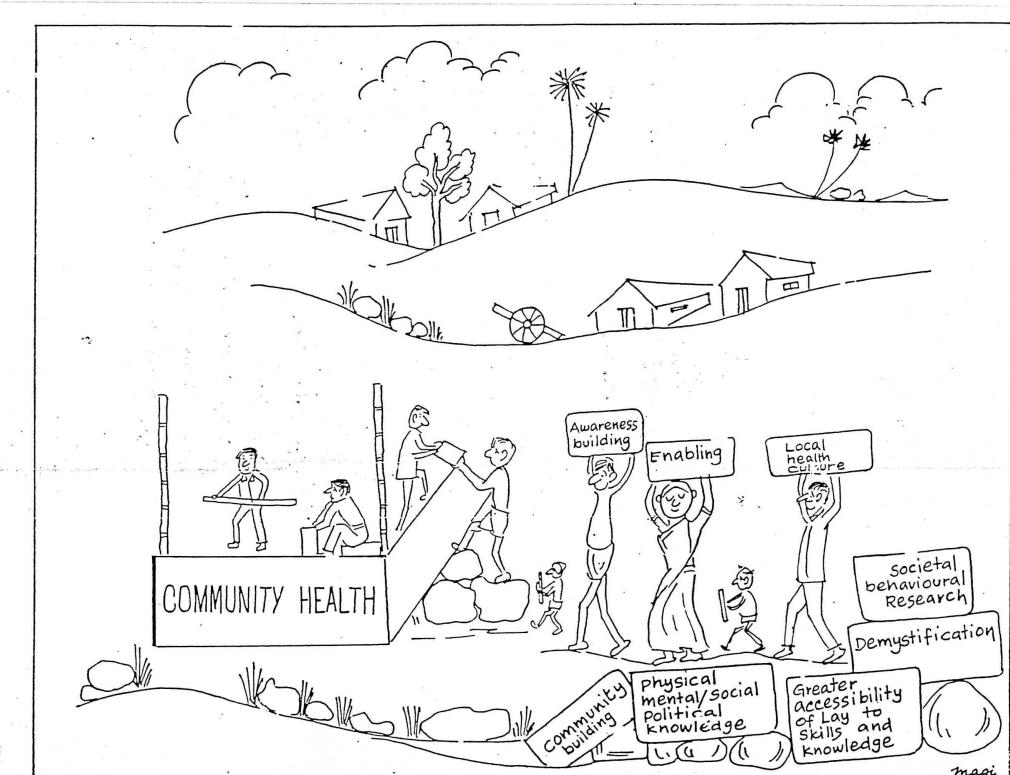
HSSOCIATION

EMAI — 300+

· EMPOWERMENT

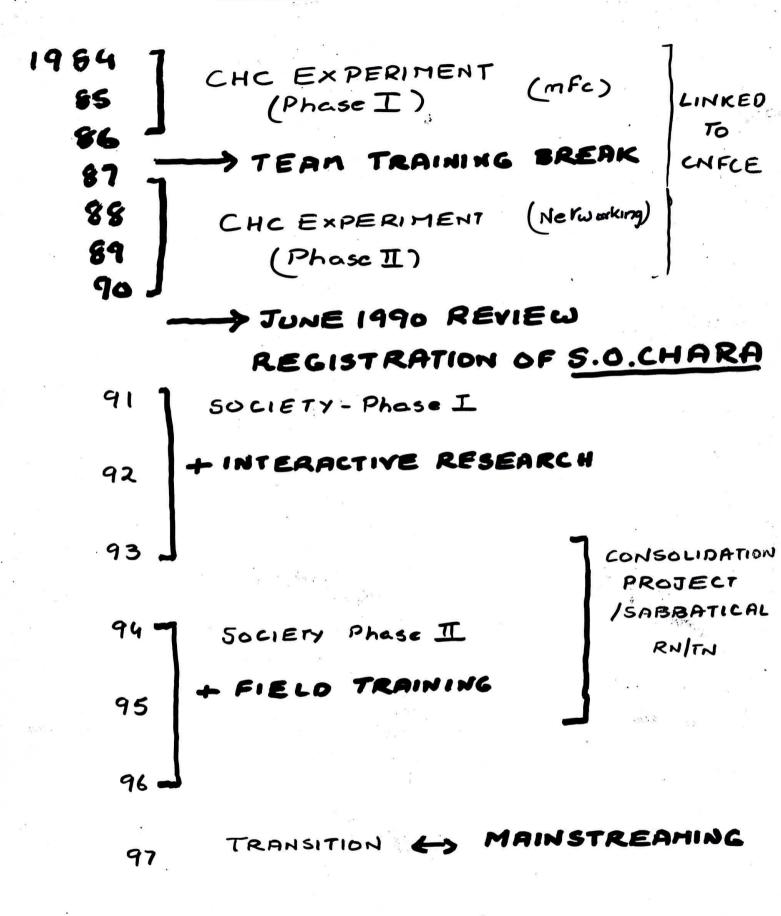






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CHC - PHASES



98-> CHC REVIEW ->
WHAT NEXT ->

Interactive Dialogue

- · TB + SOCIETY
- · MEDICAL EDUCATION
- · ENVIRONMENT -HEALTH
- · REVITALISING MFC

RATIONAL DRUG CAMPAIGN

- mfc initiatives - study -newoletter
- · AIDAN formollon

THE mfc phase (1984-86)

. 3

BHOPAL Involvement

- BOCIO EPIDEMIOLOGICAL STUDY
- · COMMUNICATION STRATEGY
- AWARENESS BUILDING
 ON ISSUES

mfc Bulens 101-120

· Special Napletters

· Medical Education
Anthology

· Bhopel Skidies
and Pamphlels

I

CREATING
AWARENESS
OF THE **CH**PARADIGM

(CH+ROU+IMS)

II

RESEARCH
IN
COMMUNITY
HEALTH
ISSUES

Z

SUPPORTING
COMMUNITY
HEALTH
ACTION

SOCIETY FOR

COMMUNITY

HEALTH

AWARENESS,

RESEARCH.

Y ACTION

IIL

EVOLVING EDUCATIONAL STRATEGIES

- · DOLTORS
- · CHWS
- . OTHERS

区

DIALOGUE WITH HEALTH PLANNERS

YL

LIBRARY

UNIT

DOCUMENTATION

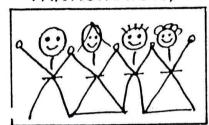
- YOLUNTARY SECTOR
- . GOVT SECTOR

POLICY RESEARCH

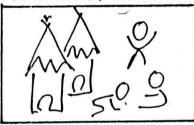
TRAINING

FORMAL NFORMAL

PARTICIPATORY

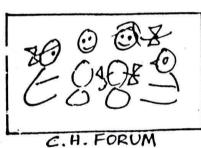


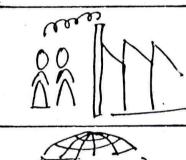




NETWORKING & LINKAGES

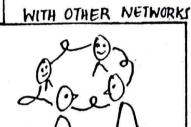






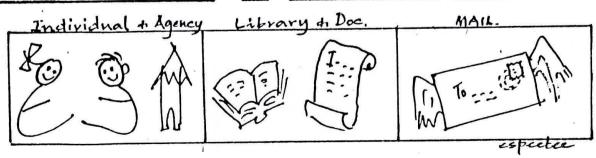
DISASTERS



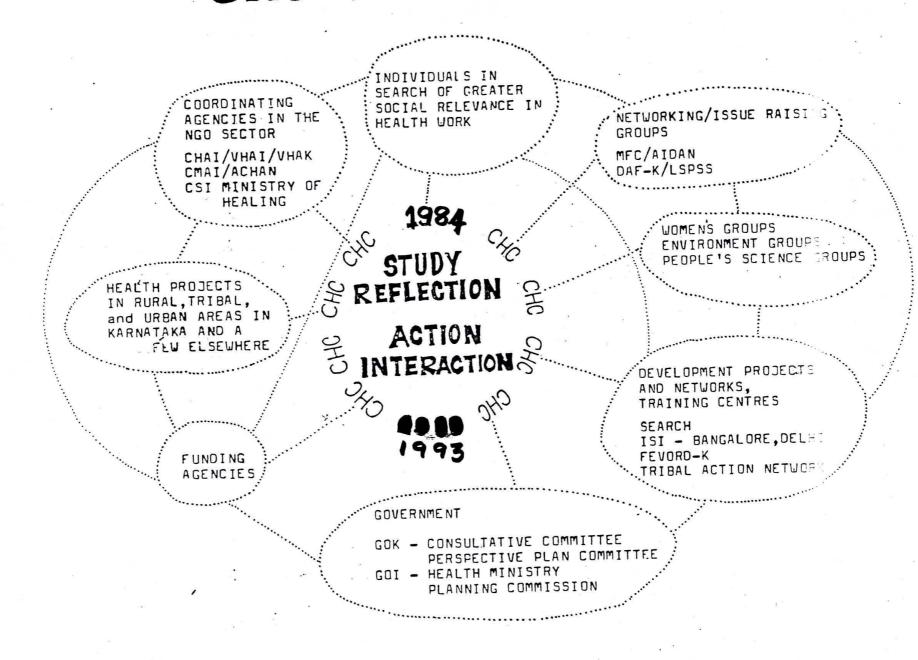


URBAN HEALTH

+ INFORMATION & ADVISORY SERVICES



CAC-THEWEB OF NTERACTION



2 ANGE OF ISSUES EXPLORED IN COMMUNITY HEALTH 1984-93
COMMUNITY HEALTH) TUBERCHLOSIS CONTROL RATIONAL DRUG POLICY
LEPROST CONTROL MITH MISSION IN HEALTH CARE IN HEALTH CARE
<i>\\</i> . <i>!</i>
POPULATION ISSUES TRAIMING OF ALTERNATIVE SYSTEMS MCH INFP
PREDICTING HEALTH MANAGEMENT ISSUES WOMEN HEALTH ISSUES
N
COMMUNITY HEALTH FUNDAGS/VOLAGS HE ALTH AGRICULTURE)
GM THEACTH POLICY
SHIFT THUS BASSOCIATE SABBERTORL

1978 VOLUNTARY HEALTH ASSOCIATION OF INDIA

1982

1983

(3000 Health Institutions and Community Health programmes)

making Community Health a reality for all people, with priority for the less privileged millions. with their involvement and participation through.

The Voluntary Health Fretor.

ASIAN COMMUNITY HEALTH ACTION NETWORK

of community based health care. Mat envisages a process of self-relient human development for he oppressed poor in ... Asian communities ...

CATHOLIC HOSPITAL
ASSOCIATION OF INDIA
(2400 member Hospitals
and Dispensories)

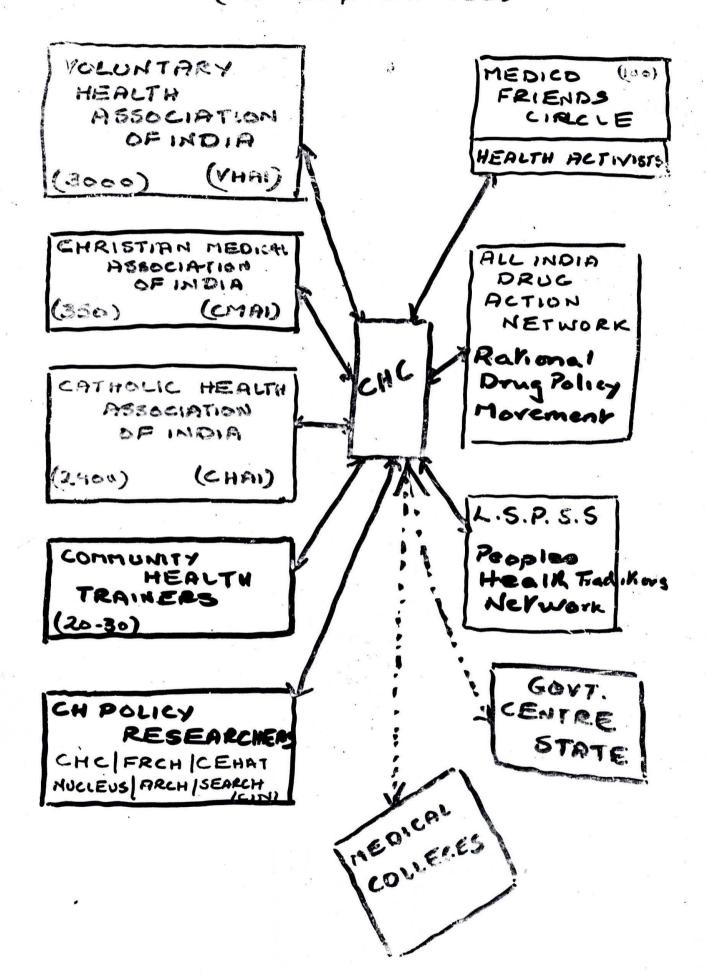
l'committed to comme it?

Health as a precess et enabling people to exercise collectively their responsibilités to maintain their health and to demand health as their might....

ASSOCIATION OF INDIA

(300 institutions (protestant) +5000 individuals as sociated with these) nealth ... a process that empowers people to work regether to promote their own health and to demand appropriate health services ... relevant low cost, effective and acceptable ...

(not for profit NGO)



Voluntary
organizations

State level
Associations

Notional Coordinating
Agencies

VHAI - New Della: CMAI - New Della: CHAI - Secundembra mfc - Bombry

Bulletins Health, For the Millions Health, Action

Jesvanija mfc + dlata

Centres IRHM, Pechod CINI, Calcutter Centres INSA, Bangalose Deenaberdhy (INI) RUHEA, Vellore Tambied (Ildimolta)

Resourch, FRCH, Rombay SEARCH, I Wintership.

Carlies ARCH, Geyand CHC, Brightone (etc.)

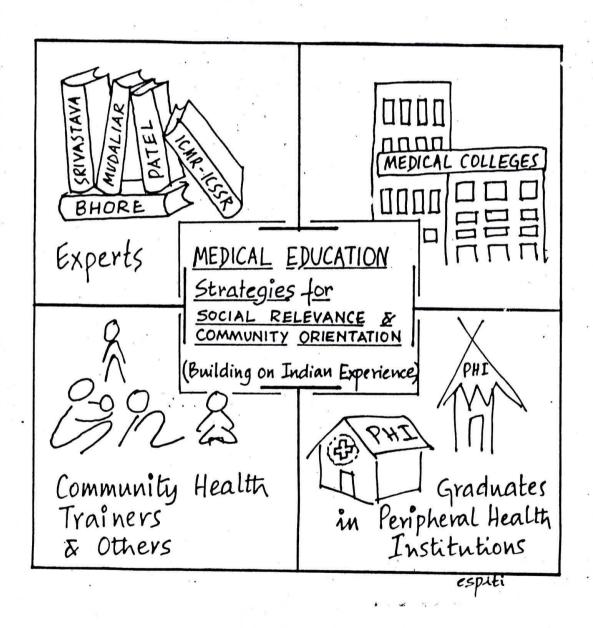
Networks: All India Drug Action Network - AlDAN (New Delhi)
Lok Swasthya Parampura Samvardhan - LSPSS
Samithi

All India Peopleo Science Network. AIPSN

Ink 10fficial) CONBULTATIVE COMMITTEES ON RURAL DEVELOPMENT

Planning Community Intok.

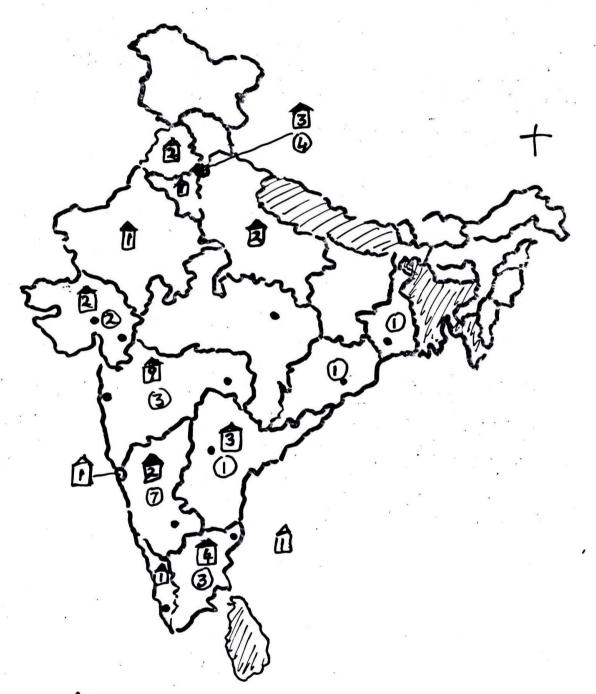




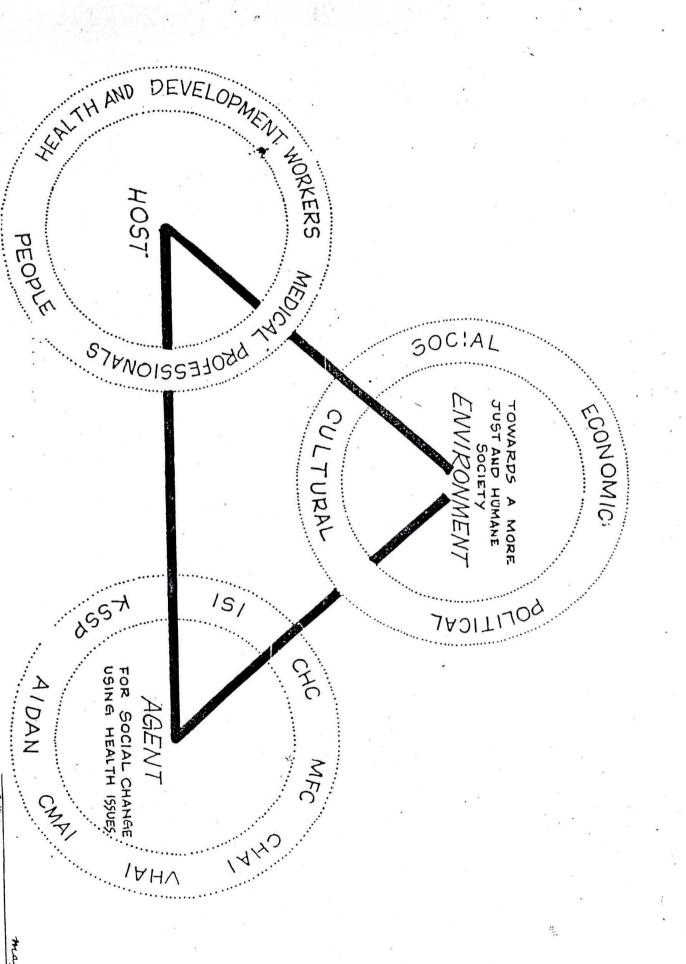
1 1/4 1 · 900 ·

MEDICAL COLLEGES

/ COMMUNITY HEALTH DEVELOPMENT TRAINERS IN STUDY



1 Medical Colleges total 32
O Community Health/Development Trainers (total -22)



TOWARDS HEALTH FOR ALL

PEOPLES MOVEMENTS

Environmental Protection)

ADEMADA BACHAO AHROLAN

FISHERMAN STRUGGLE AGAINST TRAWLERS HOVENENT

PEOPLES SCIENCE MOVEMENT

TRADE Unions Movement

CHILD LABOUR MOVEMENT

(MATIONAL ALLIANCE FOR
PEOPLES MICHEMENTS)

ಭಾರತ भारत INDIA CHC-SHIFTING FOCUS 1994 -> A MALARIA TRG. MEHISA MISEREOR STATE PROGRAMMES

O CHAI REGIONAL

TOWARDS NORTH

DECENTRALISATION

KARNATAKA

SOCIETY PHASE -IL 1993-96

ALTERNATE LEADERSHIP (SPT)

• CHC CONSOLIDATION PHASE (RN/TN)

EXTENDED SABBATICAL

SOUTH-NORTH AND

SOUTH-SOUTH DIALOGUE

- CHC TRANSITION PHASE (1997)
 - · MAINSTREAMING
 - RESEARCH TRAINING

 RESEARCH TRAINING

 RESEARCH TRAINING

CHC MEXT PHASE
1998-2003?
OPTIONS

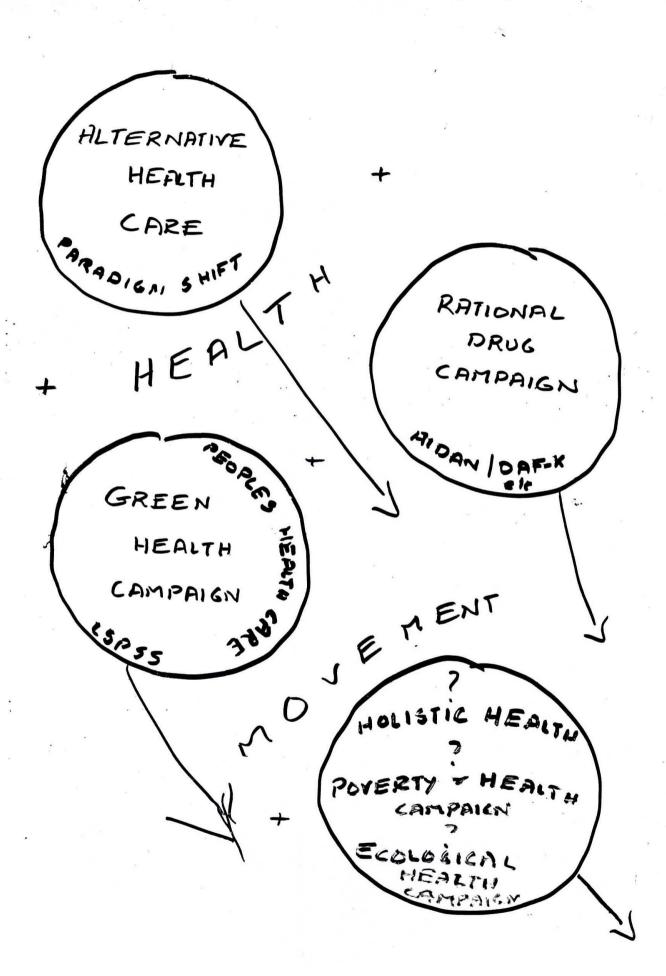
T II III

CATALYST CENTRE ALLIANCE COMBINATIONS

FOR FOR OF I, II, III

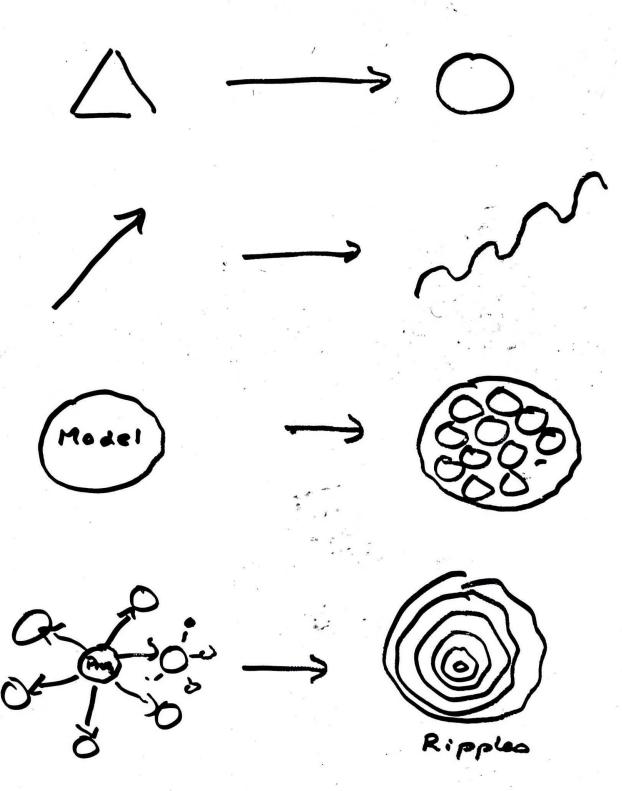
CONTINUE CH HEALTH

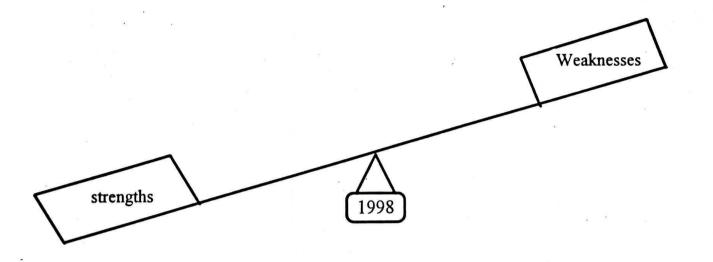
->2000 WHAT NEXT?

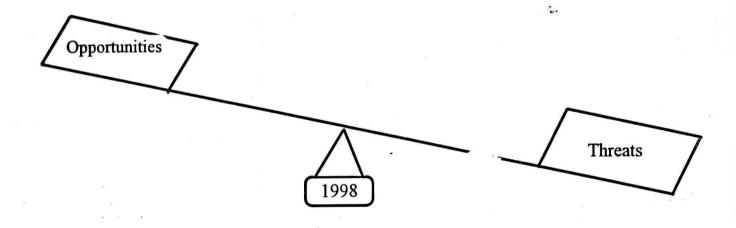


MIND-SETS

NEED TO CHANGE







RATIONAL THERAPEUTICS

AND DRUG POLICY ISSUES

HOW IT STARTED

- ◆ CHC MFC FACLITATED THE MEETING "PEOPLE ORIENTED DRUG POLICY"
- IISc DR. ZAFARULLA CHOUDHARY GONOSHASTRA KENDRA, BANGLADESH, DEC, 1983
- ◆ MFC SUPPORTED AIDAN KAR_IATAKA CHAPTER CHC DAF-K FORMED
- ♦ CHC INSTITUTIONAL PART OF DAF-K; DR. VB PRESIDENT

WHY CHC IS INTERESTED?

- CONVICTION DRUGS AND PRESCRIBING MAJOR COMPONENT OF HEALTH CARE T ALL LEVELS
- FORMS A BASIS / STARTING POINT FOR SOCIAL ANALYSIS AND TO UNDERSTAND THE BROADER
 SOCIAL-POLITICAL-ECONOMIC-CULTURAL FACTORS THAT DETERMINE HEALTH

CHC'S ROLE: PRIMARILY CATALYTICAL

- RESOURCE PERSONNEL FOR VARIOUS COURSES [eg. DHCA, SJMC]
- PRODUCTION OF BACKGROUND MATERIAL AV AIDS, POSTERS ETC.
- RESOURCE CENTRE FOR ARTICLES / OTHER MATERIAL [JOURNALISTS / OTHERS]
- CONDUCT RATIONAL DRUG WORKSHOPS / SEMINARS FOR:
 - PG MEDICAL STUDENTS CME'S
 - DOCTORS
 - NURSES
 - NGO'S VHAI, CHAI ETC.,
 - ~ HEALTH MANAGEMENTSTUDENTS / PERSONNEL
 - CONSUMER GROUPS [CREAT ETC.,]
 - PHARMACISTS

INDEPENDENTLY AND IN COLLABORATION WITH AGENCIES LIKE VHAI, CHAI, CMAI, KRVP, APD ETC.

- PUBLICATIONS I \ARIOUS JOURNALS / MAGAZINES
 [> 20; HA, PHY UPDATE ETC.,]
- PARTICIPATION AT DIFFERENT OCCASSIONS
 POSTER & VIDEO EXHIBITION WITH DAF-K ON OLLE HANSON'S DAY
 CONSUMEX FAIR
- WORLD HEALTH DAY PRESENTATIONS
- NETWORKING / SOLIDARITY AIDAN ETC.,
- SUPPORTS PUBLIC INTEREST LITIGATION THRO' DAF-K
- MEDIA AIR AND DD RECENT FOCUS
- OTHER GROUPS / PERSONNEL
 BANNED AND BANNABLE DRUGS NATL. LAW SCHOOL
- RESEARCH CURRENT

Δ

BEING SELF-CRITICAL!

WHAT CHC HAS NOT NE

- WORK WITH GOVT.
 BUT
 - SPT EDL FOR ICDS PROGRAM
 - SPT CMF EDL FOR KARNATAKA
- PHARMACEUTICAL COMPANIES DX

CONCLUSION

- FIELD OF RD WIDE PERSPECTIV -
- INTER PLAY OF VARIOUS FACTORS
- VITAL INTEREST TO
 - HEALTH PERSONNEL.
 - GOVT. & ITS AGENCIES
 - PRIVATE SECTOR HARMACEUTICAL INDUSTRY
 - CONSUMER)
 - SOCIAL GRCU

Q

ACTION CAN BE TAKEN IMMEDIATELY WITHIN THE SET-UP

CHC'S ROLE → CATALYTIC

LOTS HAS BEEN DONE LOTS MORE TO DO CHC

STAFF

DEVELOPMENT

Aparna M. Chintamani

Presentation made at CHC Review Meeting on 3rd/4th April, 1998

Staff Development

CHC has tried to promote capacity building by a process of Staff Development as part of its management policy.

Staff development:

A process by which the member of the staff is:

Enabled to develop to the fullest potential Also contributing to the better achievement of the objectives of CHC

This involves:

- i) Reflecting together on the objectives and aims of CHC
- ii) Giving feedback/suggestions on various policy documents/decisions approved by Executive Committee of Society.
- iii) Giving an opportunity for team members to think about their future at a personal level as well as in the context of CHC
- iv) Providing an ethos where individual motivation and commitment could be stimulated and brought out.

At CHC, Staff Development is achieved through:

- a) Attending short courses/workshops
- b) Participating in CHC initiatives
- c) Conducting regular staff meetings
- d) Continuing Education
- e) Organising staff development/staff transformation workshops
- f) *Introducing* incentives for development through schemes such as book allowance to all staff members.

The above may be further illustrated by the following:

a) Attending short courses/workshops

Encouragement to participate in atleast one short course/workshop each year

To enhance skill development / Gain orientation in an area

Choice left to team members

Helped by Coordinator/Member-in-Charge who is the "Light that Kindly Leads"

To cite a few instances:

- Financial Management conducted by FEDINA/ICRA (MK)
- Participatory Programme Planning conducted at CHAI, Secunderabad (JVJ)
- Nature Cure Course conducted by Karnataka Pradesh Prakruthi Chikitsa Parishad (AS)
- Screen printing course (CJ)
- Prevention of Drug Abuse & Alcoholism TTK, Madras (JVJ)
- Nature Cure & Yoga (CJ)
- Child-to-Child Approach training (SJC/JVJ)
- Management of Human Resources (SPT/MK)
- Spiritual intensive course (SPT)
- Legal Aid Programme (XA)

b) Participating in CHC initiatives

- Not dependent on job responsibility or position in team
- Within constraints & demands of CHC work, encouragement to participate in :
 - * training/orientation sessions
 - * field visits conducted by CHC

An opportunity for introspection is available through:

Staff Enrichment/Staff Transformation Workshops

- ✓ Experimentation with group sessions / activities / journal clubs / quality circles
- √ To build up team consciousness
- ✓ To explore avenues/solutions to work team related problems

There have been workshops on:

- Spiritual Health
- Job Responsibilities
- Communication
- Creativity.

On spiritual Health

- 3 Balancing intellect and emotions is the essence of spiritual health
- Broadening of vision from ego to altruism.
- Need to tap the altruism part in Community Health.

On job responsibilities

Using R.A.T. - Role Analysis Technique as a tool of self-improvement and job efficiency.

On Communication:

- Listening most difficult part of communication
- Communication is a perception bubble
- Communicating with oneself necessary to break one's own bubble
- Need to be authentic and true
- Idea to pierce through other persons' bubble to complete communication

f) Book allowance

A more recent incentive has been the granting of book allowance to all team members for their growth and development

Attending:

- Malaria Workshop in Kolar, Bangarpet (CJ)
- Workshop on "Hospital Waste Management at Victoria Hospital (CJ/AC)
- ♣ Jan Swasthya Rakshak Scheme evaluation meeting {CJ/MS/JA}
- * Community Health Training programme in Montfort College (AC)

c) Conducting Regular Staff Meetings

- ♦ Weekly/monthly/bimonthly staff meetings
 - ► A means to catch up with workshops/programmes/evaluations attended/undertaken
 - A means to catch up with events on the anvil
- Adhoc meetings organised around areas of interest (like meeting a special guest/visitor or on specific topics)
- Presentation of findings of the CMAI-CSCD evaluation at AGBM (SPT)
 A meeting with Dr. Gill Walt, Social Scientist, LSHTM, Dr. Thelma
 Narayan's PhD guide, during her visit to India.

d) Continuing Education

- Formal training courses on short-term basis
- Study leave as benefit & incentive
 - ♦ Masters course in Library Sciences (SJ)
 - MS Windows & Operating System (VNNR)
 - ♦ Diploma in PC Applications (AMC)

e) Staff Development Workshops

A time to look back and forwards:

- ₹ Reflection on all aspects of CHC work {both individual & collective}
 using a SWOT analysis framework
- Extent of success in the implementation of previous years' Plan of Action
- Annual planning meetings where Plans of Action for the year are discussed

As a process of staff development, there is scope to move:

upwards: to higher levels of responsibility *sidewards*: to alternative job responsibilities

outwards: to take on job responsibilities with one of our

partners/associates in line with individual's skill and

capabilities

In conclusion, Staff Development enables members :

voluntarily
 voluntarily
 to participate and foster participation in all activities of CHC,
 voluntarily
 voluntarily

The above is a birds' eye view of the CHC Staff Development Process.



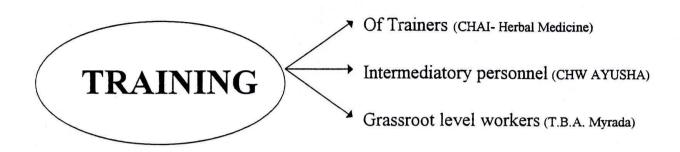
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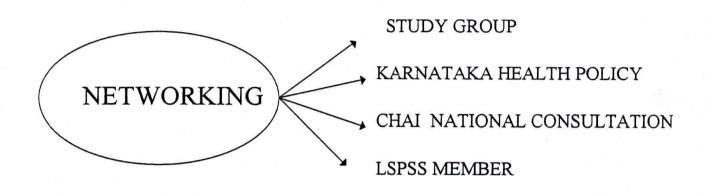
INTEGRATION

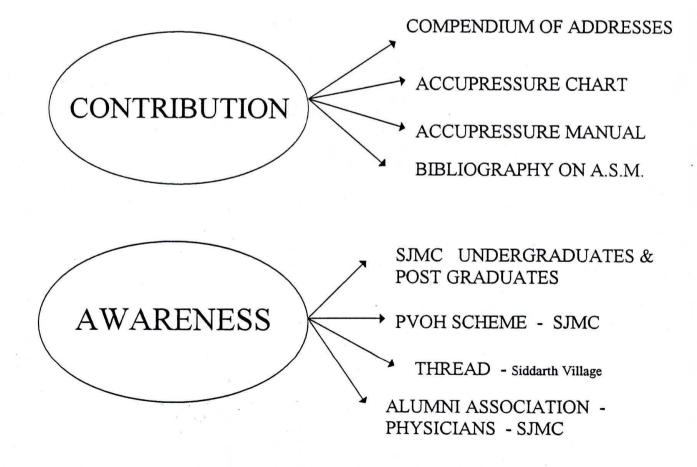
OF

MEDICAL

SYSTEMS





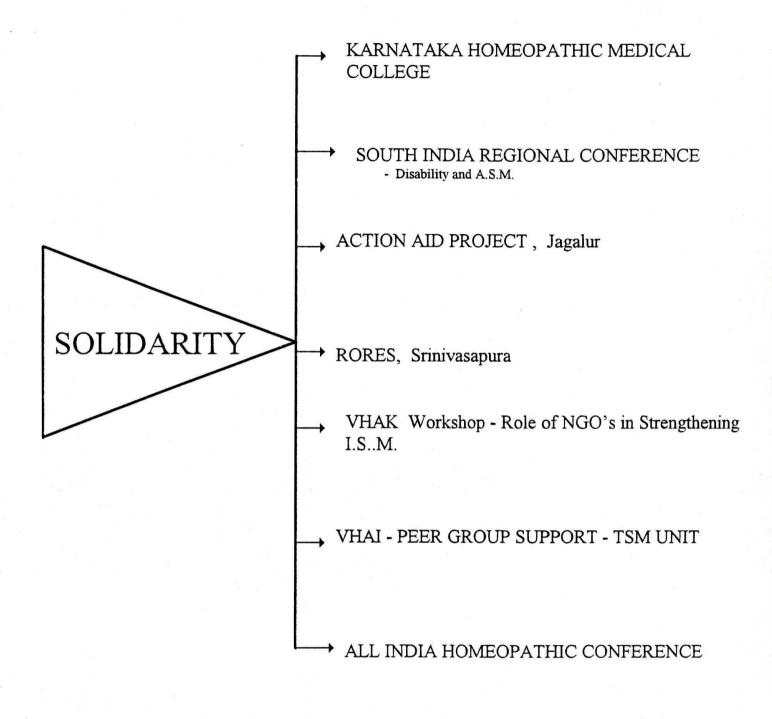




- Planning of Colloquim for CM Dept. SJMC -CHW Course
- Designing one year Diploma Course in Holistic Counselling, Montfort College
- London School of Hygiene and Tropical Medicine - 4 days short course to M.Sc., CH course
- Design herbal medicine course for CHAI

RESEARCH

- Exploration of role of Tibetan Medicine in Tibetal Settlement in Karnataka
- Study group for use of Traditional Medicine in Bronchial Asthama with Rastrothana Parishat
- Philosophical integration of various systems of medicine
- Homeopathy and Community Health Care including policy analysis



STAFF DEVELOPMENT

- · ENABLING STAFF TO DEVELOP JULLEST POTENTIAL
 - · CONTRIBUTING TO THE BETTER ACHIEMENT OF CHC'S OBJECTIVES

THIS INVOLVES:

- · REFLECTING TOGETHER ON AIMS OBJECTIVES OF CHC;
- · Giving FEEDBACK SUGGESTIONS ON POLICY DOCUMENTS / DECISIONS APPROVED BY EC;
- OVER THEIR FUTURE AT PERSONAL LEVEL/CHC.

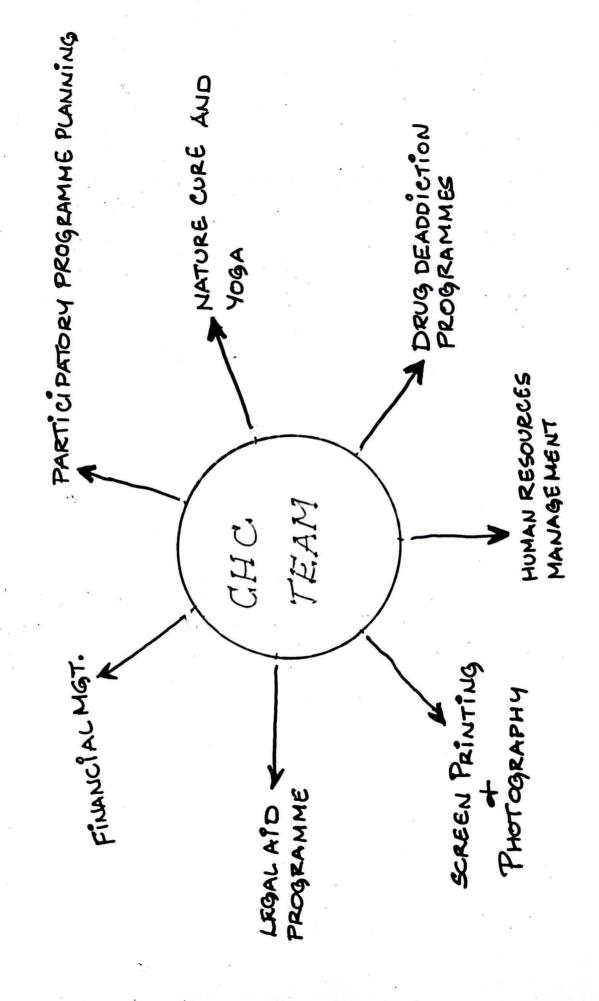
 CONTEXT
 - · Providing AN ETHOS FOR INDIVIDUAL.
 MOTIVATION & COMMITMENT

AT CHC, STAFF DEVELOPMENT IS ACHIEVED THROUGH:

- & ATTENDING SHORT COURSES/WORKSHOPS
- PARTICIPATING IN CHC INITIATIVES
- & CONDUCTING REGULAR STAFF MEETINGS
 - & CONFINUING EDUCATION
- STAFF TRANSFORMATION WORKSHOPS
- SCHEMES SUCH AS BOOK ALLOWANCE

ATTENDING SHORT COURSES/WORKSHOPS

- ENCOURAGEMENT TO PARTICIPATE IN ATLEAST ONE SHORT COURSE/WORKSHOP EACH YEAR
- · TO ENHANCE SKILL DEVELOPMENT/ GAIN DRIENTATION IN AN AREA
- · CHOÎCE LEFT TO TEAM MEMBERS
- · HELPED BY COORDINATOR / MEMBER-IN-CHARGE WHO IS THE " LYGHIS THAT KINDLY LEADS"



PARTICIPATING IN CHC INITIATIVES

- · INDEPENDENT OF JOB RESPONSIBILITY POSITION IN TEAM
- · EN COURAGEMENT TO PARTICIPATE IN:
 - * TRAINING ORIRNTATION SESSIONS
 - * FIRLD VISITS CONDUCTED BY CHC

TO CÎTR A FEW ÎNSTANCES:

- · JAN SWASTHYA RAKSHAK SCHEME EVAYUATION MEETING
- · WORKSHOP ON "HOSPITAL WASTE MANAGEMENT"
- · MALARÍA WORKSHOP FOR VOLAGS IN KOLAR, BANGARPET. · TRAINING SESSION ON "PREVENTION OF DISABILITY /
 PROMOTION OF HEALTH"

CONDUCTING REGULAR STAFF MEETINGS

- WEEKLY / MONTHLY / BIMONTHLY:
 - PROGRAMMES/EVALUATIONS ATTENDED

 OR UNDERTAKEN
 - ON THE ANVIL
 - ADHOC MEETINGS ORGANISED AROUND AREAS OF INTEREST
 - MRETING: A SPECIAL GUEST VISITOR / ON SPECIFIC TOPICS

Eg:

- EN PRESENTATION OF FINDINGS OF THE CMAI-CSCD EVALUATION AT AGBM
- A MEETING WITH DR. GILL WALT, SOCIAL SCIENTIS, LSHTM. DR. THELMA'S PhD GUIDE.

CONTINUING EDUCATION:

- IT FORMAL TRAINING COURSES ON SHORT-TERM BASIS
- A STUDY LEAVE AS BENEFIT & INCENTIVE
 - · MASTERS COURSE IN LIBRARY SciENCES
 - · MS WINDOWS & OPERATING SYSTEM
 - · DIPLOMA IN PC APPLICATIONS

BOOK ALLOWANCE:

- · RECENT INCENTIVE
- · FOR GROWTH & DEVELOPMENT OF

STAFF DEVELOPMENT WORKSHOPS

A TIME TO LOOK BACK & FORWARDS:

- · REFLECTION ON ALL ASPECTS OF CHC WORK CINDIVIDUAL/COLLECTIVES USING SINOT ANALYSIS FRAMEWORK
- . EXTENT OF SUCCESS IN IMPLEMENTATION OF PREVIOUS YEAR'S PLAN OF ACTION
- · ANNUAL PLANNING MEETINGS: P.O.A. FOR CURRENT YEAR DISCUSSED

OPPORTUNITY FOR INTROSPECTION:

STAFF ENRICHMENT /TRANSFORMATION

- EXPERIMENTATION WITH GROUP SESSIONS/
- ACTIVITIES/JOURNAL CLUBS/QUALITY CIRCLES
 TO BUILD UP TEAM CONSCIOUSNESS
- EXPLORE AVENUES/SOLUTIONS TO TEAM RELATED

WORKSHOPS ON:

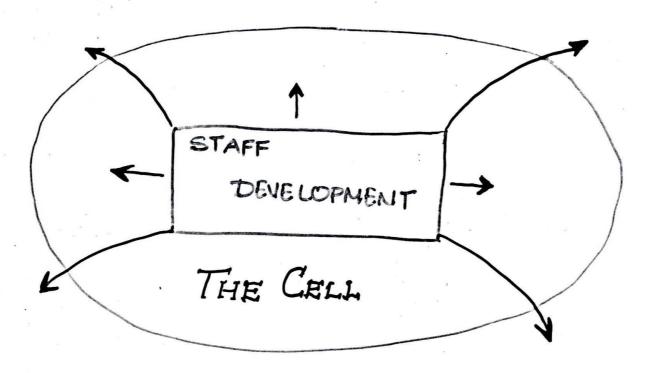
⇒ SPIRITUAL HEALTH

> JOB RESPONSIBILITIES

> COMMUNICATION.

S CREATPUTTY

STAFF DEVELOPMENT: THE SCOPE



- · TO UNDERSTAND / FIND PARTICIPATION IN OWN AREA OF WORK

 · TO LEARN ABOUT / SHARE SKILLS / ATTITUDES / KNOWLEDGE TO ENHANCE

 TEAM ETHOS
- · TO PARTICIPATE OF FOSTER PARTICIPATION IN ALL ACTIVITIES OF

RATIONAL DRUG USE

MULTIFACETED APPROACH

CHC's Role -> Catalytical

Interventional

Approach to Study RDU - 2 Levels

- WHO - Policy

· Gout. - Policy + law

· Ebbectors - Implement the law

II . Doctors - Prescribe/choose

- · day People] varying roles media/NGO - varying roles Relatives etc.
- · Patients + Consumers
 gelatives ['affected']

Doctors: Significant able parts. in India

For Intervention ? 'Scenario'

- I where/how they access Drug Information
- 2] Attitudes/perceptions on the Source/type of Drug Information
- 3) How Drs. Choose Drugs
- 4] Attitudes & perceptions on the choice of drugs.

Study Title:

A Cross-Sectional multilevel Study of How Doctors choose their drugs

Sample - All 3 levels

St. Johns, Manipal Tertiony -

Secondary - Marthas, Philomenas, KC Genri.

Paimary - Wiban-GP's

Rural-GP's

PHC Drs

Sr. Drs.

Sample - 500

Status - Data Fedin - Preliminary Analysis

Completion - End of September

Presentation - oral - SIMCH oct 16th 3 PM

- Report - 60-80P95

- Research Paper Peer Review Fournal ? Indian / Foreign

Other information

- Annotated Bibliography - Indian

- diferature - Medline/Journals L-> Lib/Doc unit CHC.

INTERVENTION

- Dissemination of Information - participating clinicians

 - others*
- Review meeting / Panel Discussion
- ? Set-up Committee

SOCHARA+ clinicians + NGO'S, GO's + Pharma Companies

Recommendations

- -> Govt
- > NGO'S
- > Doctors
- -> Pharma Companies

Future Studies.

HEALTH FOR ALL (1981)

Prescription Ry

A MASS MOVEMENT

- Reduce poverty, inequality and
 - Organise poor and underprivileged.
 To Fight For their basic rights.
 - Move away from counter-productive,

 Consumerist Western model of health

 care and replace it by an alternative

 based in the community.
 - INDIAN COUNCIL OF SOCIAL SCIENCES

 RESEARCH

 INDIAN COUNCIL OF MEDICAL RESEARCH

KEY WORDS MOVEMENT

BASIC

ALTERNATIVE

ORGANISE

RIGHTS

COMMUNITY

HEALTH FOR ALL

HYPOTHETICAL) CENTRE FOR COMMUNITY HEALTH



DR C.M. FRANCIS DR Y. BENJAMIN DR AK, CHAKRABORTHY VISITING

PROFESSORS

LECTURERS

OR

OR

CHC TEAM

MEMBERS

COLLABORATIVE

RESEARCHERS

DR. P. ZACHARIAH

DR PANKAJ MEHTA

MS SUJATA DEMACAT

DR PARESH KUMAR

DR H. SUD ARSHAN

DR. S.K. KRISHNAN

MR AS MOHAMED

DR SUKHANT SINGH DR RAVI DSOUZA RAMANI

DR ANAND ZACHARIAH

DR MADHUKAR PAI

DR PRABIR

PR DEVADASAN ROOPA

OR YOGESH JAIN

DR SUNILKAUL

PR PRAKASH RAO

DR T. NARAYAN

DR GUPAL DR & P-TEKUR

ETC DR MANI KALLATH

SJMC-CH

K-GOPINATH CMC-CHAO DR ABHAY SHUKLA

DR MATHEW ABRAHAM

DR SARA

PROF D BANERJI

DR N. H. ANTIA

DR AMARJESANI

DR ANANT PHADKE

DR DHRUY MANKAD

DR ULWAS JAJOO

DR SATY AMALA

DR MIRA SHIVA

DR NARENDER GUPTA

DR ABHAY/RAM SEARCH

ARCH TEAM

JANKHED

ROHSA

RTU

CINI DR. UMA SRI

DR VEDA

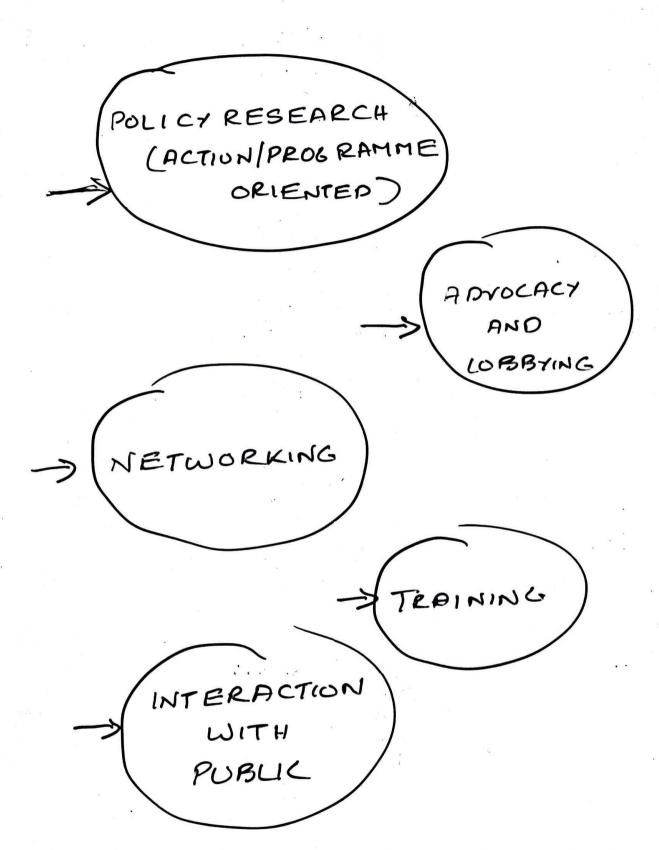
DRS-GANAPACH

ALLIANCE FOR COMMUNITY ಭಾರತ HEALTH (HYPOTHETICAL) भारत INDIA

REVIEW F FOLICY

HEALTH AS EQUITY HUMAN RIGHTS VALUES ORIENTATION Inter sectorality ENDORSEMENT ETHICS GENBER SENSITIVITY SUSTAIN - ABILITY HEALTH Central 76 DEVELOPMENT EVOLVE FURTHUR

ROLES NEEDED



TOP 10 HEALTH THE HEALTH CARE ISSUES

- 1. COMMUNICABLE DISERSES (50%)
- 2. DRUGS DRUGS POLICY (38%)
- 3. SANITATION TENVIRONMENT (367)
- 4. TSM /ASM (347.)
- 5 MEDICAL EDUCATION (34%)
- 6 ROLE OF GOVT. IN HEALTH CARE (341)
- 7 WOMEN'S HEALTH & STATUS (271.)
- 8 HEALTH POKICY ANALYSIS DEVELOPMENT
- 9 RESEARCH NEEDS INDICATORS 20
- 10 PROMOTING VOLAG' SECTOR (18)
 - b) PANCHAYATI RAJ

CD PZ. SPT RAYL. D DKS PANKAJ PK SM MJI MADHUKAP ABMI PA SARA Sv AKC. PRAKASI SVR AMAR RAO PR.ABIR DEVA ZAKHAL SUNIL YOGEGH



· IMRANA

· PARVATAMMA

NHANTIA

RAVINGEAL

· D.BANERJI

VISHNO

RATARATNAM ABEL

KAMATH

FR. IR.UDAYAM

RAJENDRA PRASAD

JACOB JOHN (P)

· GOPAD DAGAME MAYA THOMAS

STALS LOURDASAMY

SARASWATH GANAPACHI

CHERIAN THOMAS

MADHAY RAM K.RPA

· ARVIND KASTURI MANTUNATH 3

SEYANAND MELOD

· SR AGNESITA

ANANT PHADKE

PREHA RAMACHAMDRAN . AVBALA

AMMU JOSEPH

SANJEEV

SHAKUMTALA

NARASIMHAN

FR. AMBROSE

JOSECYN LUBO

FRIJOSE

DAKSHA HATHI

UNNI-FRLHT

UMIA · YEDD

PS REDDY

VANATA. R

RAMANI, D

NIMITTA BHA-

EVOLVING A SCENARIO

, 3

CATEGORIES

GOVT

COMMUNITY MEDICINE HEALTH

CLINICIAN

PSYCHIATRIST | MENTAL HEALTH

BEHAVIOURAL SCIENTISTS

MANAGEMENT

NURSING

ABM/18M

POLITICS/ECONOMICS

DOLTOR-ACTIVISTS

HGOIVOLAG

CONSUMER ACTIVIST

JOURNAUST! MEDIA

COORDINATING AGENCY

DEVELOPMENT TRAINER

POLICY RESEARCHES

RADICAL RELIGIOUS

SOCIETY MEMBERS

QI

LIST TOP TEN

HEALTH - HEALTH

RELATED ISSUES

ANP PROBLEMS

WHICH MEEDS

RESPONSE FROM

C.H. Ackion

IniKakon ?

42

TOP TEN ROLES

THAT PROFESSIONAL

/TECHNICAL!

CATALYST GROUP

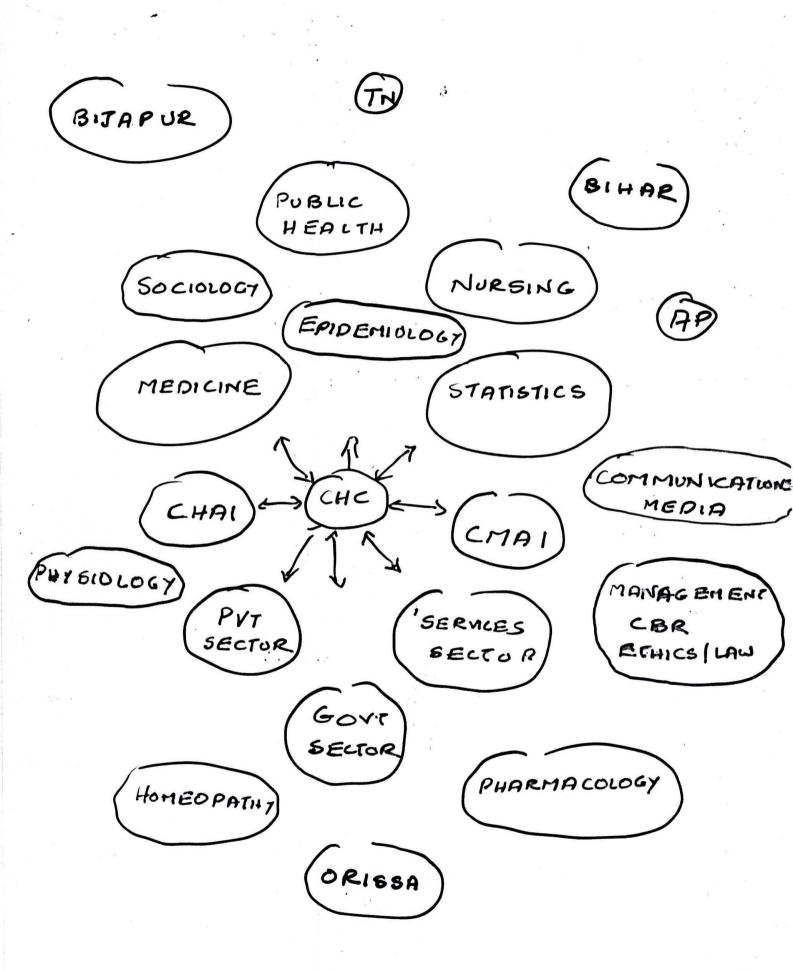
COULD PLAY?

93

ANY OTHER

EMERGING

CONCERNS ?



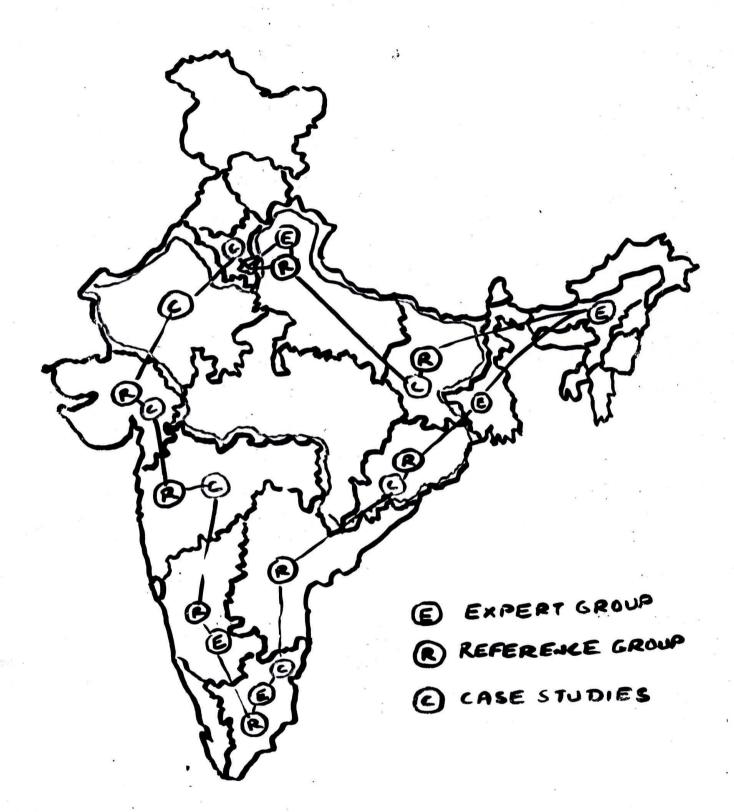
RESEARCH INSTITUTIONS Gove / National Programmer ICMR GOI NIN State Goit - UP HOIM Kat NICED . 3 NMEP TH TRC NACO IRMS RNTP MICA IPD 251 MGOS VHAI IRHM CMAI mfc Medical Colleges/P.G NFI AIIMS NS PGI CLRI 42MJ VHS-APAC KMC SBISR Others TIMC WHO-SEARO Barode M.C UNICEF Summer M.C BL TISS Simla M.C

RENEWING HEALTH FOR ALL POLICY DIALOGUE (W.H.O) (APRIL 1997) OE LHI by MAI/CHA



THE MALARIA REPORT

-A collective initiative



PARADIGM SHIFT

INDIVIDUAL

⇒ COMMUNITY

PROVIDING

⇒ ENABLING

TECHNOLOGY

⇒ FDUCATIONAL & SOCIAL PROCESS

PROFESSIONA' CONTROL

⇒ DEMYSTIFICATION

GLOBAL/NATIONAL -> LOCAL

PARTNERSHIP -> 2000A.D

Paradigm Shift

EXPANSION -> CONSOLIDATION

QUALITATIVE -> QUALITATIVE

PROJECTS -> PROCESS

Individual -> REGIONAL
Projects COLLECTIVITY

MEDICAL -> HEALTH

National Brake -> Regional / Local

PROVIDING - ENABLING

Standard -> Alkernative Approaches
Packages (Creative)

SOUTH/WEST -> NORTH & EAST

Basic Training -> CONTINUING EDUCATION

Community co

Beneficiary Parkcupant

Finding Agency CO -> SOLIDARITY PROVIDING ORGANIGATION
FINDING STENDING ORGANIGATION
ENDORGANISM

FINAL DECISION -> ENDORSEMENT OF LOCAL COLLECTIVE PECISION

POPULATION POLICY THE COMMUNITY PERSPECTIVE - VI

PARADIGM SHIFT

PEOPLE

Not Beneficiaries but participants

PROGRAMMES

Not top down distributions but

enabling/empowering from

grassroots

CONTROL

Not Technical/professional control

but community level demystification and awareness building.

Towards a Community

- Centred
- derived
- implemented

POPULATION POLICY

Are we ready to take this issue to the people

PARADIGM SHIFT (1994)

TRAINING / RESEARCH PERSPECTIVES (IN PUBLIC HEALTH)

TRAINING

PROFESSIONAL MYSTIFYING

COMPARTMENTALISED

SUBJECTS TOPICS

STUDENTS TEACHERS

DIDACTIC

JET-SET HIGH TECH REMOTE CONTROL EXPERTS

RESEARCH

SINGLE FACTOR RISK
IDENTIFYING
EPIDEMIOLOGY
AND
CLINICAL RESEARCH

DRUGS /VACCINES

Quantikerive over Qualitative DEPROFESSIONAL,
DEMYSTIFYING

INTEGRATED

PROBLEMS

ALL RESOURCE PERSONS
TOGETHER (PARTICIPATORY)

INTERACTIVE/GROUP-TEAH

WORK

PROFESSIONALS HEALTH WORKE

MULTI FACTOR PROCESS
IDENTIFYING
SOCIO E PIDEMIOLOGY

Qualitative + Quantitative

MALARIA MODEL OF MEDICINE

BIO-TECHNOLOGY SOCIAL/COMMUNITY
MODEL -> MODEL

INDIVIDUAL -> COMMUNITY

CASES PROBLEM

Patient as -> People as

beneficiary participants

ILLNESS -> HEALTH

PRUSS/VACCINES -> KNOWLEDGE TRAMSFER

TECHNOLOGY SOCIAL PROCESSES

MOLECULAR -> SOCIU-EPIDE MOLOGY
BIOLOGY

PROFESSIONAL -> DEMYSTIFICATION
CONTROL

RATIONAL HEALTH LUCAL ACTION
PROGRAMME

(NMEP)

THE PARADIGM SHIFT

	4	į.		
POLICY AREA	FROM	→	To	
PEOPLE	BENEFICIARY	\rightarrow	PARTICIPANTS	
SERVICES	PROVIDING	->	EMABLING /EMPOWERING	
HEALTH	FLOOR	>	TAP TURNER	
WORKER	MOPPER'		OFF'	
SUPERVISION	FAULT	→	Problem Solving	
MANAGEMENT	AUT HORITARI	an ->	PARTICIPATORY	
EVALUATION	QUANTITATI	VE -	QUALITATIVE	
Monitoring	PROJEC	· ->	PROCESS	
RESEARCH	INTRACEL	LULAR -	SOCIET AL	
	- CHC Po	per o	CARE SYSTEM	
PRIMARY HEALTH CARE SYSTEM				

DEVELOPMENT REVIEW

MATIONAL (GOI/WHO)

MANAGEMENT - PARADIEM SHIFT ->

TOP DOWN | GRASS ROOTS |

(ENTRALISED -> DECENTRALISED

(Block)

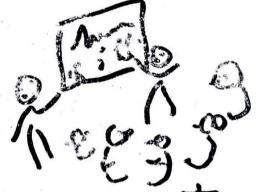
(FIELD

EVOLVED)

4117

SERVICE -> PROCESS

PROVISION FACILITATION



GOVT STRUCTURES ONLY Community Organizada
Voluntery Agencia

Parkicipate in existing

System

Those who do not - who cannot

SOURCE: CHC

PLANNING PARADIME SHIFT



PEOPLE: BENEFICIARY -> PARTICIPANT

GOAL: PROVIDING -> FINEOWERING

ENABLING



POLUS PRUGS -> EDUCATION

OF : /TENNANCY /SOCIAL PROCES

OF TECHNOLOGY ISOCIAL PROCESS

M/E I

CONTROL DOCTOR -> /HEALTH TEAM

/NURSE (FRONTLINE)

REVIEW QUANTITAVE -> QUALITATIVE

POLICING → PROBLEM

SOLVING

SOLVING

SOURCE: CHC

PARADIGM SHIFT (1987)(PUBLIC HEALTH) SOCIAL/COMMUNITY BIO-MEDICAL MODEL HEALTH MODEL (INSTITUTIONAL) > COMMUNITY INDIVIDUAL PERSONS PEOPLE PATIENT (Participants) (Beneficiary) POSITIVE LIVING DISEASE .. (IIInass) ENABLING PROVIDING /EMPOWERING - SERVICE KNOWLEDGE DRUGS SOCIAL PROCESSES /TECHNOLOGY PHYSICAL/MENTAL SOCIAL PREDOMINANTLY POLITICAL/ECOLOGICAL PHYSICAL DEMYSTIFICATION GREATER ACCESSIBILITY OF PROFESSIONAL CONTROL OF SKILLS LAY TO SKILLS / KNOWLEDGE & KNOWLEDGE SOCIETAL | BEHAVIOURAL INTRACELLULAR RESEARCH RESEARCH 1986.87 - SABBATICAL (RN)

CHC

140 H370 H)

1994, 95



a Study on FACTORS AFFECTING HEALTH STATUS OF SLUM DWELLERS

PHYSICAL FACTORS

inadequate nutrition related to poverty

safe drinking water

" sanitation and toilet facility

Shelter

SOCIAL FACTORS

- oppressed Situation of women.

- poor community leadership and Community dynamics

- psycho Social problem related to alcoholism

- Poor health education

LEARNIN G

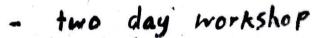
- People in slums have abilities, character, Strength and Straightforward values
- Courage to Stand up to the exploitative forces
- expectations and needs bottomless pit
- need for networking



HEALTH INPUT INTO WOMEN'S VOICE SOCIAL ACTIVISTS

- Short term training
- monthly meeting follow up.

STREET CHILDREN GRAG PICKERS



- monthly meeting

- Six month course.

Health and psychosocial input

Facilitators: Dr. Shekar sheshadhiri

Mrs. Indira Swaminathan.



RAGIGUDDA SLUM J.P. NAGAR

Health & Development

- Community organization.

- Gredit management

- land ownership issue.

- Day care Center

- Tailoring

- Income generation.

- Tutions and moral classes

- Weekly Clinics

FIVE DAY WORKSHOP ON Community Health

- Bangalore based vol ags

Facilitator pr. uma



ASSOCIATION OF PEOPLE WITH

Health input into CHW training

Urban Community Based Rehabilitation

a Project for MOW GOI

by CINI-ICH-South Bank University

funded by DFID

- Needs assessment

- Experience in relation to meeting the needs
poor people & Disabilities in Slums of
Bangalore, Calcutta and
visakhapatnam.

LIBRARY & DOCUMENTATION UNIT

COMPOSITION OF LIBRARY	No
& BOOKS	<u>No</u> 5112
BOUND YOUMESY	164
[JOURNALS [LOOSE ISSUES]	61
E NEWS LETTERS	92
E CED DOCPOST {PAPER CLIPPINGS}	67
RESOURCE FILES	27
MATERIALS:	
· Audio-Visual Cassettes	77
SLIDES	50
· POSTERS	538
· PAMPHLETS/BROCHURES · AUDIO CASSETTES	34
· AUDIO CASSETTES	12

THE BOOK COLLECTION

MORE THAN 100.

BY COMMUNITY HEALTH
BY DISEASES OF DIAGNOSIS
BY CHILD HEALTH
BY ALTERNATIVE MEDICINE
BY MOMENS' HEALTH
BY COMMUNITY DEVELOPMENT
BY DRUS THERAPEUTICS
BY ENVIRONMENTAL HEALTH
BY MEDICAL PROFESSION

DVERNACULAR CANGUAGES

MANAGEMENT
HUMAN RIGHTS OF CAW
AGRICULTURE
EPIDEMICLOGY/STATISTICS
NUTRITION
MENTAL HEALTH
OCCUPATIONAL HEALTH
NGO PUBLICATIONS
PSUCHOLOGY
SCIENCE OF TECHNOLOGY

... AND JOURNALS NEWSLETTERS

1 COMMUNITY HEALTH

A CHILD HEALTH

1 COMMUNITY DEVELOPMENT

A Disease on Diagnosis

1 WOMENS' HEALTH

A ENVIRONMENT





REFERENCE SERVICE

"LIBRARY IS THE HEART OF AN INSTITUTION; REFERENCE SERVICE IS THE HEART OF LIBRARIANSHIP" {SAVES THE JIME OF THE READER}



AK (E)

THE BIBLIOURA PHILS.

- * ANNOTATED TRAINING
 - AIDS
 - W URBAN HEALTH
- * NGO ON HEALTH CARE
- * GATT
- * MEDICAL ETHICS
- * ALTERNATIVE MEDICINE





USER'S SURVEY - A REPORT

OBJECTIVES

- TO FIND OUT UTILITY OF LIBRARY MATERIALS
- TO FIND OUT AREAS OF INTEREST
- NUMBER OF PEOPLE UTILISING THE LIBRARY

FINDINGS: COMPARITIVE RESULTS
{1994-95 of 1996-97}

1994-1995

- · COMMUNITY HRALTH
- · ALTERNATIVE / HERBAL MEDICINE
- · Drugs
- · CHILD HRALTH
- · MOMENS! HEALTH

1996 - 1997

COMMUNITY HEALTH WOMENS' HEALTH

Communicable Diseases

DEVELOPMENT

ALTERNATIVE/HERBAL MEDICINE





UTILISATION:

PERIODICALS

- · HEALTH ACTION
- · HEALTH FOR THE MILLION
- · SWASTH HIND
- . DOWN TO EARTH
- · EDI FORUM
- · UTUSAN KONSUMER
- · ECONOMIC & POLITICAL WEEKLY

AV MATERIALS

- HERBAL MEDICINE
- COMMUNICABLE DISEASES
- MENTAL HEALTH
- ENVIRON MENTAL HEALTH
- DEVELOPMENT

LIBRARY POLICY: SALIENT FEATURES

- · SELECTION OF BOOKS
- , PURCHASING PROCEDURES
- PROCESSING: CLASSIFICATION CATALOGUING
- · Issuing / LENDING PORICY
- , STOCK WERITICATION

DISCUSSION NOTE

A REVIEW OF THE RESEARCH WORK OF THE COMMUNITY HEALTH CELL (CHC) 1985-1993 *

(Functional Unit of the Society for Community health Awareness, Research and Action since April 1991)

CONTENTS

- 1. Brief History
- 2. Why the Review
- 3. Framework of review
- 4. Overview of CHC objectives pertaining to research
- 5. Points arising from review of research activities of CHC
- 6. Strengths and weaknesses
- 7. The dimension of unexpected effects
- 8. Exploring indicators, outcomes and impact
- 9. Perspectives for the future
- 10. Appendix I : Historical review of CHC objectives pertaining to research Appendix II : Research efforts of CHC from 1984 to 1993 a chronological listing

1) BRIEF HISTORY

CHC was started in January 1984. The initial team consisted of four persons. Of these, two were earlier academic staff members of a department of Community Medicine in a medical college, and had research interests. During its first phase (January 1984 - July 19880, CHC was a study-reflection-action experiment. Early project proposals referred to it as the Documentation and Research (D & R) Cell. During this period, there was an intense involvement: with health and development groups in the voluntary sector; with national level groups like VHAI, CHAI, CMAI; and with numerous individuals. Organisational responsibility for the 'medico friend circle' was undertaken simultaneously. This included initiation, involvement and support of community based, epidemiological research among people affected by the Bhopal gas disaster.

In 1986-87, the team took a break for a year during which a research approach was used to write up an overview of the involvements of CHC. An understanding of the dynamics of community health action was articulated. Based on this overview, broad principles of a community health approach in India were arrived at.

^{*} Thelma Narayan, member incharge, Research & Evaluation, CHC

A reflection regarding the future thrusts of the Cell was also undertaken. During this period, one of the team members did a Masters in Epidemiology as part of the staff development process to strengthen the research dimensions of the Cell.

Following a review of the approach and work of CHC in June 1990, the Society for Community Health Awareness, Research and Action was registered with CHC as its functional unit. Subsequently, the team strength grew to twelve members. Broad areas of work in support of community health action included -

- * training and information service, * participatory reflections, * networking,
- * research and evaluation, * and documentation/library service.

Besides strengthening of earlier initiatives, newer areas were developed. These grew in response to an analysis of earlier involvements and a perception of needs in the field. It also reflected the interests and perspectives of different team members.

In research, we moved to initiating and undertaking the prime responsibility for studies in areas of our interest, in addition to supporting and participating in studies initiated by other groups.

2. WHY THIS REVIEW

Team discussions during a Staff Development Workshop (1992), and in subsequent meetings, had raised the idea of taking an objective look at our own work on an ongoing basis. This review is a first step in applying a critical eye to the research work of CHC. It is also an appropriate and opportune time, since we have completed a decade since the initiation of CHC. It could also help in developing a longer term perspective and a broad framework or policy for further developments in research within CHC.

Having completed two major health policy related studies and several other smaller research efforts, we also feel the need to review our efforts in the area of research as part of the overall objectives and functioning of the Society.

3. A FRAMEWORK FOR THE REVIEW

- The written objectives of CHC have been taken as statements of intent as being accepted by the team and its wise counsel in the initial years, and by the Executive Committee of the Registered Society since 1991. Since planning in the early years was done on a yearly/two yearly basis, several statements are available as part of project proposals. These have been reviewed, especially those pertaining to research.
- Annual reports, reviews and other reports indicate the activities/involvements of CHC. In this report, the review focus is on the research dimensions of the work.

- Publications, reports, background papers written for various meetings etc., have been taken as important indicators of the outcome of the various research involvements.
- Presentations and participation in meetings at which contributions based on the research findings were made or discussed, have also been taken as indicators of outcome.
- Impact is much more difficult to assess in the case of research. This could be taken up for discussion.

Some learnings from the experience of research, being carried out in the ethos of the voluntary health sector have been identified.

4. OVERVIEW OF CHC OBJECTIVES PERTAINING TO RESEARCH

During the years 1984-1990, CHC was a small, informal, unregistered group, linked to the Centre for Non-Formal and Continuing Education, Bangalore. Funding and therefore planning was done on a yearly/two yearly basis. It was an 'experiment' and the objectives emphasized the research dimension (see Appendix I for details).

Moving beyond public health and community medicine, the desire of the initial team was to study the real life dynamics and praxis of community health action. With the growing realization at a national level that existing methods were inadequate to meet the health needs of a majority of people, particularly the poor, alternative approaches towards improved health and health care in the 1970's. We too had experience of experimenting with alternatives in health care approaches and in training during the earlier medical college phase. The initiation of CHC was to provide an opportunity for full time, closer interaction and study with this very alive and dynamic process.

We felt the need to study and develop a deeper understanding of:

- * the health care situation by the Governmental, voluntary and traditional health sectors,
- * underlying principles of the alternative approaches being tried.

Application of the spirit and method of enquiry was necessary for this. Existing methods of medical and health practice research, of which we had some knowledge, were inadequate. We therefore used what we called the "open-ended approach". That we were exploring and learning about different methods of health and social research is evident from the usage of different terms in the objectives during that short period chronologically. These were:

Documentation and Research,
Study - Action - Reflection,
Socio-epidemiological Research,
Participatory Research,
Action Research,
Health Practice Research,
Community Health Research,
Health Policy Research.

We moved in our objectives from "understanding the philosophical assumptions, goals, and methodologies of the ongoing, experiential process"

to "focusing on the enabling - empowering dimensions of health action"

to "using health policy research to influence or help bring about relevant changes in health policy"

'Research in Community Health Policy Issues' is presently the stated research objectives of the Society.

With registration of the Society, it is important to note that the objectives of the Society were widened to provide for the development of training strategies, the strengthening of the documentation and library services, etc.

5. <u>POINTS ARISING FROM REVIEW OF RESEARCH ACTIVITIES OF TIC</u>

Appendix II lists out the research involvement's of TIC during the decade. The two or three main researchers have had the support of research officers, assistants, investigators, and of the office team. Some general points based on the experience gained are being raised. They will need consideration when planning for the future.

5.1 Evolving appropriate methodologies

Standard methods of medical research (as we know them) were not sufficient to 'study the dynamics of community action' which was our initial area of interest. health work by the voluntary sector and health issues were essentially social processes in the community and needed to be studied as such. The methodology used therefore was "an informal discussion technique with the researchers participating with health action initiators in a common reflective exploration of their past experiences as well as their ongoing and future action plans". These were supplemented by several informal personal communications, field visits and group discussions.

The formal approach was not used. There were no research protocols, pretested questionnaires, formal interviews or statistical analysis of data.

As we began to more clearly recognize the paradigm shift in thinking from a disease-medical - providing process to a health-social-enabling process, we too, as researchers were being transformed. At moments we were totally involved with issues such as the aftermath of the Bhopal disaster, tuberculosis, or the need to build a movement towards a more rational drug policy. However, documentation of events, experiences, reactions, responses, etc., was maintained it was only later that a sabbatical break provided the opportunity to digest and analyse retrospectively the experience. This led to an articulation of certain principles of community health action and components of the paradigm shift in health. This was shared with other groups and individuals in order to get a peer review /critique, at fora in India and abroad, through meetings as well as through circulation of reports and publications.

5.2 The need <u>for further training in research methodology</u> was felt as we got involved with several health related issues, particularly the Bhopal disaster aftermath and the effects of pollution to the Tungabhadra river by Harihar Polyfibres. Training certainly provided a sound base, underscored the need for rigour, objectivity, sound data collection, tools for analysis and hopefully an open questioning mind.

The process of learning needs to be an ongoing one as we use research methodology to address different areas of study.

Looking to the future, there is probably scope for expansion into a multidisciplinary research team.

5.3 The experience with two strategies of research interventions have been interesting. These were a) support to studies initiated and conducted by other groups b) undertaking studies ourselves.

We extended the concept of 'catalyst role' to research by supporting the research work of other voluntary groups. There were eight such involvements (4.1, 4.2, 4.3, 4.4, 4.5, 8, 11, 12 in Appendix II). The time taken for these inputs ranged from a few days to few months of full time involvement. There were a few requests that did not proceed beyond preliminary discussions and are therefore not listed. We discovered that:

- * Voluntary groups in the field often do not realize the implications of research/study viz.,
 - of the need for objectivity;
 - of the need for rigour, standardization, etc;

- of the need for careful data collection;
- of the requirements for time and resources;
- factors such as bias and confounding variables are seen as being irrelevant academic issues;
- of being open to find that one's assumptions may not always be right.

There are therefore differences in expectations which could be a source of frustration on both sides.

- * Follow-up on a study project may stop at any stage, sometimes even just after planning. Here too, levels of satisfaction are low.
- * Even if taken to completion, reports may lie unutilised. We may be unable to utilise them for advocacy or other purposes as they are 'classified documents' and not our property.
- * The areas that we are called to work on are not necessarily in our prime areas of interest. In the process, given the limitation of time, we may then not be able to work adequately on areas of deep interest to us.

After this experience we feel that being of support to the research/studies undertaken by other groups could be an additional involvement, while our "prime time" could be in the area of interest/priority of CHC and of the concerned researchers. Thus the support role could get lower priority.

The <u>longer term research involvements</u> (eg. understanding community health action, medical education, CHAI study, & Bhopal study), while demanding sustained interest, patience, and much 'shoe-leather' work -were deeply satisfying.

It is evident from the listing in Appendix II that the output in terms of publications, reports, presentations and interactive meetings has been fairly substantial from these studies. It provides us a very good base for continued involvement from these studies in these areas. There is a concurrence between analytical and emotional interest which provides enough energy to go through periods of overwork and stress that sometimes occur.

Therefore for each major area of research work taken up by CHC, there must be atleast one key person to whom it means a lot, and who can sustain the study process to completion.

<u>Creative Tensions</u>: As the team grew, with a greater variety of areas of interest, and with increasing amounts of work in the different areas, there sometimes developed creative tensions between and within people. There was need for greater communication in an understandable way between the difference areas of

interest. The demands of open ended catalyst functioning with an open door and often open house policy competed with the demands for consistency, time schedules and the technical and organizational needs of the research studies. Disciplining of oneself and organisation of one's time was not always easy. It is hard to keep away from the attractions of interesting meetings and assignments when one is committed to completing a long term research project. Perhaps time for such involvements should be built into the planning cycle.

Demands of the research study like mass mailing, organising meetings, cyclostyling and printing also put pressures on all staff especially as some of these were time bound activities. Facing up with the quantitative dimensions of research work as also its long desk based periods also needed adjusting to.

This experience draws attention to the need for adequate staff strength and infrastructure to reduce strains. The possibility of separating research from the other functions or vice versa needs to be avoided, so as to enhance the richness of work. However while no compartmentalization is necessary - commitment to research work for substantial part of one's time may be required for research staff.

6. STRENGTHS AND WEAKNESSES

6.1 We start with weaknesses and limitations so as to end on a positive note.

a) Personnel

Involvement in several types of work simultaneously cause delays and if excessive affects the concentration required for the job at hand.

Change of research assistants requires an orientation process each time. It would therefore be better to build a small core team and take on investigators, data entry operators, etc., on a project basis.

b) Infrastructure

Lack of computers, and of word processing and computing skills at the time of the major studies was a problem. There has been a subsequent build up of such capacity. However this infrastructure as well as secretarial and staff time is being used for all other CHC needs as well. This causes delay and inability to get reports out, carry out maintenance procedures, etc. Adequate secretarial assistances and infrastructure (computer, software packages, typewriters, storage space) will have to be planned for. The secretary of the research unit would be somewhat different from the office section and this could be seen as a specialisation opportunity.

c) Planning and Management of time and other resources

The CHAI study was initiated rather late, when we already had commitments to the medical education project, as well as work required during the early phase of registration of the Society. Since the CHAI study was time bound to a Jubilee and rather extensive in scope, there was some strain on the team and on the system. Expectations and objectives of studies need to be based on realistic planning of all aspects including time and human resources.

d) Clarity of roles

There is some ambiguity within us, and hence also with the groups we deal with as partners in research, regarding our roles. We have swung between being researchers, trainers, planners, and resource persons. While this is very interesting, it does adversely affect the quality of the research work.

6.2 Strengths

- e) The wise counsel and executive committee as well as the leadership of CHC promoted and supported the research dimensions of the work.
- f) The flexibility of the Cell allowed us the freedom to undertake wide ranging studies, build linkages, modify timings, etc.
- g) Our previous linkages with national networks like CMAI, CHAI, mfc, VHAI provided support including peer support. This was particularly needed since we were not based in an institution or linked to a University.
- h) The commitment of CHC team members made it possible to undertake the workload required for the studies.
- i) The technical quality of the studies has been appreciated by senior professionals and others. However, this is a matter for others to judge.

4. THE DIMENSION OF UNEXPECTED EFFECTS

- a) One of the greatest benefits was the tremendous learning and personal growth that resulted from involvement in the research studies.
- b) People who have participated as investigators, panelists and respondents also mention this dimension of learning and growth, even as contributors to the studies.

c) There are a few groups and individuals working in areas unconnected to the studies who have commented that the reports are useful to their thinking and work.

1. EXPLORING INDICATORS, OUTCOMES AND IMPACT OF RESEARCH

This is an area on which we need to brainstorm with others.

Study or project reports, publications, and related meetings, conferences, discussions and peer reviews are one aspect. Appendices I & II list these out for the studies undertaken by CHC.

To look for outcome and impact for instance in the case of medical education, one would need to have a long term perspective. It would be difficult also to make a cause effect link between the study and any changes taking place, since there are several other factors promoting and hindering change.

The CMAI study provided information about the distribution and type of work undertaken by the membership as well as critical feedback from them regarding the functioning of CMAI. Changes in the Constitution have been made and a Plan of Action drawn up. An understanding of the membership could be used for better designing of training programmes and other strategies of support. Here again a linear relationship between changes taking places and the study cannot be drawn with several factors and personalities playing a role. Unintended effects are also occurring, with discussion generated on many issues.

2. PERSPECTIVES FOR THE FUTURE

Focus of Research

- 9.1 Need to focus our areas of research on selected health policy issues, for a period of time (5 years) and review the situation once more.
- 9.2 Continue research in the area of medical education and education for health sciences.

- 9.3 Other areas in health policy that could be taken up are:
 - * decentralisation of health policy and health care (initiated as part of doctoral programme);
- * role of the voluntary sector and Government-Voluntary sector interlinkages (initiated);
 - * health financing.
- 9.4 New researchers could develop their own areas of interest and skill.

Team Development

- 9.5 A multi-disciplinary team could be considered in the long term, possibly covering the areas of bio-statistics, sociology, anthropology, and possibly political science, economics, besides health service research, epidemiology and health policy research.
- 9.6 Other skills needed are computing and data management, documentation and library basics, office management, editing and publishing. While much of this could be from the common CHC pool, there would be need for one/two full timers.

Infrastructural Development

- 9.7 Build up of library in the area of research methodology, research study reports and journals.
- 9.8 Computer and software packages
- 9.9 Typewriter, storage space and room as part of CHC pool.
- 9.10 Since there is a possibility of shifting the CHC office, the present building may be retained for the research unit.

Finance

9.11 We could consider the possibility of applying to ICSSR, ICMR, DST and CAPART for research grants. International donor agencies supporting research could also be contacted eg. IDRC, SIDA, besides partners who have already supported us.

Other

9.12 For peer group support, there is a need to build up and strengthen linkages with research groups and individuals in Bangalore. Also with institutes of Advanced Studies in India and with research groups in the voluntary sector eg. FRCH, CINI, SEARCH Gadchiroli.

3. CONCLUSION

This is draft discussion note. We would value your comments particularly on strengths and weaknesses and on perspectives for the future.

APPENDIX I

HISTORICAL REVIEW OF CHC OBJECTIVES PERTAINING TO RESEARCH

When the initial team members left the medical college, the stated need was to set up an informal, small, Documentation and Research (D & R) Cell, to encourage and catalyse the growing awareness and interest in Community Health and Health by the People' (1). This was to "provide a sound information base for voluntary health effort".

Objectives included the study of:

- a) Government health policy documents,
- b) health statements of major groups in the voluntary sector, and
- c) existing evaluation studies in the voluntary sector. It was also planned to study:
 - i) health care projects,
 training courses for health care personnel,
 health components of curriculum of formal/non-formal educational
 programmes in the governmental/voluntary sector.
 - ii) people's perceptions of community health programmes,
 - iii) perception by community health project personnel of coordinating agencies/training institutions.

Special focus was to be given to Karnataka.

The primary thrust of CHC in its early years was therefore on documentation and research. This was undertaken by involvement and reflection with several groups working in (or interested in) community health in the field. By the understanding and insights ('findings') gained through this "study-action-reflection" process of enquiry ("research")_ it was hoped to contribute to the emerging peoples' health movement especially through evolving relevant training and support strategies that could be put into action by local institutions or state level/central units of national organisations'.

During the first two and a half years (January 1984 - July 1986) the focus was on 'understanding the dynamics of community health action' and getting an overall perspective of the situation in Karnataka, evolved as an unwritten objective. To this was also added the organisational responsibilities for the **medico friend**

circle (mfc) which resulted in a research involvement in the aftermath of the Bhopal disaster.

A review after two years (in 1986) brought out the need to write up the CHC experience in an analytical way, so that the major learnings could be shared with others. This also resulted in a note on `an approach to the future'.

Besides Networking, Documentation and Communication, an important need identified was 'to support ongoing health initiatives with relevant and quality socio-epidemiological research with an inter-disciplinary field oriented team that could promote wider appreciation of socio-epidemiological perspectives in problem solving in health and health care by a participatory research team plan to focus their efforts in the future. Participation in networking, documentation and communication efforts will remain an important but secondary goal".

"The main objective was to gradually interact with all the groups involved in /community Health Action in Karnataka, including individuals, health project teams, network, 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".

It was envisaged that two types of research interventions could be organised, viz.,

- a) Research to support ongoing health work done at the request of health projects;
- b) Research initiated by the team itself as long term funded projects in areas of its own interests or of its individual team members. This would also offer opportunity to evolve methodological alternatives in response to varying field situations.

Both approaches were considered are necessary to maintain viability of a research team whose overall goal would be to support the ongoing community health process.

A subsequent action plan for the period October 1987 - December 1988 mentions the "crucial but unmet need for action-research (primarily socio-epidemiological and health practice oriented) to support on-going health projects and the evolving issue based health movements in the State".

Early discussions in 1988-89 regarding the formal registration of a body evolving out of the earlier CHC, spoke of a "registered community health research society".

The plan of action for 1989 mentions the "evolution towards an Action Research Cell supported by a network of individuals and initiatives, committed to promoting community health action". Focus of action research on the enabling - empowering dimensions of health action was thought of.

In 1988, the importance of health policy research was recognised as a means to influence or help to bring about relevant changes in health care policy. This was seen as a support to and a logical extension of the enabling/empowering process with communities. The needs of staff undertaking policy research assignments to be free of other CHC responsibilities for periods of time was expressed, to allow for completion of research work. Early experience also suggested that it would take a little time for the voluntary health and development sector to sustain the rigorous methodology that community health research would entail.

The team expanded to eight persons at this stage. Team reflections in 1990 raised the option of registering a Trust/Society and to "build up over the years a more distinctive image, moving beyond the philosophy of "catalyst action" to a more specific research focus. Different team members also identified their own areas of interest and priority areas for focus for work. These ranged from health issues of urban slum dwellers, personnel management, medical pluralism, child health, and open-ended catalyst work to policy research.

A five year review meeting in June 1990 indicated that registration as a Society was necessary to maintain autonomy and flexibility. Supportive community health work was to continue," while at the same time developing a sharper policy research focus in its work".

The Society for Community Health Awareness, Research and Action was registered in April 1991. The objective pertaining research (out of six objectives) reads as follows:

"To undertake research in Community Health Policy issues, particularly:

- community health care systems;
- health human power training strategies;
- health and development interactions; and
- medical pluralism and integration of medical systems.
- Ref: 1) Proposal for a Documentation & Research Cell (D & R cell) in Community Health, 28th August, 1983.
 - 2) Community Health Cell an approach to the future.
 - 3) Community Health The Search for an Alternative Process, CHC, 1987-88 (Red Report).

APPENDIX II

<u>RESEARCH EFFORTS OF CHC FROM 1984 TO 1993</u> <u>- A CHRONOLOGICAL LISTING</u>

Phase I January 1984 - September 1987

- 1.0 Involvement in and report of the study reflection action experiment with community health and development groups
 (June 1984 June 1986)
 - 1.1 Community Health The Search for an Alternative Process, (red and brown mimeo reports, 1987-88, pp 100 & 32 respectively)
 - 1.2 Community Health in India, (cover story) Health Action, July 1989 Vol 12, No. 7.
 - 1.3 <u>Community Health</u> <u>The Quest for an Alternative</u> Narayan R., Social Action, Vol. 35, No. 3, July September 1985, Indian Social Institute, New Delhi.
 - 1.4 <u>Community Health</u> <u>The Quest for an Alternative</u> Narayan R., in Development with People' Ed. Walter Fernandez, Indian Social Institute, New Delhi (1985).
 - 1.5 <u>Towards a Paradigm Shift in Health</u> Narayan R., Link, Vol. 7, No. 2, August September 1988. (Newsletter of Asian Community Health Action Network).
 - 1.6 <u>Towards a People-Oriented Alternative Health Care System</u> Narayan R., Social Action, Vol. 39. July September 1989.
 - 1.7 Presentation at the Indian Peoples' Science Congress, Bangalore, 1989.
 - 1.8 Concepts used as a basis for presentations sharing with groups in India and abroad (UK, Germany, Canada). Also used in CHC's training and research efforts.
- 2.0 Initiation and support to community based epidemiological research by the medico friend circle, following the Bhonal gas disaster.
 - 2.1 Several reviews & papers (mimeo), articles in m.f.c. bulletins, mfc publication of full & summary report of study

- 2.2 The health impact of the Bhopal disaster an epidemiological perspective' (Narayan T., dissertation for the Masters in Epidemiology at LSHTM, London University, September 1987). Later published in Economic and Political Weekly, August 18 and 25, 1990.
- 2.3 Presentation at Second National Convention on Bhopal, New Delhi, April 1991.
- 2.4 Submission on Health Effects of Industrial Hazards to the International Permanent Peoples' Tribunal, Narayan T, October 1992.
- 2.5 <u>Submission on the health status and health care of victims of the Bhopal gas disaster of 1984</u>, Submission to International Medical Commission on Bhopal, Narayan T., January 1994.
- 3.0 "An approach to the study of health aspects of environmental pollution caused by a viscose rayon factory" Narayan T., m.f.c., mimeo, July 1985.

4.0 Support / guidance to surveys and workshops:

- 4.1 Support to community survey among adivasis in Mysore district (Dr. Mahesh)
- 4.2 Survey of Government health facilities in Tumkur district (Jyothi and Raj)
- 4.3 Short term studies on use/misuse of drugs in small hospitals and health centres (Dr. G.D. Ravindran)
- 4.4 Study of the training of village health workers in OXFAM funded health projects (Vanaja Ramprasad)
- 4.5 Participatory evaluation of community health projects organised by Indian Social Institute, New Delhi (Preliminary Planning).
- 4.6 Seminar on Research Priorities in Occupational Health organised by the Regional Occupational Health Centre, Bangalore, National Institute of Occupational Health, Ahmedabad & Indian Council of Medical Research

5.0 Health and Agricultural Linkages

5.1 <u>Health, Nutrition and Agricultural Development</u> - A Bibliography (August 1987) - Narayan R., sabbatical assignment, London School of

- Hygiene and Tropical Medicine, London.
- 5.2 Health, Nutrition and Agricultural Development an overview of the situation in Karnataka. (August 1987) - Narayan R, sabbatical assignment, London School of Hygiene and Tropical Medicine, London.
- 5.3 Epidemiological Patterns associated with Agricultural Activities in the Tropics (paper co-authored by Narayan .R., with Professor David J. Bradley, Ross Institute, London) for joint WHO/FAO/UNEP Panel of Experts on Environmental Management for Vector Control: meeting in Rome, September 1987. (Effects of Agricultural Development on Vector Borne Disease, FAO Monograph Agl/Misc/12/87).
- 5.4 The Tea Garden as a Research Eco-System, paper co-authored by Narayan R. with Professor David J. Bradley, Ross Institute, London and Dr. V. Rahmathullah, UPASI, India, 1987 (In Capacity for Work in the Tropics Ed. Collins & Roberts, Cambridge University, 1988).

Phase II 1988 - 1989

- 8.0 Participated in the planning of an `Evaluation of the National TB Control programme' with ICORCI (March 1988). Report `An indepth study of the National TB Control Programme' by ICORCI, for Government of India, sponsored by WHO.
- 9.0 Health Status of the people of Karnataka in the context of the health situation in India, Narayan T., background paper for FEVORD-K, Annual Meeting, May 1990.
- 10.0 Evaluation of the Community Health Development Programme of Kottar Social Service Society, 1990.
- 11.0 Support to analysis of a study by the medico friend circle on the reproductive outcome of women exposed to toxic gases during Bhopal disaster.
- 12.0 Support to study on diarrhoea related morbidity among children.

Phase III 1990 - 1993

13.0 Medical Education Project, sponsored by the Christian Medical Association of India (CMAI) and the Catholic Hospital Association of India (CHAI) viz., 'STRATEGIES FOR GREATER COMMUNITY ORIENTATION AND SOCIAL RELEVANCE OF MEDICAL EDUCATION IN INDIA'.

This included a multi pronged research strategy, viz.,

- * a review of Expert Committee recommendations,
- * a review of medical college experiments/innovations,
- * feedback on major aspects of undergraduate medical education from medical education from medical graduates with peripheral health institution experience, and
- * a review of experience of community health trainers in the voluntary sector.

The methodology comprised a literature review, correspondence with medical colleges and community health training groups, field visits and discussions with medical college faculty and interns, interviews, questionnaire to medical graduates, a dialogue (2 day meeting) with community health trainers. A medical educators review meeting was organised in June 192 for presentation and review of findings.

Reports/Publications/Meeting arising thereof:

Publications

- 13.1 Narayan R., Narayan T., Tekur S.P., Strategies for Social Relevance & Community Orientation of Medical Education - Building on Indian Experience. Bangalore, CHC, March 1993, pp 74.
- 13.2 Narayan T., Narayan R., Evolving Medical Curriculum from Graduate Feedback based on experience in Peripheral Health Institutions Bangalore, CHC, March 1993, pp 74.
- 13.3 Narayan R.

 Stimulus for change: An Annotated Bibliography
 Bangalore, CHC, August 1993, pp 48.

- 13.4 Narayan T.Training Doctors for IndiaHealth Action, June 1991, Vol. IV, No. 6
- 13.5 Narayan T. & Narayan R.
 Evolving a Curriculum framework through research of Indian Praxis
 Trends in Medical Education, First issued, August 1994 (in press)

Reports / Papers / Presentations

- 13.6 Preliminary Communications of (13.1) and (13.2) in mimeograph form presented at the XXXI Annual Meeting of the Indian Assn. for the Advancement of Medical Education, Bombay, 1992.
- 13.7 Towards an alternative medical education Step by Step (An Anthology of CHC papers and initiatives), December 1992.
- 13.8 Community Health Trainers Dialogue, On an Educational Policy for Health Sciences October 1991, Bangalore, CHC, 1992, pp. 103.
- Narayan R. (ed).
 Proceedings of the Medical Educators Review Meeting,
 June 1992, Towards a Collective Commitment
 Bangalore, CHC, December 1993, pp. 152
- 13.10 H.J. Mehta Memorial Oration at St. John's Medical College:

 Rebuilding The Foundations: Reexamining Preclinical Medical
 Education, Narayan R., December 1991.
- 13.11 Presentation at meeting of Indian Association of Physiologists and Pharmacologists, December 1991.
- 13.12 Summary papers of 13.1 & 13.2, along with posters presented at August 1993 bi-annual General Meeting of the International Network of Community Oriented Educational Institutions for Health Sciences at Sherbrooks, Canada, at the Conference on Student Centred Education.
- 13.13 Paper on Public Health Training in the Undergraduate Medical Curriculum was also presented at the above meeting.

Presentations of findings were also made.

- 13.14 to different groups of staff and students at Medical Medical Centre, and
- 13.15 to faculty of the government Miraj Medical College.

14.0 THE GOLDEN JUBILEE EVALUATION STUDY OF THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA (1991 - 1993)

A miltipronged research strategy was employed. Key aspects included:

- a detailed study of 20% of the membership (discussions with a sample of health institutions across India by trained investigators using a semi structured interview schedule)
- ♦ Mailed Questionnaire to the remaining 80% of CHAI membership
- Structured feedback from members of the Executive board, representatives of Regional units, and Staff members of CHAI.
- ◊ Financial Review, and the
- O Policy Delphi Method of Research

Publications / Reports / Meetings arising thereof are given below:

Publications

- 14.1 Narayan T., Jacob J., Philip T.Seeking the Signs of the TimesSecunderabad, CHAI, October 1992, pp. 64.
- 14.2 CHAI Study team

Major problems faced by CHAI member institutions in their medical / health work.

Are national / regional collective solutions possible?

Secunderabad, CHAI, February 1993, pp. 10.

14.3 Veliath A.

A Golden Harvest - New Horizons Secunderabad, CHAI, November 1993, pp. 112 (Abridged, adapted revision of study reports)

14.4 Francis C.M. (Ed)

Towards Life in its Fullness: Action Plan arising from the CHAI Golden Jubilee Evaluation Study.
Secunderabad, CHAI, March 1994, pp. 43.

Reports

14.5 Narayan T., Jacob J.

Two Thousand AD and Beyond: Contextual & Policy level issues important for the future health related work of CHAI Findings from the Policy Delphi Method of Research Bangalore, CHC, March 1993, pp. 64.

14.6 Narayan T., Philip T., Jacob J.

At the Fiftieth Milestone - Evaluative Feedback from members concerning the Catholic Hospital Association of India. Bangalore, CHC. June 1993, pp. 132.

14.7 Narayan T.

Report of the feedback from Staff Members of CHAI, March 1993, pp. 39.

14.8 Srinivasan P.

Report on Financial Management of CHAI, March 1993, pp. 39

14.9 Narayan T.

Report on Feedback from members of the Executive Board & Regional Unit Representatives

14.10 Narayan T.

Report prepared for the first meeting of Sister Doctors

14.11 Narayan T.

Report from Delphi Research on 'The role of voluntary organisations in health care services' prepared for National Meeting of Community Health Trainers organised by CHAI.

Meetings arising thereof

- 14.12 Eleven regional meetings
- 14.13 Nine professionals/special interest group meetings
- 14.14 49th General Body Meeting of CHAI at Guntur, A.P (Nov. 1992)
- 14.15 50th General Body Meeting of CHAI at Secunderabad, A.P. (Study team members facilitated/made presentations at the above meetings)

14.16 Others:

Several core group meetings to arrive at the Plan of Action

Presentation to CEBEMO/Misereor at Oeestgeest, Netherlands.

Presentation to Students/Faculty of COADY Institute, Canada.

15.0 Narayan T.

'Research issues in Decentralised Health Care'.

Paper presented at National Workshop on Health Policy in the context of Decentralisation, organised by the National Institute of Advanced Studies, September 1990.

- 16.0 Evaluation of 'Reaching the Unreached' project, Madurai, 1992, (Dr. Shirdi Prasad Tekur & Dr. V. Benjamin)
- 17.0 Evaluation of CMAI, Child Survival Programmes (Dr. Shirdi Prasad Tekur)
- 18.0 External Evaluation of Indian Social Institute
 Training Centre, Bangalore,
 Report by R. Katticaran, Thelma Narayan, and S. Raghuram, September 1992
- 19.0 Evaluation of Madhya Pradesh Voluntary Health Association Dr. Shirdi Prasad Tekur, 1993.
- 20.0 Paper on Conceptual Framework for Assessing Women's Health Needs (Thelma Narayan), background paper for a national workshop organised by Child in Need institute, Calcutta, later printed in m.f.c. bulletin, August December 1993 as background for the 1993 m.f.c. Annual Meet on Reproductive Health.

- 21.0 Narayan T., participated in brain storming meetings concerning research on following issues:
 - ♦ Coronary Heart Diseases at SJMCH with Dr. Salim Yusuf (National Institute of Health, USA), Dr. Prem Pais and Dr. Ranga Nayak.
 - Pre & post assessment of health education aspects of water and sanitation projects with Dr. Ramakrishna, International Union for Health Education.
 - ♦ Reasons for stagnant status of IMR in Karnataka (Epidemiology cell of SJMC)
 - ♦ Risk factors for cancer cervix with Dr. Sudhir Krishna of Bangalore unit of Tata Institute of Fundamental Research
- 22.0 Support to study of drug prescription patterns (Dr. Shirdi Prasad Tekur).
- 23.0 Developing a baseline questionnaire for a development project, RORES, Srinivasapura (Dr. Shirdi Prasad Tekur).

(*tn/ac/msword/ c:\off\ resrev.doc/pp. 24/May, the 13th, 1997)

Organisational Reviews of SOCHARA-1998



The Fifteenth Milestone . . .

A BIRD'S-EYE REVIEW OF COMMUNITY HEALTH CELL

JANUARY 1984 - DECEMBER 1997.

Distributed at the CHC REVIEW MEETING - held on 3rd & 4th April 1998 at

The Brothers of Holy Cross, 47, St.Mark's Road, Bangalore - 560 001.

Community Health Cell

Society for Community Health Awareness, Research and Action No.367, 'Srinivasa Nilaya' Jakkasandra I Main, I Block, Koramangala, Bangalore - 560 034.

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A bird's-eye review of CHC from January 1984 to December 1997.

A. Introduction

- 1. The Community Health Cell (CHC), the functional unit of the Society for Community Health, Awareness Research and Action, began its fifteenth year in January 1998. Over the last fourteen years, it has grown from a small, informal team of four persons working from a small, single room office in the front room of a private residence, to a team of 14-15 people supported by network of around 40 CHC professional associates based in a small centre, which apart from group offices for the staff, has a well organised library and documentation unit and a training/seminar room with a wide range of teaching/learning aids. The centre is also governed by an autonomous registered Society with specific aims and objectives.
- 2. During these years, the CHC has gone through various growth phases; identified various functions to support community health action through non-governmental and governmental partners; explored various aspects and issues relevant to Community Health action; promoted networking on various issues and actively participated in emerging networks in the country; evolved educational and research strategies in community health; and initiated dialogue with health planners and decision makers to enable the formulation and implementation of community oriented health policies.
- 3. On 3rd and 4th of April, the CHC team has organised a 2 day review exercise which will focus on all the important aspects of CHC's activities, both technical and managerial: share the CHC team's own SWOT analysis (Strengths, weaknesses, opportunities, threats) of the Centre's functioning and organisation; share some future scenario building exercises conducted by CHC initiatives; and explore ideas and suggestions by all its Society members and a group of reviewers and associates, invited specifically for the purpose. The event is a serious reflection on the past, present and future. It is also a celebration, of reaching an important milestone, when with a small core group of invitees, from a large network of associates, friends and contacts, CHC wishes to record its appreciation for the solidarity, the fellowship, the interactive, participatory peer group support it has received all these years.
- 4. This short reflection will highlight some facts, some initiatives, some concern and some perspectives that will provide useful background information to the reviewers and participants of the exercise. It is neither comprehensive nor a complete report but outlines the key and salient features of CHC's 14 year history - that has been marked by opportunity, and challenge.

5. This note is supplemented by short reflection/review of our research; our Field training; our management; a publication list and 6 newsletters that have been sent out since we registered CHC as a Society in June 1990.

B. The beginning (or the Roots)

- 6. CHC was established in January 1984 when the two co-initiators of CHC moved beyond the Department of Community Medicine, Department of St. John's Medical College after completing nearly a decade, as teachers/field trainers. During this decade, they had been involved in the development of six rural field practice areas in Sidlaghatta, Hesarghatta and Dommasandra talukas around Bangalore with an enthusiastic, field oriented, multi disciplinary team under the guidance of visionary leadership and senior public health peers (An interesting feature of the CHC experiment has been that even today in 1998 - most of that initial group at St. John's are linked in one way or another to CHC's ongoing initiatives).
- 7. Apart form bringing to CHC, interactive field experience from field training of medical students, interns, nurses, community health workers and plantation medical officers, the co-initiators also had established links with Indian Social Institute, Bangalore, the SEARCH experiment in Bangalore; national coordinating agencies like VHAI, CHAI and CMAI; and were members of the medico friend circle.
- 8. A year of extensive travel to community based projects in the States of Karnataka, Tamilnadu, Gujarat, Maharashtra, Haryana, Orissa and West Bengal - visiting CHWs/Doctors trained at St. John's and a wide spectrum of mfc core group and innovative health and development projects was also a key inspirational experience in 1982.
- 9. The decade of community oriented training experience at St. John's (1974-83) and the involvement with VHAI, mfc, ISI, SEARCH, CHAI as resource persons and or participant during this phase and the 'balloonist perspectives' acquired from an intense grassroots contact during the 'Bharat Darshan' of 1982 could be regarded as a foundational experience, on which the CHC framework and process was built.
- 10. Between 1982 and 1983, the co-initiators had extensive discussions with a wide range of contacts, peers and inspirational resource persons at various levels. The broad parameters that emerged from all these interactions was the need for a Cell / Centre that:
 - i) focussed, studied and built on the wealth of Indian grass roots experience, that was still marginal to the efforts of most formal training and research institutions.

- ii) Provide information and advisory support in an interactive, participatory and responsive way to the increasing number (especially since the early 1970s) of community health action initiators in the voluntary sector in India.
- iii) Facilitate the coming together of health action initiators to network, learn from each others experiences and build collective linkages and action thrusts.
- iv) Move 'Health' beyond its severe bio-medical orientation and professional control by the medical profession and facilitate the emergence of Health and Health action as an agenda of groups outside the medical system.
- 11. These perspectives required moving beyond a medical college base and evolving a small centre whose ethos and function and milieu would allow the development of an alternative paradigm in health care - a new set of ideas and concepts that would endorse and sustain community health action at the grassroots and simultaneously challenge the 'bio-medically' constrained mainstream system and institutions to be more community oriented and socially relevant.

In retrospect, the evolution of CHC was as much a proactive experiment of evolving a new paradigm, as it was a symbolic protest against the constraints and limitations of a predominantly bio-medical and technomanagerial approach to health and health care, represented by the medical colleges of the early 1980s.

C. CHC EXPERIMENTAL PHASE - I: 1984 - 1986

- 12. CHC was initiated as a study reflection action experiment in Bangalore in January 1984. It was established as an informal resource Cell supportive of ongoing and evolving community health actions. The experiment started with a small group of four (RN, TN, KG, KC), of whom three had moved beyond a department of Community Medicine of a Medical College. Since it was an experiment, the Cell was a health project supported initially by the STAND trust and later the Centre for Non Formal and Continuing Education-Karnataka, both educational trusts supporting informal education initiatives focused on the marginalised especially in rural / tribal areas. The framework of support negotiated with these trusts allowed a creative autonomy and a participatory form of governance supported by a 3 member team of Senior Peers (CD, CMF & GJ).
- 13. The main objectives of the Cell were:
 - i) to support community health action by voluntary agencies
 - ii) to provide a sound information base for voluntary health effort
 - iii) to encourage groups
 - to recognise the broader dimensions of health

- to see health as a process of awareness building and organisation among people
- to a greater sharing among field workers and activists to build an understanding of 'process' rather than 'project' in health action
- to see health efforts as part of a broad based movements free of labels.
- iv) to create closer links between groups so that these efforts become part of a health awareness building process leading to a 'peoples' health movement'

For objectives (i) - (iv) the Cell initially planned to relate particularly to groups in Karnataka, focussing specially on the needs of the underprivileged. As the months passed, however this focus was not easy to maintain because within a year or two requests for support began to come in from a larger geographical region - South India and beyond.

- 14. During the first 30 months of our involvement, we were able to deepen our understanding of the dynamics of community health action in India and also get an overall perspective of the situation in Karnataka. During this experimental phase of 30 months, we perceived phenomenal enthusiasm and experienced a wealth of learning from all those we worked with and a deep sense of confidence and satisfaction began to develop in the CHC team:
 - a confidence that the moving beyond the 'medical college base' had not been in vain
 - a satisfaction that we were beginning to respond and provide support to an urgent but greatly unmet need.

The whole experiment was proving to be a two way mutually supportive process - with the CHC team not only providing support but also learning and enriching its own perspectives in the process.

D. The mfc phase (April 1984 - March 1996)

15. Very early in the experiment, the Cell also accepted, for two years (1984-86), the organisational and bulletin responsibilities of the Medico friend circle - a national network of doctors and health activists interested in making health services and medical education more relevant to the needs of the large majority of the people in India - the poor and the underprivileged. The mfc experience was a very rich learning experience - because while our focus was on South India, it provided us an opportunity and challenge to support a national network of health activists and action initiators.

- 16. The mfc phase which overlapped with the first two years of CHC's evolution had some highlights
- Facilitation of the mfc interactive dialogue on TB and Society {Bangalore}; examining Medical Education {Hoshangabad}; Environment and Health {Khandala}; Revitalising mfc {Patiala}
- Active participation in the Rational Drug campaign of mfc and in the evolution of the All India Drug Action Network - a national network of health and development agencies, science groups, academic departments, regional networks, trade unions and others promoting rational drug policy perspective.
- Organisation and supportive facilitation of mfc's Bhopal disaster related initiatives which included a socio-epidemiological study; a communication strategy to support the ngo health network in Bhopal and informing the affected people of issues and findings of the study.
- Publication of mfc bulletins from 101 to 120 and occasional rational drug newsletters - and conversion for this phase of the bulletin from being just a vehicle of debate/discussion on issues, to becoming a vehicle of enhancing collectivity in action and effort

E. The CHC TEAM Training Break (1986 - 87)

- 17. After the first 30 months, three members of the CHC's four member team, identified a need to equip themselves further with certain skills that would enhance our abilities to support the emerging requests from Community health action initiators. A one year break in the process was operationalised and three CHC team members spent a year undergoing training in:
 - Epidemiology (TN)
 - ii. Personnel management (KG)
 - iii. Low cost communication (KC)

The fourth member of the team - the coordinator of the earlier phase (RN) spent a considerable part of the year evolving CHC's first Report on Community Health the search for a process which was later circulated to all our partners and associates and many friends in the 'community health movement' inviting their reaction and comments (see next para). He also spent a sabbatical year doing a short focussed project on linkages between Agriculture, Health and Nutrition which resulted in an approach paper on "Epidemiological patterns associated with agricultural activity in the tropics with special reference to vector-borne diseases" as part of a FAO/UNEP/WHO document.

18. During this year, RN also got an opportunity because of the year in UK to give guest lectures at various training and resource institutions in UK - e.g. the London and Liverpool Schools of Tropical Medicine & Hygiene; the Institute of Child Health, London; AHRTAG - London; Oxfam - Oxford; and other centres. Perspectives on the Axioms of Community Health - derived from our experience were shared with students doing Community Health/Public Health postgraduate courses - (From various parts of the developing world) and well received.

F. The 'Red Report' - 1987

19. A Report entitled Community Health: The Search for an Alternative Process which was a report on the study-reflection-action experiment by CHC, Bangalore from January 1984 - June 1986 - was the first major documentation effort - that was circulated to a wide network of Community Health enthusiasts and action initiators in India - for comments, suggestions and an invitation for interactive dialogue. The Red Report (as it was called because of a bright Red cover) included a situation analysis of Health care in India; methodological overview of the CHC teams process of reflection; a reflection on Community Health in India; a note on the Movement dimension; an outline on the Tasks for the future; and a reflection on the evolving dimensions of the Community Health approach. The report also listed out all the groups, initiatives, individuals we were in touch with; the key meetings; a reading list and additional reference and a list of materials generated by CHC in the first phase.

The report was well received, and many who read it sent us comments. It also helped CHC be accepted by a large group of innovators and action initiators in India - as a serious group attempting to build on the collectivity of Indian experience - a reputation which continues till today.

G. CHC Experimental Phase II (1987 - 89)

- 20. On regrouping at the end of the training phase, the team functioned from a rented accommodation centrally located in Bangalore where facilities for office, library and a room for meetings and discussions was available. Apart from the four original team members from experimental phase I, the team was joined by two part time members (SPT, MK) who greatly enhanced the scope and outreach of the work. Additional team members also joined to support the work of CHC (MSN, VNNR, RU, SS) (see Appendix)
- 21. Building on the first phase, the CHC team now concentrated on certain new thrusts after the training phase. These included:

- i. Building up our documentation cell and getting more organised for easy access/referencing
- ii. Networking with persons involved with community health action and involving them in various initiatives or responses of the cell
- iii. Exploring areas of research with NGOs mainly in a supportive role.
- iv. Preliminary exploration of management issues with some voluntary sector projects
- v. Training programmes in Community Health both formal and informal based on participatory and interactive approach.
- vi. Continuation of the involvement in the campaign for Rational Drug policy and Rational Drug Use
- vii. Development of a study group on Traditional Systems of Medicine and some additional initiatives towards the exploration of integration of Systems of Medicine.
- viii. Some training and research initiatives focussing on health in urban slums
- ix. Continuing the peer support work which involved reflections and exploration of options whith individuals seeking greater relevance in health and development related work.

H. The June 1990 Review - (The end of the experiment)

- 22. In 1990, six years after in its inception, CHC was reviewed by a team of resource persons specially invited together for the task in June 1990 (included DKS, MI, VS, MJ, PK). A report entitled the CHC Experiment (1984-89) was presented to the group through short poster sessions/OHPs. The areas covered were Community Health Cell - An overview (TN); Networking and Formal and Informal Training (MK); Rational Therapeutics and Drug Policy issues and Integration of Traditional Systems of Health Care (SPT); Managerial and team building process (KG); a SWOT analysis (RN) and Looking to the future (CHC team).
- 23. The report arose from a series of internal reflections in the CHC team, to identify and clarify individual goals and to explore group goals as well beyond the end of the experiment (December 1989). The experience of the years 1984-89 was reviewed critically to understand various dimensions and learning experiences from the experiment. The team reflection and the June 1990 review lead to three important conclusions about the next phase of CHC.
 - The overall consensus was the that experiment had been innovative/interesting/effective enough to lead to the establishment of a more long term identity made possible by registering an autonomous trust/Society with the objective of continuing the promotion of community health action and research.

- In terms of focus, while open ended catalyst technical support role with the growing voluntary health sector had been enriching and had greatly helped to build CHC's evolving credibility, a need was felt to allow team members, particularly fulltimers to initiate more focussed research (action or policy oriented) primarily under their control to enhance the long term commitment and their own work satisfaction.
- Policy Research emerged as an important priority area because this seemed a major lacunae in voluntary sector effort in the beginning of the 90s. There was need to take a reflective overview of the diversity of experience and the wealth of innovations/alternatives/options that have emerged in the voluntary health sector at the 'micro' level and evolve large macro policy guidelines that can strengthen the Social Relevance thrust of evolving health policies.
- While efforts to register a Society was initiated in the post review phase CHC team members began to plan to focus on three areas that had key policy implications
 - a) Community oriented/Social Relevance in Medical Education
 - b) Medical Pluralism and Child Health
 - c) Community Health in Urban Slum.

I. The Registration of SOCHARA (1990-91)

- 24. After the post experiment transitional phase, CHC metamorphosed from an autonomous, little Cell, linked to the Centre for Non Formal Education and Continuing Education, Ashirvad, to a fully registered autonomous Society for Community Health Awareness, Research and Action. Since the team had become widely known as the CHC team, the Community Health Cell (CHC) continued to remain as the name of the functional unit of the Society. The informal team coordinator of the experimental phase (RN) became the Secretary/Coordinator of the Society; the three member wise council of the experimental phase (CMF, CD, GJ), the key resource persons in the team (TN, SPT, MK, KG); and many members of the June 1990 review committee, all became members of the Registered Society (DKS, MI, VS, PK, MJ); The registered Society and CHC moved to an independent, rented accommodation in Jakkasandra, Koramangala, where CHC continues to be presently situated. Some team members moved on to newer assignments (MK, KG). Newer ones joined (MK, XA, SJC, RM, CJ, HNV).
- 25. The key component functional initiatives of the experimental phase became the six objectives of the registered Society. The metamorphosis was carefully operationalised so that all the salient features of the ethos, framework and

traditions of the experimental phase were internalised into the formation of the Society without letting the legal requirements; the minimum but unavoidable institutionalisation; and the increasing structural definitiveness, from obscuring what the review process had identified as the essential core strengths of the CHC experiment, which were:

- its essentially interactive, participatory, catalyst linkage with the diversity of evolving Indian experience
- its commitment to participatory management
- its commitment to enhancing the empowerment dimension of health action.

26. The Objectives of SOCHARA were:

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

In the paras that follow, we shall look at each of these dimensions and objectives of CHC's work.

J. Creating Awareness of the Community Health Paradigm

27. The Social / Community model of Health

Since CHC's evolution was symbolised, by a moving beyond a 'bio-medical' institution base (even though it was a base already undergoing a social/community reorientation) - the development of the concept of a paradigm shift from Biomedical model to a social/community model was a natural evolution. The evolution of the concept was inspired by atleast two other events:

- the mfc debate on Health Care which way to go which tried to find a way forward between the inactive cynicism of those who believed that sociopolitical change had to take place before health care could change and the unrealistic euphoria of the alternative health care approach initiators of the 1970s and early 1980s who saw community based health workers and appropriate technology as the answer to all our problems.
- ii. A very serious reflection initiative with the CHAI Community Health Department in May 1983, which brought together the key thinkers of VHAI, CMAI, ISI, SEARCH and others to help, the now famous vision of CHAI - which defined community health as a process beyond community medicine

Community Health

is a process of enabling people, to exercise collectively their responsibility to their own health,

to demand health as their right......

Building on the above definition but going far beyond the Red report identified many components/axioms of community health, which were brought together as 'The Community Health Approach'. It was in the 1989 - special issue of community health of Health Action however that the concept of the Paradigm Shift was first enunciated. The idea of this 'concept' was to go beyond the ideological debate of capitalist/socialist view of health which was common among radical health thinkers and activists in the country and to identify changes and focus of efforts on new approaches/ideas that constituted a new interconnected group of ideas - a new paradigm! And a shift from current mainstream thinking! It was also an attempt to provide a more simple, inspirational framework to help action initiators understand shifts that were needed at various levels components of action to stimulate further experimentation and also to endorse emerging ideas that were already becoming action initiatives all over the country.

The 'paradigm shift' concept may have been seen as being rather simplistic at the time of its evolution - but as time went its ability to stimulate/inspire/endorse the evolving experiments become obvious.

The concept of the shift in paradigm then began to be used by CHC in many of its further explorations and soon the issues covered by the concept begin to increase (a more detailed presentation of this concept is part of the Review).

In short, the shift was from medicine to health; from patients as beneficiaries, to people to participants; from providing to enabling and empowering; from intracellular research to baloonist research; from professional control to demystification; from individual focus to collective/community focus and so on. The shift has now been evolved as tables for management, training, disease control etc., as further adaptations to the idea.

28. Promoting Rational Drug Campaign

CHC's role in the area of Rational Therapy and Drug Policy issues has been catalytic in the initial phase and complementary to Drug Action Forum-Karnataka, in the later years.

CHC contributed to the evolution of AIDAN both through its double role (mfc & CHC) in the later 1980s. In later years, its efforts and initiatives in Bangalore helped in the development of DAF-K, and since then CHC team members have contributed constantly to DAF-K management and action initiatives.

CHC's role has been primarily that of a documentation and clearing house for RDU / RDP / RDT information; technical support to workshops for different sectors; CME for doctors and postgraduates, and support to health education efforts in the Rational Drug Campaign (posters, slides, etc.)

It may seem surprising that so much effort has been spent by a team interested in Community Health - on the issues of Rational Therapeutics and Rational Drug Policy. This is however not 'accidental'. It is our firm conviction that 'drugs and prescribing' from a major component of health care at all levels and are an important part of the expectations of the lay consumers and general public. Since most professionals and health care action initiators have some knowledge in this area, we have found it a good starting point for social analysis and to understand the broader social-political-economic-cultural faction that determine drug availability, affordability, accessibility, use and misuse in society. It is a relatively non-threatening field and of equal interest to health professional and consumers. It is also an area in which some action can be immediately undertaken within a health care organisation. In addition, it also greatly helps the appreciation of the 'new paradigm'.

29. Towards an Integrated view of Medical Systems

A major component of the new paradigm of thinking promoted by CHC particularly through the initiatives of SPT have been the attempts at the integration

of Medical Systems. The Allopathic dominance that pervades health and medical care systems needs to be countered by a more wholistic, dialogue oriented approach to Indian Systems of Medicine like Yoga, Nature Cure, Ayurveda, Siddha, Unani, Tibetan Medicine and to alternative systems of medicine like Homeopathy and Acupuncture.

The focus of efforts have been centred around demystifying these systems and making skills such as herbal remedies / folk remedies and acupressure part of peoples and community based health workers skills. So they have formed an important component of all our training programme.

Attempts have been made to increase openness to these systems among medical students, doctors and voluntary agencies. Special training programmes organised by CHAI, AYUSHA and VHAI/VHAK have been supported and some years ago, a study group of practitioners from different systems was organised for a while to evolve this process further in a collective way.

More recently, team members have been exploring integration through more interactive research approaches and qualitative methods of enquiry.

Solidarity has been shown to efforts of LSPSS, FRLHT and CHAI in this year and more recently, the initiatives Faith and Healing Cell of CMAI have been supported through active participation in collective reflection.

While the community health paradigm has primarily focussed on the shift of community health action from 'providing package of services' enabling/empowering health action by the community, CHC efforts at promoting rational drug use at all levels and integration of medical systems have been complementary strategies towards 'the new paradigm'.

K. UNDERTAKING RESEARCH IN COMMUNITY HEALTH

30. A more detailed Research review will be presented at the CHC review but here, the key framework and initiatives are highlighted.

CHC's involvement in research started as part of its catalyst work and researchers initiating field research were among the various groups of people who sought CHC's advise, and support from the earliest phase of the experiment. CHC believed that if the alternative health care approach and or movement had to move towards providing quality counter-expertise on behalf of the poor and marginalised in society, then this counter expertise needed to be based on good research effort; collection of valid evidence/data; and a serious effort in evolving/addressing policy issues and imperatives. These ideas/dimensions of work were strongly stimulated by CHCs involvement in the mfc/CHC responses to the Bhopal disaster aftermath both in the research and communication strategy responses.

31. Key research initiatives were:

- The study on Community Orientation and Social Relevance in Medical Education;
- ii. Study on building curriculum framework from Graduate Doctor feedback.
- iii. The Jubilee Evaluation of CHAI through both questionnaires and structured interview of member institutions:
- iv. The Delphi forecast of Economic, political and social trends that have an impact on Health; the Health issues and problems emerging from this emerging scenario and the challenges to the voluntary and Mission sector.
- v. The recently concluded Public Policy Analysis of TB Control in India based on semi structured interactive interview with TB patients in H.D. Kote and Yelandur Taluks of Mysore District and complemented by interviews with community members, local leadership, health care workers, doctors and decision makers all the way upto the State Health minister.
- vi. The Review of the Malaria situation in the country and the Report on "Towards an appropriate malaria control strategy" that built up through an interactive process - the identification of issues of concerns and alternatives for action.
- 32. The CHC research process was flexible and while building on existing methodology it tried to innovate and strengthen the peoples perspective; the field/grassroots perspective; and the community perspective; While building on a sound foundation of Epidemiology and research methodology, CHC initiatives in research focussed on interactive, participatory, qualitative approaches beginning from balloonist situation analysis.

As part of the overall paradigm shift, the research efforts went beyond reductionist, intracellular, bio-medically focussed efforts of many of the current mainstream researchers to exploring, balloonist, social, epidemiological analysis that looked at social, economic, cultural, political, management, environment and other issues of a broader framework. Hopefully this has resulted in a deeper understanding of health and health care realities in our work.

L. Evolving Educational Strategies

33. The Alternate Community Health Training Sector

From the very inception, the CHC team has been constantly invited to provide inspirational and technical inputs into various ongoing courses organised by various institutions, networks and agencies. These have been in the from of workshop inputs or course inputs and have included INSA, RUHSA, SEARCH, ISI, SJMC, NIPCCD, CMAI, VHAI, CHAI, VHAK, CHAI-KA, FEVORD-K, XIME, KIMS, KRVP and so on. All aspects of Community Health have been covered and also Rational Drug Use, Integration of other Medical Systems and Health policy issues.

Recognising the significant contribution of the alternative training institutions in the voluntary sector, CHC tried three times to bring all the CH trainers in the country to network and work together. These were supported by VHAI, CMAI and CHAI respectively. While the first dialogue supported by VHAI led to a plan of action to maintain the information sharing effort and the second dialogue supported by CMAI/CHAI led to a Statement of Shared concern and evolving collectively on Educational Policy for Health Sciences; the networking efforts did not proceed further because of the preoccupation of coordinating agencies with other initiatives. In the Medical Education Project - this group was studied and ideas based on their work was collated and incorporated into the new strategies. This is an area that may have to proceed further with CHC's proactive and sustained effort

34. Field level Training - focussing on the grassroots

While most of the training especially in the initial phases was focussed on the team/staff members of voluntary sector projects in health and development, a concerted shift was made particularly from 1993 to focus on grassroots/community based health workers. A separate review of this aspect of our training efforts is available as a supplement to this report. This shift was a challenge to CHC since we moved from English as a primary medium of instruction to a vernacular ethos where instruction had to move to Kannada, Telugu, Tamil and Malayalam and often a multilingual effort as well. Under the able and committed leadership of SPT, this shift was not only possible but it developed phenomenal credibility for CHC at grassroots level, challenging the CHC team to evolve new methodologies more relevant to such training (see separate report).

35. Community Health Courses for young seminarians/trainees

In the early experimental phase of CHC, a workshop was organised for formaters from seminaries and training institutions to help catalyse a shift of approach from the institutional response of earlier Mission related health work to the new paradigm of community based and oriented approaches. Since St. John's, CHAI and INSA are others were primarily catering to those who had completing training and then reached the field situation, CHC decided to complement these efforts by focussing on young seminarians under training. The experiments at Jyothisadan, Kripalaya, Saccidananda training centres have also been a very good training / learning experience for CHC team, where the participatory / interactive training methodology has been developed further. (See next section)

36. The Alternative Medical College project

Building on the mfc anthology CHC initiated a medical college research project which studied Community Orientation and Social Relevance Strategies in Medical Education - building on various sectors of experience and experimentation. During the Medical College Project - the major effort was to evolve a strategy for Miraj Medical College (an alternative experiment) in collaboration with CHAI-CMC-Vellore, SJMC, CMC-Ludhiana, CHAI and others. When the 'Miraj Project' failed to materialise, the project seemed to have been in vain. However over the next few years interest in the ideas generated have resurfaced and atleast three colleges in the region are hoping to develop some linkages with CHC to explore these ideas and their translate into programme (Pramukhswami Medical College, Karamsad Gujarat; B.P. Koirala Institute of Health Sciences, Dharam, Nepal; and G.K. Medical College, Savar, Bangladesh).

More recently, the newly established Rajiv Gandhi Institute of Health Sciences (RGUHS) in Bangalore has begun to establish a Medical Education Wing and the CHC team has begun to work closely with the Medical Education Consultant of RGUHS. Apart from helping to facilitate the first M.B.B.S. course restructuring workshop, efforts are being made to evolve shorter courses on Rational Drug Use, Research Methodology for PG students, Involvement in restructuring workshops for II MBBS and final MBBS are also possible. Reorienting mainstream medical education by voluntary incrementalism is the new guiding principle for CHC's efforts in Medical Education because no serious alternate experiment is a reality as yet.

37. Community orientation of 'Mainstream' efforts / requests

More recently, the range of training requests have broadened, moving from voluntary sector training projects to mainstream - academic centres like medical colleges, nursing colleges, colleges of other systems of medicine, pharmacy

college, homescience and general arts and science colleges, governmental training institutions including IPP-VIII etc., and so on. This increasing requests from mainstream colleges is both a sign of CHC's evolving credibility as well as a very positive sign that mainstream institutions are increasingly concerned about social/community issues.

M. Dialogue with Health Planners

38. Voluntary Health Sector

The initial phase of CHC's experiment was focussed on the voluntary health sector especially in South India and an increasing involvement over the years with coordinating agencies of the voluntary sector at national level like VHAI, CMAI, CHAI and at state level - VHAK, CHAIKA, CMAI, WBVHA, MPVHA, APVHA, FEVORD-K, etc. Dialogue with these health planners/coordinators of the voluntary sector was an important beginning.

Even though, we were a secular group, CHC recognised early in its development that the 'Mission Hospital sector' which was a large component of the voluntary sector was in deep 'vision crisis'. Unable to handle the medical market economy, it was simultaneously being challenged to more beyond institutional approaches to community based/oriented options. CHC has played a very significant role in harnessing this creative crisis and helping coordinaters/policy makers/leaders develop new visions, community oriented missions and pro-people oriented policies. The Mission sector has been a pioneering contributor to the medical/health care sector in the country and our goal has been that it can became a pioneer for the newer health care approaches and policies as well.

Some of the contributions of CHC have been

- * Significant contribution to the evolution/clarity of CHAI's Community Health vision since the inception of its Community Health Department and thrust.
- * Facilitating discussion/dialogue on a more People Oriented/rational drug policy within mission institution. CHAI and CMAI's involvement in the larger movement was catalysed by CHC.
- * Participation in the evolution of the CHAI Health Policy for Member Institutions (1989).
- * Participation in the evolution of CBCI Health Policy for Church related Health institutions in 1991

- Helping CHAI and its members to understand the emerging Health challenges and the responses required (Seeking the signs of the times; and the Action Plan etc., are well known documents).
- Stimulating CMAI membership through a provocative 'Health Advocate' column in their medical journal to seriously consider significant policy commitment to new challenges.
- Participating in the evolution of the CHAI AIDS policy, etc.

39. Government Health Sector

Gradually, as our credibility was established we were increasingly called upon to attend government policy meetings, dialogue or workshops to bring macro perspectives that built on micro level action. The significant involvement in this area included:

- Involvement in Consultative Committee on Rural Development initiated by Government of Karnataka at Planning Commission's request:
- Response to Planning Commission initiative on peoples participation in planning and implementation;
- Involvement in the reviews of Primary Health Care System Development in 1990s by GOI and WHO in southern region (Bangalore) and at National level (Lucknow);
- Involvement in various dialogues organised by GOI/GOK on Govt.-NGO collaboration and linkages;
- Response to Perspective Plan for Karnataka (GOK);
- Dialogue on Health Section of 8th Plan Document of GOK;
- Dialogue of VHAK with GOK Health Ministry and Directorate: and involvement with the Report on State of Peoples Health in Karnataka
- Involvement in the multicountry dialogue on Govt. NGO collaboration organised by World Bank in Indonesia for India, Pakistan, Bangladesh, Philippines and Indonesia (represented VHAI at this meeting).
- Contribution as an Associate to the Independent Health Commission initiative of VHAI concluded recently.

40. In more recent years CHC involvement in Malaria and TB Control related initiatives with VHAI and CMAI has resulted in dialogue opportunities with NMEP and NTCP planners on control related issues and options.

In addition dialogue and interactive reflections organised by NIPCCD, WHO, Planning Commission, IGNOU and other governmental agencies have quite often seen active CHC participation. While these opportunities have been good for presenting CHC's evolving perspectives they have been somewhat adhoc and need fairly vigorous and sustained follow up if they need to make a meaningful impact. CHC has always participated and supported policy evolution/lobbying efforts through national coordinating agencies. This experience has been very varied with some nagging questions about goals, process and sustainability of efforts which will be discussed in the review

N. Promoting / Supporting Community Health Action

41. CHC's field training and interactive workshop have increasingly moved towards supporting community health action. The 'Intense Field training' phase 1993-95 were specifically geared to supporting community health action.

Many requests that come from voluntary sector organisations on a day to day basis is often field action or atleast field event oriented. Due to shortage of staff and also a realistic, appreciation of the inability to sustain field action due to the demands of a catalyst function CHC has never taken on a field practice area for sustained public health/community health action.

42. Should a Resource Support organisation also have its own field practice areas? This has been an ongoing dilemma and issue for debate! CHC has all along encouraged younger team members to focus on field action and field related experiences to develop skill, sensitivity and confidence. This has always been possible by linkages with our partners without having to administer the RFPA as one of our responsibilities. This policy has allowed CHC to relate to real life situations in a number of project areas rather than getting preoccupied by the demands and distractions of a field practice area totally under ones control. The pros and cons of this policy have been debated and all along we have decided to actively support action by voluntary sector projects, government organisation, health and development activists in a wide variety of areas and sectors, without getting tied down to action in a defined geographical region. This has also helped us to root in actual real life situations rather than focus on 'models' and 'ideal field practice' areas.

In all our involvement and partnerships, we have tended to discourage the event oriented, project oriented, adhoc camp type approaches in community health action and have always tried to enhance the process oriented, people empowering long term involvements, so that people/communities benefit from these interactions and do not get used as guinea pigs for the varying agendas of institutions, projects and professional initiatives.

O. THE CHC LIBRARY AND DOCUMENTATION UNIT

- 43. The CHC Library and Documentation is our prize possession. It reflects the CHC paradigm shift in its focus and its collections. Grey literature based on action and experience rather than typical professional literature is our focus. We focus on reports, bulletins, newsletters, CED documents by post, resource files of papers and handouts, research reports, field reviews, etc., rather than scientific journals The unit has helped a wide range of users come in contact with the diversity of Indian experience.
- 44. The audio visual unit now has posters, pamphlets, slidesets, videos and has been supportive of all our training programmes and also that of other groups. We have a very open and flexible loan policy which is being increasingly used by a larger number of users.

Recently, the Raja Rammohun Roy Trust has agreed to support the library as an example of a special interest public library.

In keeping with the demands of the information age, CHC is in the process of computerising the collection and increasing the interactive dimensions of its collection

A detailed note on the library and its collection; the library policy; the classification used; the list of journals and newsletters and a catalogue of the audio visual teaching aids is available on request.

45. The library owes its development to all our contacts at a national level and friends and associates who continue to send us materials. A surprising aspect of the growth has been the continuous inflow of 'gratis' material. More recently various professionals (associates) are contributing their personal collections of materials - a trend which augurs well for CHC Library. The organisation based on the VHAI classification is entirely due to the long standing efforts of SJ our earliest CHC part-timer and later supported by others (NG, JCN, MS).

P. THE CHC WEB OF INTERACTION (The matrix of the CH Network)

46. In the last 14 years, the CHC team has interacted with a rich diversity of people and groups in Community Health and this matrix/web of interaction is today a major strength. The people and groups who have been involved from all over the country include:

- i. Individuals in search of greater social relevance in Health and Development work;
- ii. Health and development projects in rural and tribal areas and in urban slums
- iii. Health and Development trainers in the voluntary sectors;
- iv. Networking and issue raising groups like mfc, AIDAN, Drug Action Forum-Karnataka, etc.,
- v. Coordinating agencies at Centre and state level like VHAI, CHAI, CMAI, VHAK, CHAIKA, FEVORD, CSI, ACHAN, etc.
- vi. Development projects, networks, training centres like SEARCH, ISI, ICRA, INSA etc.
- vii. Groups working with women, street children, AIDS problem and patients; leprosy projects; child labour, environmental groups; Human rights groups, etc., and more recently with peoples movements.
- viii Government officials and planners and resource persons at Karnataka, Madhya Pradesh, Rajasthan and National level.
- ix. Staff and postgraduates of St. John's Medical Colleges and other medical colleges in Karnataka, CMC-Vellore, JIPMER Pondicherry, and other colleges.
- x. Academics and researchers from a wide variety of background both national and state level institutions and governmental, voluntary sector and private backgrounds.
- xi. Health and Development advisers and resource persons and India-desk offices of a range of funding partners Oxfam, Misereor, Cebemo (now Bilance), Memisa, EZE, BFW, DANIDA, SIDA and other agencies mostly of European origin.
- xii. A very wide range of academics/researchers and resource persons from key resource centres and training centres abroad especially in UK, USA, Canada, Norway, Sweden, Germany and more recently since the involvement in the WHO policy process with resource persons from Africa, Latin America and South and South East Asia.

xiii. An increasing number of journalists, media persons, teachers, lawyers, social workers, consumer activists and from other walks of life as well.

Q. PEER GROUP SUPPORT - RECOGNISING THE PARADIGM SHIFT IN INDIVIDUALS

47. This has probably become one of the most important of CHC's contributions to the evolving movement - the provision of peer group support, reflection, review, interactive dialogue with a very large number of individuals, both young and old, who at various levels in their career wish to seek an involvement in the voluntary health sector, and the community health movement or wish to consider changes of vocation, direction and life experiences. This catalyst work has meant providing time and space for individuals to share their experiences; their anxieties; their frustrations; their creative ideas; their fears and their plans. Many CHC team members have themselves experienced the sorts of crisis that often mark these shifts, in an individuals paradigm in the context of work or vocation and having valued all those who supported them at this stage - we have tried to offer the same to others in solidarity.

Hours have been spent responding to such requests - all times of day - all days of week and though it has always been quite exhausting and demanding for the core CHC team, particularly RN/TN/SPT who made this as part of their responsibility, it has also been worthwhile

48. Today CHC's very live, deep and rich linkage with a wide cross section of health action initiators in the country is partly the outcome of this activity. It is very heartening to meet, people who have felt this support to have been very useful, meaningful or significant at the time it was offered. For many, it was a crucial decision making phase in their personal lives and the CHC team's support, time, understanding, fellowship was seen as a very helpful input - a very significant reaching out!

In more recent years, there have been many NRIs who are returning to the country with good skills and knowledge and wish to support the process and they too have been in touch and the supportive process continues.

49. This activity is always high on CHC's agenda and is also referred to as the 'coffee club' approach in our work, leading to a reputation that CHC is a centre where you can always find a person interested in your work and interested to learn from your experiences and at the same time provide professional / technical expertise to solve the visitors specific problem. This is a sort of information advisory and vocational counselling service that has been very satisfying but also rather demanding. While this is a significant contribution, this activity/response makes time management more difficult and unexpected number of requests in

quantity and quality often compromise the system. While recognising the need and importance of this activity the CHC team needs to find a good balance between catalyst peer support and focussed definitive commitments.

R. PARTICIPATORY ETHOS IN MANAGEMENT (trying to practise what we preach)

50. The participatory ethos in CHC's experimental and Society phase derives inspiration from a learning experiment of the 1982 Bharat darshan of the coinitiators. It was found that all projects which had participatory, relatively non hierarchical functioning seemed to have a better morale among the team and was generally more effective and more sustained in its action responses. hypothesis in the CHC experiment was that individuals in teams could not be expected to build Primary Health Care / Community Health as a democratic process through interaction with members of the community, if they themselves did not experience democracy in their team functioining and experience. A participatory management ethos was thus geared to the development of an experiential laboratory where new team members understood the challenges and responsibilities, the approaches and the dilemmas of working with the people.

This factor soon spread beyond the management administrative framework of CHC and become a touch stone of all our interaction with partners and other resource groups. So we moved from participating management; to participatory evalution; to participatory interactive action and policy research. It greatly helped to get the team to slowly began to consider, partners, team members, other resource persons, as participants of a joint partnership rather than as beneficiaries of our specific project initiatives.

51. Participatory evaluations

All the reviews/evaluations, we have done have strong elements of participation. KSSP (SPT/MK/TN), RTU (SPT/VB/GG), CMAI-CSCD (SPT), ISI (TN), Memisa Partnership Review (RN/TN), CHAI Study (TN, JJ, TP, XA), DSS (SPT/VB/RKN).

The review or evaluation efforts have attempted to involve all those who participate in the project being evaluated, plan the process with them and make the review a learning experience for all concerned. CHC team members have therefore, played the role of facilitators of a participatory learning experience rather than a topdown - outside evaluator.

S. Networking and Solidarity

- 52. CHC has been an active participant of all the current networks in the country. These include:
 - i. Formal coordinating networks like VHAI, CHAI and CMAI and their Karnataka based regional networks VHAK & CHAIKA;
 - ii. Issue based networks like LSPSS, AIDAN, DAF-K, AIPSN, VANI;
 - iii. Networks at Asian level like ACHAN;
 - iv. Thought currents and networks like mfc;

In solidarity, it has supported as many initiatives of all these networks as possible and has worked closely with many in specific partnerships and in solidarity.

- 53. From time to time, it has taken up specific leadership roles as well eg.,
 - CHC was the Convenor and publisher of the mfc and mfc bulletin 1984-86; (RN/TN)
 - ii. CHC team members have been on the Governing body of DAF-K, VHAK, INSA; (SPT/VB/TN)
 - iii. CHC team members have been on VHAI Educational Council; (RN)
 - iv. Chairperson of Malaria Expert Group of VHAI; (RN)
 - v. Participated and contributed to report of the Independent Commission on Health organised by VHAI 1994-96 (CHC was an associate).
- 54. For a few years, CHC also facilitated a Community Health Network in Bangalore bringing together all its contacts and resource persons for regular dialogue on issues related to Community Health. This network then moved from regular meetings to occasional ones and from general community health issues to specific ones that could be supported by definitive action initiatives like CHC's response to the Latur earthquake, Bangladesh cyclone, Uttarkashi earthquake, all of which were greatly supported by the Network. After a few years, the network became an informal network of associates, forming a multidisciplinary group helping CHC in its work (the CHC Associates Network).
- 55. Networks and collectivity building are important needs and CHC's involvement has shown that it is possible but not easily sustainable. Cultural factors like

dependence; inability to take full responsibility, institutional egos, agenda and styles of action; and power and prestige issues often prevent networking efforts from becoming very effective. In absence of true, democratic participation and ethos, these often lose their focus, their creatively their relevance. However, in today's climate of alliances - there will continue to be a need for increasing collective perspective generation and collective action. There is an urgent need for an alliance in Health which will work together and raise key issues of significance for the people especially in this growing climate of globalisation, privatization, inequity and market economic distortions of medicines and health care. CHC will need to seriously respond to this challenge.

T. BUILDING COLLECTIVITY IN LOCAL/STATE/NATIONAL EFFORTS IN HEALTH

56. From its very beginning and because of the involvement of some team members with the mfc network since 1980, and the evolution of the early, VHAI concept of a community health movement (1975) CHC has all along pushed for this process for this sort of commitment to collective functioning at all levels - local, state and national level

From the mfc convenorship; through the Bhopal work, the involvement in the RDP campaign; and all the way to the recent efforts of building on collective Indian perspectives on Malaria from the grassroots, CHC has tried to build collectivity.

57. The key collectivity building exercises/initiatives are

- * The Delphi survey was an effort to bring together the predictions of 40 key health and other professionals in the country;
- * The three meetings of the training network for VHAI, CHAI and CMAI were for the some purposes;
- The medical college project started with 4 medical colleges and built up solidarity and collective interest with 14 institutions by the end of the process;
- The Malaria expert group started with 6 expert members in the group but by the time the report was published there were 44 + reference group members who had contributed to the report.
- * Finally, the WHO policy process and the 5 city based meetings in New Delhi, Chennai, Secunderabad, Mumbai and Bangalore - brought together over 125 health projects and professionals to respond to the document.

However, a sustained collective effort to promote an alliance particularly propeople, pro-empowerment, pro poor, pro ethics, pro-equity, demystification, pro-health issue raising and lobbying are still a distant dream but perhaps a good millenium goal.

U. CHC SOCIETY PHASE II (1993-96) - New directions

- 58. In the beginning of 1993, RN & TN who had been co-initiators of the Cell, suggested that from the end of the year, they would like to take a long extended sabbatical break, to consolidate the perspectives of CHC and also provide space for alternative leadership and for new directions. From July 1993 till June 1996 this consolidation project was operationalised. Many interesting responses from the CHC team members and Society members to this 'opportunity' lead to a smooth transition into Phase II of the Society phase:
 - i. SPT who had been a part time resource person took over as full time coordinator and ably handled the leadership challenge;
 - ii. CMF and VB who had been members of the Society and helped to govern CHC in Phase I of the Society phase agreed to give time to the centre as consultants in Planning & Management and Information and Advisory Service respectively;
 - iii. Four new young team members were identified and the team was strengthened at the second level (RKN, AS, VJJ, ARS). Some team members joined to help the office (JN/AMC).
 - iv. A major shift in focus was towards grassroots training mentioned in Section L, Para 34 and described in detail in a complementary report;
 - The transition into Phase II was important because withdrawal of the full time co-initiators helped CHC develop new styles of growth and response without becoming too reliant on specific individuals and resource persons.
 - v. Some interesting features of this phase was that all CHC contacts continued to function with CHC and many new contacts developed. CHC grew in scope and function showing that the links were not personality centre.
 - vi. Staff development programmes looked at new dimensions with regular quality circles and staff transformation workshops including exploration of spiritual health and the creation of small work groups, etc.,

Many programmes continued and many new directions developed. These have already been included into "J" to "T". However, since the number of member level fulltime resource persons decreased, the overall burden on the new coordinator was rather excessive further complicated by the intensive travel commitments necessitated by field level training. After a 3 year period of providing alternate leadership, SPT decided not to continue and so CHC began the transitional phase 1996-97 prior to the next phase beginning 1998 - under new leadership once again (this time TN).

V. CHC Consolidation (1994 - 1996)

- 59. The consolidation phase or extended sabbatical that was operationalised by RN & TN from January 1994 till December 1995 consisted of many components:
 - i. Review and consolidation of CHC perspectives into monographs on community health and training (a task only partially completed);
 - ii. Short term formal teaching, and research / evaluation assignments;
 - iii. TN initiated a Doctoral programme at the Health Policy unit of the London School;
 - iv. Extended South-South and South-North dialogue opportunities because of the northern educational base;
 - v. Reflections on the future idea drafts on creative option.

60. The key events/initiatives of this phase were:

- TN's initiation of her Doctoral Policy on Public Policy Analysis of TB Control in India; linked to the Health Policy Unit of the London School of Hygiene and Tropical Medicine (LSHTM).
- RN was linked to Tropical Health Epidemiology Unit of the LSHTM as an Academic Research visitor facilitating learning session and workshops on CHC work related themes;
- iii. A critical study of World Bank Report WDR-93 (RN);
- iv. Lecture assignments in Scandinavia Bergen University (Norway) and Uppsala University (Sweden) (RN);
- v. Editorial Advisory board of AHRTAG newsletter Health Action (TN);

- vi. Three short term review of Indian partnerships for (a) Misereor (b) Memisa (c) Cebemo & ICCO (RN/TN);
- vii. Review of Malaria Control Programme in India ODA/Malaria consortium meetings (RN);
- viii. Planning of a short summer course on Health Research in Developing countries at the invitation of Canadian University consortium for Health and Development at McGill University (Montreal, Canada) for August, 1995 (RN & TN);
- ix. Participation in emerging Health Policy meetings in India, Women Health (WHO, New Delhi, February 1994), TB Revised Strategy (GOI/VHAI), AIDS Policy (CHAI, Bangalore, June 1994) (all TN);
- x. Opportunity to read/review wide diversity of health publication and interacting with northern/southern community health and public health colleagues and peers.

The key learning experiences of this phase have been circulated in a separate document.

W. CHC's initiatives in South-North and South-South Dialogue

- 61. Twice during the 14 years history of CHC, as explained in sections E & V, two team members of CHC (RN & TN) spend a year linked to LSHTM London. Both these years were an opportunity for South-North and South-South dialogue Lecture Discussions were held in various UK based health training institutions and NGOs on Community Health in India and related themes.
- 62. In addition, over the years, TN participated in an evaluation of CBH projects in Philippines; RN represented VHAI in a 5 country dialogue on Govt.-NGO collaboration (Indonesia, Philippines, Pakistan, India, Bangladesh) at Yogyakarta; RN lectured in Canadian Universities (McGill, McMaster and Dalhousie) and facilitated a workshop on Building Coalitions in Health at the invitation of Canadian Society of International Health; RN/TN lectured at Coady Institute, Antigonish; RN at Bergen University (Norway) & Uppsala University, (Sweden); TN attended the conference of the Network of Community Oriented Health Science Institute at Sherbrooke (Canada); SPT led teams to Bangladesh for cyclone relief; and Sri Lanka to help in the Tamil Refugee camps; RN also facilitated a workshop on State of India's Health at Aachen, Germany, at Misereor Head Office; and both RN & TN have provided policy reflection at Cebemo, Memisa, Misereor headquarters in Europe.

63. More recently the WHO Policy process document - Renewing Health for All had active CHC participation in many preparatory meetings. At Geneva, WHO-NGO dialogue (April 1997) (RN); at WHO Assembly - International NGO forum meeting (May 1997) (RN); at Geneva, meeting on Equity (September 1997) (RN & TN); at Helsinki, meeting on Sustainability (November 1997) (RN & TN); at London meeting on Poverty and Health (December 1997) (RN & TN) and on Business & Health (December 1997) (RN).

X. The Challenge of Mainstreaming

64. In the last two years, particulars CHC has begun to get invitation from Government to participate in policy reflection, evaluation and training strategies in Health. This new development in very significant because CHC is now getting opportunities to impact on mainstream health care providers, action initiatives and developing policy.

Some significant recent examples are:

- * Training of all medical officers of IPP-VIII MCH Centres in Bangalore in Management issues;
- * Review of Jana Swasthya Rakshak Scheme in Madhya Pradesh and organisation of a Peer group review of the Diarrhoea Control Mission in Madhya Pradesh;
- * Participation in the development of an IGNOU linked CME course for ANMs in the country;
- * Reflections on a Population Policy for Karnataka organised by ISEC and other institutions:
- * Involvement in restructuring of the MBBS course with Rajiv Gandhi University of Health Sciences in Bangalore, Karnataka;

Apart from being an opportunity to promote a paradigm shift in mainstream thinking, the opportunities also a challenge to CHC team to begin to make an impact on the system by small incremental changes from within. We need to be realistic in our expectations but even small percentage changes in attitudes, skills, , knowledge or perspectives can have major effects/impacts on the system.

Y. CHC Communications / publications

65. The CHC publication list, one of the outcome of the consolidation project shows that communicating ideas and perspectives has been a major contribution of CHC during the entire phase.

The topics covered have been Community Health, Health Policy, Health Human Power training including Medical Education, Rational Drug Policy and Rational Therapeutics, Alternative Systems of Medicine, Bhopal Disaster, Environment Health including Agriculture & Health, Child Health, Womens Health, Family Health, Disaster relief and response, Medical Ethics, CBR and more recently Malaria & TB among the communicable diseases.

The medium was primarily existing bulletins, magazines and journals which included EPW, Health Action, HFM, CMJI, Link (newsletter of ACHAN), mfc bulletin, Madhyam Journal, Annals of Community Oriented Education, Trends in Medical Education, Medical Ethics, bulletin, and so on.

66. As publication of CHC - there have been seven newsletter over the years but these have been mostly information on our work and some perspectives from the initiatives, circulated mostly to all our friends, associates, contacts and visitors to CHC.

The Medical Education Project resulted in three published reports and 2 photocopied reports and the CHAI study resulted in the Document entitled "Seeking the Signs of the Times".

More recently CHC has been having good interaction with medical persons and journalists and CHCs perspectives and concerns are being written about in Deccan Herald, Times of India, etc.

CHC team members have just begin to use AIR and Doordarshan opportunities to promote Rational Drug Use through DAF-K initiative.

Perhaps, lobbying through the media must be explored further in the years ahead.

67. CHC's collections of posters are used by NGOs for training, exhibitions, camps and jathas. These include our own informal productions and also collections from VHAI, CHETNA and other health education material producing organisations.

The only slide cassette set (now available as video) which CHC has produced in its 14 year history - is the popular Ramakka's Story - which has been used extensively in training programmes as a starting point to a discussion on Rational Drug Policy issues or Community Health issues.

Z. WHAT NEXT - on the edge of a Medtamorphosis

- 68. CHC's 14 year history and process has seen many challenging opportunities and interesting initiatives.
 - From a small team of 4 it has gradually become the Centre of a large network of Society members; CHC team members; CHC associates; CHC friends and CHC contacts
 - * It has a wide matrix of linkages and is involved with all the key health related networks or associations in the country.
 - * It has promoted the concept of a paradigm shift in health action and has promoted collectivity in Indian experimentation and initiatives in Health.
 - * It has explored Community Health and many of its dimensions through collective reflection, informal participatory training, interactive research and has tried to enhance the enabling empowerment dimension in action.
 - It has done all this through a small intensely involved catalyst team keeping a participatory management and a low cost, simple ethos and an open ended catalyst approach to requests and has been responsive to emerging needs.
 - All along it has tried to build up an increasing solidarity of collective action; an increasing commitment to developing counter expertise which is pro-people and rooted in Indian experimentation and perspective that has links with grassroots action.

69. Second line leadership crisis

CHC has reached the 15th milestone facing many challenges and responding to a wide range of opportunity. The continued involvement of the core leadership (RN, SPT. TN and earlier KG & MK) have made these 15 years sustainable even though there have been changes from time to time in the level of linkage by them, due to short-term burn out and or phases of further study. The support of the Society members especially 'the three wise men' of the experimental phase and all the others who are presently members of the Society, and the rich diversity of the multidisciplinary professional CHC associates network has been significant and the core leadership have been constantly supported, encouraged and stimulated by it.

Over the years (see Appendix) many other team members have joined for short term or longer term linkages, and time and effort have been spent to provide support and encouragement for some to seize the opportunity to become the core of the second line leadership.

However, a wide range of factors have contributed to this process not being sustained and all potential second line leadership have moved on to other options either due to career advancement plans, matrimony, or unable to manage the demands and challenges of CHC type work, which apart from its interesting opportunities also has its own insecurities and pressures.

More recently, in the last few years, with the development of the concept of Training/Research Associateships / and Assistantships, many young professionals and potential team members have operationalised short term linkages to find time and space to consider areas of common interest with CHC, and also to get to understand CHC's framework and structure.

We believe that we may just be on the threshold of the discovery of a new second line - that could gradually take over from the core first line, over the next phase. CHC has tried to address the 'insecurities' and related issues through new policies and new forms of linkages may be on the anvil.

However - the second line leadership issue remains a major concern of CHC, inspite of all our efforts. The challenge is to find a small group that is able to recognise the phenomenal potential and opportunity that the core team has experienced through the development of this interactive/responsive Community Health Oriented Cell and facilities over 4 phases and be willing to take it over and respond to the emerging challenges of the next millennium.

70. CHC has now reached an important 'milestone' - which is why the review has been initiated.

There are many options before it as it reaches towards the end of the millenum:

- 1. Continue the catalyst ethos and explore new ideas, initiatives, responses;
- 2. Metamorphose into a Centre for Community Health which builds on its 14 year experience and large and creative matrix of linkages and undertake more proactive training and policy research projects to impact on the mainstream system;
- 3. Facilitate the evolution of an Alliance of Health which is pro people, pro poor, pro equity, pro ethics, and which helps to harness evolving community health action into a peoples movement;

- 4. Do 1, 2 and 3 or combinations of them?
- 5. Do something else which is urgently required and very specific perhaps and which best draws upon its unusually responsive, interactive, collective experience?

AS WE MOVE TOWARDS 2000 AD AND HFA IS A DISTANT GOAL WHAT SHOULD BE CHC'S ROLE?

WHATNEXT?

CHC Team: Past - present - Future (in order of joining)

- 1. Ravi Narayan * (RN)
- 2. Thelma Narayan * (TN)
- 3. K. Gopinath (KG)
- 4. Krishna Chakravarthy (KC)
- 5. S. John (SJ)
- 6. Shyam Sunder (SS)
- 7. Shirdi Prasad Tekur * (SPT)
- 8. Mani Kalliath (MK)
- 9. M.S. Nagarajan (MSN)
- 10. V.N. Nagaraja Rao * (VNNR)
- 11. Raphael Udayakumar (RU)
- 12. M. Kumar * (MK)
- 13. S.J. Chander (SJC)
- 14. Xavier Anthony (XA)
- 15. C.M. Francis (Consultant) * (CMF)
- 16. V. Benjamin (Consultant) * (VB)
- 17. C. James * (CJ)
- 18. Nalini Gururaj (NG)
- 19. H.N. Vishwanath (HNV)
- 20. R. Murali (RM)
- 21. Reena K. Nair (RKN)
- 22. Anjana Srinivas (AS)
- 23. J.V. Jaimon (JVJ)
- 24. A.R. Sreedhara * (ARS)
- 25. Jayachitra Narayan (JN)
- 26. Aparna Chintamani* (AC)
- 27. H. R. Mahadeva Swamy * (MS)
- 28. Joseph Anthoniappa * (JA)

29. Rajan R. Patil * (RRP)

<u>Research/Training Associates/</u> <u>Assistants</u>

- 1. Magimai Pragasam (MP)
- 2. Johny Jacob (JJ)
- 3. Tomy Philip (TP)
- 4. Arvind Kasturi (AK)
- 5. Madhav Ram (MR)
- 6. Soumya Kumar (SK)
- 7. C. Mallu (CM)
- 8. Madhukar Pai (MP)
- 9. Rakhal Gaitonde (RG)
- 10. N. Devadasan* (ND)
- 11. Denis Xavier* (DX)
- 12. B. Murali (BM)

Volunteers

- 1. Sumangala Pai
- 2. Anupama M.C.

in team currently

() Abbreviation used in report

CHC Associates

- 1. Fr. Claude D'Souza * (CMF)
- 2. Dr. George Joseph * (GJ)
- 3. Valli Seshan * (VS)
- 4. Mohan Isaac* (MI)
- 5. M.J. Thomas* (MJ)
- 6. A. Arumugham *
- 7. H. Sudarshan* (HS)
- 8. Paresh Kumar* (PK)
- 9. Prof. S.V. Rama Rao* (SVR)
- 10.Dr. M.K. Vasundhara *
- 11.Dr. D.K. Srinivasa*
- 12.Ms. Vatsala Nagarajan*
- 13.Ms. Padmasini Asuri*
- 14.K. Gopinath* (KG)
- 15.Mani Kalliath* (MK)
- 16.Gopal Dabade
- 17.Prakash Rao
- 18. Vanaja Ramprasad
- 19.Uma
- 20.K.V. Sridharan

- 21. Saraswathi Ganapathy
- 22. Veda Zachariah
- 23. Pankaj Mehta
- 24. As Mohammed
- 25.Wg. Cdr. S.K. Krishnan
- 26.G. Gururaj (GG)
- 27.T.N. Manjunath
- 28.S.B. Pruthvish
- 29. Arvind Kasturi
- 30.Girish
- 31.Muralidharan
- 32. Kishore Murthy
- 33. Satish Rao
- 34.G.D. Ravindran
- 35. Sanjeev Lewin
- 36.Sukhant Singh (SS)
- 37.Dhruv Mankad
- 38.Madhukar Pai
- 39.Ravi D'Souza

^{*} Members of SOCHARA

CHC Associates

- 1. Fr. Claude D'Souza * (CMF)
- 2. Dr. George Joseph * (GJ)
- (3; Valli Seshan * (VS)
- 4. Mohan Isaac* (MI)
- 5. M.J. Thomas* (MJ)
- 6. A. Arumugham *
- 7. H. Sudarshan* (HS)
- 8. Paresh Kumar* (PK)
- 9. Prof. S.V. Rama Rao* (SVR)
- 10.Dr. M.K. Vasundhara *
- 11.Dr. D.K. Srinivasa*
- 12.Ms. Vatsala Nagarajan*
- 13.Ms. Padmasini Asuri*
- 14.K. Gopinath* (KG)
- 15.Mani Kalliath* (MK)
- 16.Gopal Dabade
- 17.Prakash Rao
- 18. Vanaja Ramprasad
- (19.Uma
- 20.K.V. Sridharan

- 21. Saraswathi Ganapathy
- (22. Veda Zachariah
- 23. Pankaj Mehta
- 24. As Mohammed
- 25.Wg. Cdr. S.K. Krishnan
- 26.G. Gururaj (GG)
- 27.T.N. Manjunath
- 28.S.B. Pruthvish
- 29. Arvind Kasturi
- 30.Girish
- 31.Muralidharan
- 32. Kishore Murthy
- 33. Satish Rao
- 34.G.D. Ravindran
- 35. Sanjeev Lewin
- 36. Sukhant Singh (SS)
- 37. Dhruv Mankad
- 38.Madhukar Pai
- 39.Ravi D'Souza

^{*} Members of SOCHARA

THE CHC REVIEW (1984-97)

(A celebration and group reflection at the 15th milestone)

Date

: 3rd and 4th April, 1998

Venue

: The Brothers of Holy Cross, 47, St. Mark's Road, Bangalore - 560 001.

Time

: 9.30 a.m. to 5.00 p.m. (both days)

Participants

1. All members of the Society for Community Health Awareness,

Research and Action

2. Invited team of Reviewers

3. Some CHC Associates

4. CHC team - Past and Present

PROGRAMME

DAY ONE		
3rd April (Friday)	THEME: Learning from the Past and Present	
	SESSION I - Introductory session Chair Person : Fr. Claude D'Souza	
9.30 a.m.	Invocation Welcome and background to Exercise Self introduction by Participants	VB
10.00 a.m.	The CHC at the 15th Milestone (An overview of 1984-97)	RN
10.30 a.m.	Clarifications	
10.45 a.m.	Tea	
	SESSION II - CHC: Some Vignettes Chair Person: Dr. D.K. Srinivasa	
11.00 a.m.	Overview of interactive Research - issues and challenges	TN
11.30 a.m.	Comments and clarifications	
11.45 a.m.	Urban Health Initiatives	SJC
12.00 a.m.	Rational Drug Campaign	DX
12.15 p.m.	Integration of Medical Systems	RRP
12.30 p.m.	Comments and clarifications	
1.00 p.m.	Lunch	
9	SESSION II (Contd.) Chair Person : Dr. V. Benjamin	
1.45 p.m.	 Training - middle level and field level Participatory Evaluation 	SPT SPT
2.15 p.m.	Comments / clarifications	

2.30 p.m.	Building the alternative paradigm collectively	RN	
3.00 p.m.	Comments and clarifications		
3.15 p.m.	Tea		
	SESSION III: CHC Management: An overview Chair Person: Ms. Vatsala Nagarajan		
3.30 p.m.	Organisation for Catalysis	CMF	
4.00 p.m.	Financial Management	MK / KG	
4.15 p.m.	Staff Development	AMC	
4.25 p.m.	Library & Documentation Unit	SJ	
4.35 p.m.	Comments and clarifications		
	(End of Session - 5.00 p.m.)		
DAY TWO			
4th April (Saturday)	THEME: Reflections, Critiques and Directions for the Future		
	SESSION IV - The CHC Experiment: Reflections, Critiques Chair Person: Dr. C.M. Francis		
9.30 a.m 10.45 a.m.	All Reviewers / Participants		
10.45 a.m.	Tea		
11.00 a.m 12.30 p.m.	All Reviewers / Participants		
12.30 p.m.	SWOT Analysis by CHC team	DX	
1.00 p.m.	LUNCH		
	SESSION V: Scenario Building Together Chair Person : Dr. H. Sudarshan		
1.45 p.m. to 2.15 p.m.	Scenarios from various initiatives of CHC	RN/TN/SPT	
2.15 p.m. to 3.00 p.m.	Comments and suggestions	All participants	
3.00 p.m. to 3.30 p.m.	Tea	*	
3.30 p.m. to 5.00 p.m.	SESSION VI: Concluding Session Chair Person: <i>Dr. Mohan Isaac</i> Priorities and Directions for the future	All	
		participants and CHC team	

COMMUNITY HEALTH CELL BANGALORE

REVIEW

DRAFT FOR DISCUSSION

Amar Jesani Mumbai

September 18, 2004

The report is divided into the following sections:

- Terms of Reference
- Methodology
- Findings pertaining to Terms of Reference and any other relevant observations
- Discussion on some crucial issues in the priority concerns of the organisations
- Suggestions for the way forward

Acknowledgement: My sincere thanks to all who cheerfully spared time to share with me their experiences with and the views on the CHC, at my convenience. My thanks also to the staff of the CHC who made my stay and travel in Bangalore comfortable.

TERMS OF REFERENCE

A team of two external persons were supposed to undertake this review, but one of them could not join the team. Thus, with the cooperation of the team members drawn from the SOCHARA, this review was completed.

The Terms of Reference for the review very broad and all encompassing. Although they provided free hand to reviewer, all issues in the terms of reference could not be adequately dealt with in the review process. The Terms of Reference were as follows:

- 1. The philosophy in founding the Community Health Cell. The objectives at that time. Modifications of the objectives what, why, when? The present objectives. To what extent have these objectives been achieved?
- 2. The organizational structure of the Society (CHC). Is this optimal to achieve the objectives? Modifications, if any, needed to achieve the objectives better. Recruitment of Staff, training and re-training. Staff development programmes and their usefulness. Staff turnover. Staff satisfaction. Is the organization democratic / decentralized in its functioning? Is there a system of planning, monitoring and evaluation of the functioning of the Society and taking action on the findings?
- 3. Strengths, weaknesses, constraints and opportunities. Have the strengths and opportunities been utilised to achieve the objectives? How have the constraints and weaknesses been reduced / overcome?
- 4. Values and life styles of the Society members and team. Did they have any impact on the functioning of the Society and on other organizations / people? If yes, how?
- 5. Important programmes of the Society (CHC) and their impact local, state, national, international. Involvement of the Society in advocacy and networking with other organizations governmental and non-governmental; experiences and learnings from them.
- 6. Quality assurance in the activities of the society. What are the procedures in place to assure quality? What steps are needed to assure better quality?
- 7. Society (CHC) as a learning organization. How has the Society (CHC) utilised its programmes for learning by the members / staff and in creating awareness leading to action among the people on the health related problems?

- 8. Contributions of the Society (CHC) to equity, social justice, environmental and gender issues, intersectoral action, community organization, mobilization and participation and empowering the people, especially the disadvantaged.
- 9. Contributions of the Society (CHC) towards health planning and policy formulation of the state / country. Involvement with the Panchayati Raj institutions at the district, Taluk and village levels.
- 10. Have there been innovative, creative contributions made by the Society (CHC)? If yes, what is their impact?
- 11. Education/training: what has been the involvement of the Society (CHC) in training and education in Community Health? Public Health? Is there a need for greater involvement? If yes, how should this be done?
- 12. Management of finances of the Society (CHC). How can we ensure financial sustainability in the long run?
- 13. Factors, which facilitated the Society (CHC) to work as a team. Suggestions to enhance teamwork.
- 14. Recommendations for improved functioning of the society and suggestions for new directions.

METHODOLOGY:

- 1. The SOCHARA made available the documentation of last 20 years, starting from it inception 1984. The documentation included reports and publications of the CHC, from 1991 onwards the minutes of the meetings of the SOCHARA and the executive committee minutes, the financial information of last five years, the documents pertaining to work plans, the previous review of 1990 and 1998, various writings related to the CHC and its work, the newsletters of the CHC, rules and regulations of the society and so on. All of them together run into over 1000 pages of documentation. The reviewer spent lots of time going through the documents, though selectively, in order to get a fair idea of the mission and history of the organisation.
- 2. An internal review of the CHC by the staff was undertaken between April and November 2003 in five meetings. A draft of the internal review report was made available.
- 3. A mailed survey of opinion of members of the SOCHARA and associates; was undertaken by Dr. Mohan Issac, president of the SOCHARA. 27 individuals responded to this questionnaire. A summary of their responses was made available to the reviewer.
- 4. Starting from January 2004 at the World Social Forum, the reviewer conducted a series of interviews with the individuals presently working at the CHC, those who have left the organisation, those who associated with their work in some capacity, some of the members of the SOCHARA, some individuals and organisations who have associated with the CHC/SOCHARA from time to time in collaborative work and one meeting with the Bangalore based field workers involved in field based project of the CHC. Two individuals were interviewed using email and telephone.

The following individuals were personally or on email/telephone interviewed in this process:

Those presently working with or associated with CHC:

Dr. CM Francis,

Dr. Thelma Narayan,

Dr. Ravi Narayan,

Dr. Paresh Kumar,

Ms. Sylvia,

Mr. Prasanna,

Mr. Krishna Chakravarthy,

Dr. Mohan Isaac.

The CHC administrative staff in groups – Ms. Noreen, Ms. Deepu Shailaja, Mr. DG Srinidhi, Mr. James; Dr. Rajendran

Those who have worked in the past (full-time, part-time or associated in some capacity), collaborated in some work, are presently collaborating, members/associates of SOCHARA, etc:

Dr. Anant Bhan,

Dr. Sabu George,

Dr. Rakhal,

Dr. Naveen,

Dr. Abraham Thomas,

Dr. AR Shreedhara,

Fr. John Vattamattom,

Fr. Tom (CHAI)

Dr. Mani Kaliath,

Dr. Nirajakshi (Karnataka VHA),

Dr. Shekha Sheshadri,

Dr. Girish Rao,

Dr. LC Jain,

Dr. Rajagopal (NIAS),

Dr. DK Srinivasa,

Dr. Unnikrishanan,

Dr. H. Sudarshan,

Dr. As Mohammed,

Dr. Danis Xaviers,

Dr. Sanjiv Lewin,

Dr. Shirdi Prasad Tekur,

Ms. Valli Seshan,

Dr. N. Devadasan,

Dr. Rajan Patil,

Dr. Sampath Krishnan,

Mr. Anant Padmanabhan (GreenPeace, India)

Totally over 40 persons were interviewed, some of them in more than one sitting while some were interviewed for only few minutes.

A brief note on my experience in the review process: A few important issues must be put on record so that the findings and the over all report of the review is better appreciated:

(a) I know CHC for last more than 20 years now. I have been its admirer and at the same time, as it is my researcher's temperament, its critic. One's respect, personal friendship with the leading group of the individuals, etc could become some handicap in objective assessment of the task at hand. I did feel some conflict of interests or to put it better, some amount of confusion and tension, and emotional turmoil while doing this work. It

often slowed me down, and at least once made me to question myself the wisdom of accepting this work.

- (b) My work was made bit more difficult by the fact that many of the informants or respondents whom I interviewed were also known well to me, though not as well as Ravi and Thelma are. They trusted me and tolerated my way of interviewing. I often became very provocative, taking position of devil's advocate in order to make the informant give the best response on the topic. They mostly tolerated this, and gave me as frank information as possible. More than once I was told that they were giving some sensitive information or view simply because they trusted me, or thought that at least I would bring it make note of it in my report. I do not know how far I have succeeded in giving representation to such points, but surely such information made me to work and think overtime to judge about how to assess and interpret such information.
- (c) Lastly, I noticed discrepancy in the responses given by individuals to me and in their opinion given in writing to the organisation. This was partly due to the fact that in personal discussion one tends to elaborate and explain better than in writing brief responses to questions. But in four cases there was major variation in the content, making me uneasy about what to use as authentic. Ultimately I decided to use the information provided to me in interview or on email as authentic position of the individuals and I have used the same in the report.

FINDINGS IN RELATION TO TERMS OF REFERENCE

(A) PHILOSOPHY AND VALUE SYSTEM OF THE ORGANISATION, VALUE AND LIFE STYLE OF MEMBERS:

These aspects of the CHC/SOCHARA are considered to be its greatest strength. On scanning through the documents from the very inception of the organisation, there is constant explicit commitment to certain type of the organisational philosophy and the value system. Under the rubric of philosophy and value system one finds several things mentioned. The philosophical understanding of voluntarism and its necessity, the way one looks at the health issues - the social paradigm of health, the appreciation and faith in collective community actions, participatory way of functioning, non-hierarchical relationship, commitment to equity and empowerment, and so on. My first discovery while interacting with many individuals during the review was that these terms were used by most of them, but their meaning was understood differently or not understood at all. A part of the problem is that these terms are very general, with omnibus meanings. Voluntarism, participation, non-hierarchical relationships etc. need rigorous discussion and consensus development on how they are operationalised in the CHC's international functioning, work and in its relationship with other organisation. Keeping this in mind, I probed only few elements of philosophy as they were viewed as well as perception of their actual operation at the organisational level.

Voluntarism:

I got different meaning of voluntarism from the SOCHARA members who are not working in the CHC than those individuals who work or worked in the past as full time staff. This was in a way natural and found so in many NGOs. The SOCHARA members are either professionals involved in their own work or come from more institutionalised NGO background or are retired from some such work. On the other hand are those staff members of the CHC, who are not or were never a part of the SOCHARA. With a few from each category I had some discussion on this aspect, with the rest such issues came up by chance or I was enlightened indirectly.

I could discern three levels of understanding of the voluntarism. The first level was more at the individual level, wherein I was told why it was necessary to get involved in some voluntary activity while being engaged in one's own mainstream work. The justification for that ranged from religious to simple need to derive satisfaction and give back something extra to the society. At this level, there was deeper commitment to the individual morality. The second level was more political, and associated it with the need for social change. The voluntarism was to undertake activities, both professional and political, that could lead to some impact on changing, for better, the lives of the deprived. And third level was more pragmatic, and looked at the voluntarism as a part of more satisfying career choice. At this level the responses ranged from the idea of assisting

those who were doing good work, to attraction for involving in organisation that was not bureaucratic, allowing some initiative and experimentation of new ideas. No individual responded only at one level, all of them used points that partially overlapped at least with one more level. Interestingly, one relatively new staff member felt very sad that in the NGO sector the staff were becoming more of full time functionaries and losing their spirit of voluntarism. The voluntarism as non-remunerative, altruistic and purposive action came more from those who did not depend upon the CHC for their basic survival or who had other sources of income.

At another level, there appeared to be some amount of conflict between the work as professional commitment and voluntary activism. The professional staff, most of them interviewed not presently working with the CHC, expressed more dissatisfaction to voluntarism that misguidedly reduced the professional commitment to work and ideological orientation that prevented balanced appreciation of evidence. On the other hand, one former professional staff and one present staff lamented about increasing orientation of the CHC to research, projects and professionals at the detriment of voluntarism and activism. These two diametrically different perceptions flow from the dilemma of transiting the CHC to be an institution in last five years.

The voluntarism in terms of organisational activities is evidently very high. This is because of its foundational principle of being catalyst. As a consequence, last two decades of the organisational work show tremendous awareness of responding to disasters — both natural and social, responding to smaller and rural organisations — whether working as organised groups or as informal voluntary group on wide variety of issues — health as well as non-health, professional support to various social groups and movements, participation in democratic rights and human rights movements and groups, etc. etc. Such activities were evidently taken up irrespective of having specific projects on such subjects and at the risk of over-burdening the staff with multiple activities. Thus, irrespective of how individual members of the organisation perceive voluntarism, one gets strong impression that organisation as such is not driven only the funded projects but by certain commitment to voluntarism.

Participatory:

Similarly, the appreciation of the term participation was different among the SOCHARA members from the staff, and within staff there were perceptible difference between the administrative and non-administrative staff. Before I go into details of responses, it must be said again that discovery of differences is not new; it has been there in most NGOs. There is bound to be variation in the understanding of the initiators of the NGOs and those who join later on, the variation is also related to one's ideology, with the position one has in the organisation and the aspiration. What is important is the consciousness that such participatory method is considered good and desirable, and such consciousness was very strong among all interviewed.

The members of the SOCHARA either looked at the participatory functioning as the most suitable way or they assumed that that is how, broadly, the CHC is functioning. Within the CHC, the participation is looked at as ethos and process; and not as systematic component of organisational structure. At the heart of participatory processes and structures is the willingness to promote participation, so in a way it is difficult to judge whether one should rely more on processes or structures. However, a combination of the two is an ideal situation but difficult to sustain.

In the CHC I discovered that all people I met testified to the participatory functioning of the organisation. The responses ranged from defining participation as consultation by the seniors with juniors to participation in decision-making. The former was stated by all while the latter was mentioned by only a few persons. The critical elements in my discussion with the staff on issue of participatory functioning were high level of appreciation for discussing issues with as broad a layer of individuals as possible, so much so that there were criticism of being too consultative and thus wasting time in meetings on one hand, and on the other hand some disquiet on the way decisions were made, the criteria used for decisions taken, opinion of the person not finding echo in the decisions, etc. However, there was general appreciation of the fact that some space exists in the organisation to question decisions or have a discussion on the subject. Some individuals in discussion mentioned their unhappiness about certain decisions but at the same time were very clear in their appreciation of openness and humility that exists in the decision- making bodies.

Some disturbing comments were also received. A non-staff member who, while appreciating greatly the commitment to participatory way of functioning, informed that he had heard from others as well as from some junior and senior staff members that decision-making in the CHC was too centralised in the hands of one or two persons and that there was one individual pulling strings from behind those two decision-makers. However, he refused to give his source, and since no staff member mentioned it to me despite my probing, I was not able to validate this information.

A former senior staff member felt that organisational environment was not conducive to the articulation of problems of the staff as it was looked down upon as trade union activity, and as a consequence, some of the staff members could never make their grievances or views heard. He also felt that there was not much encouragement to bring together staff on non-work basis – like picnic, cultural events. At least two other persons – one former staff member and one who spent few months there getting initiated to community health made critical remarks of the issue of participation. One of them called the environment paternalistic, and thought that it was useful to begin with but as one grew on the job, it started stifling. Another called it paternalistic and condescending, and thus, participation was at the mercy of the need of the top leadership rather than as a need of the staff. These three and two others who had worked with the CHC (as staff or as trainee), and one senior staff member commented about the lack of autonomy in work, and that being justified as the need for participatory functioning.

Political philosophy:

There two essential elements among others that characterise SOCHARA/CHC's political philosophy, viz. community orientation and social paradigm of health. Both these elements are very broad, their meaning need to be upgraded based on the accumulation of empirical data and their practical application tested in specific contexts. Going through the work of last two decades, I get an impression that the CHC has operationalised its philosophy in three major ways:

- a. Promoting and providing inputs to the NGOs and individuals for voluntary action, for undertaking different kinds of work at the community level and by motivating them to deepen their commitment to community work. The CHC functions related to catalyst role, networking, grassroots (community-based NGOs and others) training etc, fall in this category. However, it must be noted that the CHC has not opted for its own long-term area specific community work.
- b. The social aspects of illnesses, social-economic conditions affecting health and illnesses, promotion of healthy practices, etc. have been taken up both for research as well as educational campaigns and training.
- c. While general critique of the health service system and commitment to primary health care were integrated in the social paradigm from the beginning, their expressions were nebulous in relation to the health service system. In last few years, the CHC has made transition from generality of critiquing health system to touching basic contours of the system and design its research and advocacy plans around them.

Generally, there seems to be a dynamic development of political philosophy – from a voluntarist critique and civil society efforts to training and consciousness-raising to a more system research and change approach. If one takes this dynamism as a break from the past than one is likely to conclude that CHC has radically changed its philosophy, but if one looks at it in a more integrative manner than it can also be said that the CHC is making efforts to strike balance between the three. It is not possible to pass definite judgment on the situation as of now, the dynamic of further development in coming time would make clear the real trajectory.

While evolving will be seen by some as radical change in priority, I believe that evolve one must. There is not doubt that health and health service system is more complex and cannot be simplistically explained. The terms such as de-professionalisation needs to be examined more closely and weighed against the strategy of regulated and ethically committed profession. Similarly, demystification needs to be related to people's and patients' right to information and patients rights within the health system. Thus, while the basic political philosophy of the SOCHARA/CHC is not outdated, the need for its

dynamic interpretation and application in changing situations must be appreciated and should be looked at as a positive part of the CHC.

As against this interpretation of mine, there are few strong critical remarks on the political philosophy needing mention and discussion. These remarks can be grouped in two categories. The first category remarks show extreme alarm on the CHC fast discarding its "community orientation" "training role", "grass-roots activism" etc in favour of the "health policy" orientation. The second category of remarks are from other extreme, show dissatisfaction over the CHC's refusal to shed its "ideology" in favour of "evidence-based public health", refusal to change the language and priority of work, and criticise the CHC for having half-baked, hesitant (vacillating) approach to professionalising its work. Interestingly, the SOCHARA members are divided on this issue — a few making remarks in each category, but the former staff members from professional category (except one) and some trainees all made comments belonging to the second category.

Indeed, the political philosophy will be more under scrutiny in coming time. It therefore makes necessary that the integrative character of development emphasised. More work needs to be done to ensure that wrong perceptions do not generate destructive debates.

Others issues related to value system:

Talking to some of the senior members of the SOCHARA I was deeply impressed by their concerns such as commitment to such mundane things as simplicity and cleanliness, readiness to do any work, the concept of living wages – looking after the needs rather than greed, strong concern for reducing gulf between the intellectual/specialised and manual/unskilled works, not allowing the ratio of remuneration to the lowest and the highest category of staff to exceed 4, non-hierarchical relationship and functioning. All of them, I am told, are parts of the foundational values of the organisation, and efforts have been made to operationalised them over all these years.

Evidently, operationalisation of such values was not found to be so easy. In last 20 years they were experimented, discarded or modified. For instance, the idea of reducing the gulf between intellectual and manual work is not attainable in any organisation unless we are able to create condition where basic minimum education and skill of all staff is same and very high. Such situation may provide and objective basis for not having division of labour in the traditional way (manual vs intellectual). Overcoming such division of labour through voluntarism in an organisation is not only unsustainable, it could also make organisation authoritarian by forcing those who are not convinced about it. Thus, certain values may look attractive in terms of personal morality, it is difficult to make them ethical code of the organisation without creating pre-condition for making them practical and sustainable.

While I think that value such as promoting equity by ensuring appropriate ratio of basic pay between the lowest and the highest salary is both appropriate and to certain extent sustainable, we need to review it regularly to ensure that organisation does not lose good professional due to that policy. The staff and ex-staff members of the CHC are divided on this issue. The professional staff is critical of this policy as they find that it is a hindrance to paying higher salary to them, the staff at the lower level find it a good policy as they get salary at the level higher than available elsewhere. This criticism of the operationalisation of value CHC considers important is going to only increase.

The sustainability of this value is directly proportionate to three critical factors: (a) Having senior professional staff with commitment to working at low salary or they have other family sources not requiring good salary. (b) The CHC is looked at and used only as the administrative support base of for the otherwise full-time employed professionals in the SOCHARA and thus the CHC not having any paid full-time professional staff. (c) By technologically upgrading the work system so that the low paid non-professional staff is not required.

All three options are difficult ones. In the (a), almost all NGOs have found difficult to get professionals not needing "decent" salary. Adhering to this factor has either made the founders as the only professionals in the organisation or they have attracted only the spouse of well-paid professionals or businessman looking out for semi-voluntary employment or they have attracted retired professionals. This inevitably pushes out the professionals hailing from lower strata. Such individuals would be there to use the organisation as stepping stone for higher jobs. The strategy (b) would change the CHC from functional centre of the SOCHARA to its administrative centre. And (c) would make the CHC without peons/office assistants and secretaries, thus demanding technological up-gradation – a debatable value in itself in the SOCHARA.

I found the issue of technology, location and space as value related considerations as part of value debate in the SOCHARA/CHC as somewhat misplaced and extreme. I believe that practical considerations rather than moral should be applied on these issues. The politics of technology or ideological underpinnings of technology and technological change should be separated from the appropriate practical use of technologies and space.

Lastly, the issue of life style of individual members is problematic. There are over 30 members of SOCHARA, and then we have staff members of the CHC. There is no way to find a uniform consideration in the way each member lives his or her life. There are also variations in the extent of social and family support each one enjoys, as that could be important consideration for taking risk in life. And at another level, it is difficult to determine the appropriate standard or level of life style that could be adequate for the value system of the organisation or for the simple middle class living in present-day urban jungle of India.

Summing up:

Issues related to philosophy are not easy to resolve. More so if the philosophical considerations and values; are eclectically put together. Somehow I kept getting a feeling that the list of values to be followed is too long, too eclectic, not having a coherent structure or being part of one theoretical position. This was less problematic when the organisation was small, was trying not to be become an institution, did not require more professional staff for undertaking projects, etc. For at the time, the value system was judged more in terms of its founder's or Ravi/Thelma's value system rather than value system of all members and staff. With the SOCHARA growing into big organisation (over 30 members) and expansion of staff and work of CHC, the longer list of values and philosophical considerations is going to keep creating problems. By narrowing down the focus and ambition of the CHC it may be possible to provide better coherence to value system and bring down number of values to be universalised within the organisation. Lastly, it must be kept in mind that all values cannot be and should not be legislated as rules within the organisation. Just as some people call laws as minimum ethics, the rules of the organisation should also be looked at as minimum value or only those values necessary to be universalised for the socially useful and efficient functioning of the organisation. The rest should be left to the commitment and goodness of individuals.

(B) ORGANISATIONAL STRUCTURE

The factor of structure is very important in keeping organisation alive to newer challenges, impersonalise it by making it a public space and by ensuring a system of participation. My first glance impression of the structure was that it was very weak and traditional. Later, my detailed examination of it only provided confirmation of my feeling. It is not surprising that unconventional thinking and work by NGOs in our country are often carried out in an organisational structure that is very conventional. But this produces imbalance and keep creating its own crisis. So one needs to pay more attention to the structure and be innovative in evolving something more appropriate to the work for which the organisation is created.

Another important fact is the organisational processes, and there is dynamic relationship between the structure and processes. Those who do not see structure and processes as inter-dependent, normally pay more attention to processes rather than structures. Besides, structures would be virtually empty and useless if there are not good processes to make them workable. The problem with the emphasis on the processes without structures is that they could appear and get perceived more as top-down, benevolent and paternalistic. The structures with good processes help in making the power-relationship explicit and good structures could help in distributing power in such a way that it allows more initiative and development of new leadership or political voice.

The organisational structure of the SOCHARA/CHC is very simple and based on the legal requirement of the society. In that sense the organisational decision making structure is basically that of society rather than CHC. The general body of SOCHARA elects the executive committee and the secretary to the executive committee also works as coordinator/director of the CHC, the functional unit of the SOCHARA. Since within the CHC the structure is only around the job designation or position accorded to each staff member, the participatory functioning and participatory decision-making are left to the processes sustained through coordinator's initiative.

General Body:

All members of the SOCHARA constitute the General Body. It has 34 members. For last few years the SOCHARA has been making lots of efforts to expand its number by motivating individuals to join the society. The membership appears to be drawn from three constituencies. The first one is its core-constituency made up of those who have been associated with the society from its inception or for very long time. The second constituency from where members are drawn are the peer and network groups, the long time supporters and participants in the training and other programmes. The third section is made up of the former CHC staff members, trainees, associates and others.

The annual general body meeting of the society, as compared to the number of members, is not well attended. A quick look at last ten years of the annual general body meetings show that the attendance was from 60% to 30% of the total membership. The core team of 7 to 10 individuals has been consistent in attending the meetings and also in sharing the responsibility as Executive Committee members. This consistent low attendance could have been one reason why the SOCHARA tried to recruit more individuals in its general body as members in last few years. However, the attendance has not improved.

The efforts to get more people involved and take responsibility in running the society are laudable. In every organisation there is always time when one needs to think in terms of getting fresh blood and new ideas. However, it needs to be kept in mind that such initiatives must be well planned and membership offer should be based on mutual compatibility as appreciation of the responsibility for being a member. Besides, in a society having lots of people who are otherwise very busy in their own profession and activities, it will be impossible to find a time convenient to all for the meeting. So a smaller body would provide more flexibility in arranging meetings at the convenience of all. Thus, it would be much better to look for replacement of members who are retiring and not able to take more responsibility and the new entrant's membership must be accepted only on the promise of discharging some minimum responsibility.

There is one more reason for exercising caution in expansion of membership. The SOCHARA/CHC are not activist organisations, though some amount of activism they undertake as a part of their activities. They are essentially institutions or establishments with full-time jobs at stake, high budget raised through grants and stakes in terms of at least moveable properties, instruments, books and so on. Add to that an impressive history of twenty years of work. For such establishment it is necessary to ensure that its chief governing body is trim, active and involved. There are also examples – several of them in Western parts of India – where the establishments run by societies have been taken over by the members who made slow but deliberate entry.

Thus, those members not meeting minimum requirement of discharging responsibilities should be allowed to drop out and the entry may be restricted to only those who make commitment to provide minimum inputs in the society's work.

Executive Committee:

The executive committee is the real day-to-day decision making body. It is exclusively made up of the members of the SOCHARA elected on this body at the AGM and has tenure of three years. With strength of seven members, it is natural that a big majority of the core and regular members of the SOCHARA work as EC members.

First of all, the attendance at the EC meetings is fairly good showing that the core-regular members of the SOCHARA are deeply interested in the work and welfare of the CHC

and all other activities of the society. Second, the frequency of the meetings is as per the legal requirements. Minimum two meetings in a year do take place, in a few years the maximum number of the EC meetings is four. Three, the minutes of the meetings show that EC carries out a wide range of decision-making. It decides on all major policy issues related to the work of the CHC and the SOCHARA, receives reports of work carried out the CHC and takes decision on it; and at the lower level takes or ratifies decisions on simple administrative matters like sanction of rejection of leave application and other problems. Between two meetings, the secretary, who also works as the coordinator of the CHC, is empowered to take decisions on the routine matters and also take initiative, with the aid of staff and others, new activities; but the same are reported at the EC, discussed and ratified.

The EC as a decision making structure in the period between the General Body meetings seems to have worked well for the SOCHARA. The general acceptance of it in the staff of the CHC has something to do with the processes in which care is often taken to invite staff members for discussion during the EC meetings. At the same time in my discussion with a cross section of the staff and former staff members about it in last five years has elicited some responses that need to be addressed to. The administrative staff has been finding itself in some disarray of late because of the sense of insecurity generated by the uncertain future of the organisation or due to discussion on the re-organisation. Somehow, the message from the EC has not been clear enough to allay some of the problems of theirs or they are not able to articulate their problems or they are finding themselves not fully competent to the new tasks coming in the way. My collective discussion with them could not generate enough material to pin point the problems except a statement saying that they are not trusted enough, but their problems, if they are significant, are worth looking at. In any case more needs to be done to tackle this issue of trust as it has been articulate.

Some of the former staff members have also raised issues related to the considerations that go in making certain decisions. The former professional staff also aired some similar issues. One area they showed lots of concern was that criteria used for judging their competence and contribution. For instance, at least two former staff members said that one the reasons they left was related to non-appreciation of their competence to represent organisation in meetings, particularly national and international meetings. They also raised issue that such decisions normally favoured the SOCHARA members for representing the organisation while they were actually working on the subject on which such meetings took place.

The critical remarks on the decision making process throw some light on the need to work out a structure that has formal representation of the CHC staff and at least strengthening the inter-phase between the SOCHARA and the staff. This issue will keep becoming critical as the CHC expands its activities (as it is doing now) and more professional staff keeps joining.

The CHC Staff:

There are several structural and functional issues related to the staff raised by individuals I interviewed. Most of these issues take into consideration only last five-years as they seem to have come more forcefully with the expansion of the project based activities and community health training.

Two issues discussed above are found to be important. (1) The issues of formal representation of the staff in decision-making process to ensure that there is wider clarity and understanding of the decisions among the staff. This does not mean that informal processes of the consultation with the staff are weak, on the contrary, they are very much there and consultations and their democratic nature are acknowledged by most, but that has not overcome the uneasy feeling about that decisions and the justification for decisions taken. It might help to formalise those processes so that participation does not look selective. (2) Structurally it is important to demarcate the areas of direct involvement of SOCHARA members in the work of the CHC and the areas where the CHC-staff has full autonomy to represent organisation (CHC and not the SOCHARA) and autonomy to design and undertake activities. This demarcation should go hand-in-hand with the strengthening of the inter-phase between the SOCHARA and the CHC so that there is a formal forum for interaction and resolution of problems cropping up.

Other issues raised in interviews are as follows:

- (a) Some of the former senior, professional staff has found the designations used problematic. The designation as Fellow was found to be less useful while working with the outside organisations and they felt that better designations are needed so that they could help them in facilitating their work.
- (b) The issue of right mix between the project work and general work underpinned some of the discussion. While nobody opposed the idea that project staff should also be undertaking other works, there was some amount of disquiet on how that could be achieved. Issues like the projects also flowing from the core concerns of the organisation, the mix should not be looked at administratively in terms of number of hours put in for each activity but in terms of the extent to work put in on the topic of the project beyond the work committed in the project proposal, how and who decides the work that is project-based and general, etc were mentioned. This does demand not only some clarity but also consensus among the staff.
- (c) An indirect mention of the way projects are formulated and their connection to the overall plan of organisation development made both by some SOCHARA members, peergroups members and present and former staff. A muted concern whether the project would be taken on the basis of availability of money from the funders or they would be evolved as a part of the raising funds for the short and medium term activities planned was also raised.

- (d) Several people raised the issue of second-line leadership and lamented on the structures not being conducive to development of such persons. A few were outright looking for motives for "not allowing second-line of leadership to develop", while all others (big majority) were more understanding about the problems of developing and retaining second-line of leadership in the NGOs but wanted more reforms to ensure that such leadership develops at the earliest time. Interestingly both the groups generally were of the opinion that such leadership would evolve only through better planning, positioning of individuals in the organisation, provision of autonomy in work and more tolerance to different ways of doing things. The former on the other hand articulated need for more institutionalisation, representation in decision-making, professional approach to work and better salary structure to retain emerging new leaders, the latter group was more reticent in talking about such issues but wanted such second line to develop by paying extra attention to the task within the existing structures.
- (e) The coordinator has decision-making powers between two EC meetings, and some of the major decisions by the coordinator are reported to the EC, discussed and ratified. Much of the criticism on the decision-making of the coordinator reported was related to the style of functioning, and so comparison between the past and present coordinator. were at that level. While I did suspect some motives in some of the responses particularly those that made comparisons, I chose not to confront but accept them at the face value as it is always very difficult to have individuals with same style. At least one former professional staff while airing criticism of style, on his own admitted to the humility and transparency, thus dismissing the ideas of motives. My inference is that much of such criticism came because of three reasons: (1) the tension between direct organisational commitment and desire for autonomy at the level of work, (2) inadequate appreciation of the deadlines for completing tasks and accountability to the funders, and (3) strong disapproval of quick administrative measures without allowing the process of negotiation on the problem at hand. Structurally, one of the ways to reduce (they can never be fully stopped) such problems related to style is to have a small formal committee of drawn from the staff to assist the coordinator so that such tricky decision as wider support within the staff and at the same time the coordinator retains both the veto power as well as emergency power to make decisions.

My own feeling while going through responses on the organisational structure is that the complexity of the evolving work and organisation demands more formal involvement of the staff in the management of the organisation, more frequent meetings of the EC or the EC to act like a governing board and devolves the day to day executive powers to the coordinator with a staff committee to assist in the process. The minutes of the regular meetings of the committee could provide better insight to the EC about prioritising its intervention. This process could be a beginning of both more thinking in the SOCHARA-CHC relationship on the managing the staff-based organisation and promotion of the principles of participatory and self-management at the level of CHC. This would provide a meeting ground between progressive staff policies (rules and salaries) with the

organisational management. It will also provide some alignment between the demand of commitment and political consciousness among the staff from the SOCHARA and problems of working as employees in an organisation whose objective is to operationalised objectives and decisions of the SOCHARA.

Rules, Salary scales and financial position:

The rules and regulation governing the CHC are fairly elaborate and cover most of the essential requirements. There is healthy respect for labour laws – making provision for the social securities and staff welfare.

The salary scales are also better than the most of the community-based NGOs. One person from the NGO made a comment that they are high. A salary revision was carried out about a couple of years back. However, as mentioned in the discussion in the philosophy and values system section, there is definitely a tension between the commitment to equity and the salary expectations of the senior professionals, and that has resulted into loss of some professionals. Another tension mentioned by a former professional is about the parity of salary practiced between the social science professionals and medical/public health professionals. Third tension, reported by two individuals, is between the lowering of salary of seniors thus paying them less than "market value" while giving salary that is more than "market value" to lower level staff in order to meet the value of equity. The fourth tension, not mentioned by any respondent but implicitly present (and found to be a tension in other NGOs) is between emolument for those who involve themselves in community level work and those who do research and higher levels of training. The last two issues, equity and the action-research, are the most difficult to resolve and that is the reason why the action/community based NGOs are not able to build good tradition of rigorous research by retaining good researchers, and the research NGOs are not able to provide place of pride to action oriented community workers without violating principle of equity. There is no easy way out of the

Unless an NGO keeps getting adequate number of highly committed professionals ready to work at relatively low salary (less than "market value" of their labour, or less than UGC scales of associate and full professors), it has struggled to retain good researchers. The supplementary ways in which relatively low salary is matched with retaining them, are providing them more autonomy, rapid career development and high profile, possibility of becoming coordinator of the organisation, allowing them to undertake private consultancy outside office hours (on sharing basis with the organisation or by allowing full benefits), and so on. That is making it possible for them to have higher job satisfaction and other non-material benefit with possibility of getting material benefit by working extra in private time. They need to be looked at to understand the extent to which such strategies and other innovative strategies thought of are compatible with the value system of the organisation.

The financial condition of the society is in very good health. I had an opportunity to study the balance sheet of the organisation for the years 1999-2000 to 2002-3. The annual income of the organisation more than doubled in this period and number of activities for which funds are utilised has shown steady increase. I have not studied the books of accounts but based on the auditor's report and the details given in the balance sheets I feel that management of funds is done in a fairly good manner. There is no doubt that the CHC as an organisation has established a good financial base to take off in case it wants to make a transition to a more complex institution.

Other issues of structure and policies

- (1) One former senior staff member expressed very strong feelings on the organisational and staff policies, particularly with regard to the professional staff. According to him, organisationally the CHC had become: (a) a nursery centre for fresh medicine graduates join explore the field of community health as a possible career, (b) a sabbatical centre for highly qualified professionals when they are on sabbatical period from the parent institutions for very short period of 6 months to 2 years, (c) Post disaster make-shift shelter for professionals who quit their jobs or had to shift to Bangalore due to untoward professional/personal distress, and they join CHC until they find alternative, and (d) Professional vruddhashram centre, as a good retreat centre (retired men's paradise) rehabilitating 60+ yrs retired professionals. I was not able to separate out humour from the serious point on my own, but soon I realised that this was a serious point as he went on giving few examples in each category to buttress his argument. Essentially he was arguing that there was too much reliance on stop-gap arrangements rather than building core professional group within CHC; and was arguing for development of an institution that provided opportunity to professionals both for doing something socially good as well as develop their career within the CHC.
- (2) In the appreciation of organisation, the personalities cannot be kept out because they both shape the organisation and provide it with public profile. More so in the case of the CHC as for outsiders, it has somehow got identified with Ravi and Thelma for very long time - and this despite the fact that they had taken sabbatical for considerably long time in 1990s. I has lots of difficulties during the interviews to separate out points made on the CHC as organisation and on both or one of them. As far as possible, I did ask for clarification but it was not possible always. When such clarification was sought, I had found that the issue pertained more to the individual than to the organisation or it was assumed that both were same. While this is not surprising, it makes simple issues more delicate than they ought to be. On the other hand, some of the respondents very forthright in making some strong comment on the place of Ravi and Thelma in the CHC. This was also natural because an association of such a long time was bound to personalise the place and the image of it. With that explanation, few strong points made are worth mentioning so that in future planning of the organisation they are kept in mind. Six out of all individuals interviewed (included three former staff members and three others) felt rather strongly that the CHC was a family affair and others had only temporary place

there. There was also an indirect mention by a few others in terms of availability of "public" space within the CHC. At another level, several respondents positively appreciated (three even saying that they idealise them) Ravi and Thelma but were highly concerned about the future of the CHC if they burnt out, or decided to do something else. Such individuals usually also felt that for the sake of future, the SOCHARA should take the path of institutionalisation – as one respondent put it, "it is inhuman to keep expecting them doing the kind of work they have done in last 20 years". They felt that only institutionalisation could motivate some professionals to stay with the CHC for longer time and thus relieve Ravi and Thelma from all responsibility. Three of the six respondents who saw CHC as family affair imputed different kind of motives for not institutionalising; such as they were insecure, they could not work with equals, and so on.

(3) Although there is no evidence that the SOCHARA/CHC have connection to the church or Church-based organisations, or that its policies and work have anything to do with religious activities, several persons, including a few members of the SOCHARA, talked about their unease or just mentioned that it had some Church connections. However, none questioned its secular credentials and did not make allegations on religious lines. The major concern shown was about the narrow-base such orientation was providing to the organisation. Yet, in my assessment of the work of the CHC and the number of people inspired and motivated by the CHC show that its base is much wider at national level. Perhaps their concern is about its direct interaction and network at the local level – Bangalore and rural Karnataka.

(C) STRENGTHS AND WEAKNESSES

My notes on the interviews provide a very lengthy list of strength and weaknesses. I suspect that I was told more about weaknesses than the strength because – as one person put it – "it will be easy for you to put together strength because generally CHC has an excellent history, but there is less critical reflection on weaknesses as not many would be ready to be very frank about them or they just do not want to hurt". On the other hand, for each response on strength I found another response that characterised it either as weakness or recent erosion of the strength. As a consequence, it was not possible to separate out strength from the weaknesses and vice versa. In a way I felt that this was a much better situation, as it is not possible to look at anything in terms of only positive and negative, but identify positive as well as negative in each aspect of the work of organisation. Thus, given below are the issues raised and the range of responses characterising them as strength or weakness in a dynamic manner.

(1) The most important strength highlighted very frequently is its long tract record of work of last 20 years. Even those who left the organisation acknowledge the commitment and sincerity of the CHC though they have other criticisms of the organisation. This tract record, its survival of two decades, the amount of inspiration it has provided to individuals and organisations, the support – both moral, intellectual and material – it has

provided to otherwise weak movements within health sector, the interaction and networking it has promoted, made more and more people to look at the social aspects of health, the advocacy it has done on some crucial issues, the good will and respect it has gained in the circles of activists as well as policy makers, and so on – the list is too long to mention – have given the CHC a national profile and prominence. An overwhelming majority of the persons interviewed and those who responded to a questionnaire, including its critic, described this as the biggest strength of CHC, and a base and potential on which the organisation can embark on its next phase of development.

- (2) The documentation centre was seen as strength as well as weakness strength in the sense that it provides very valuable source, particularly on movements and works of NGOs, but weak because it looks frozen in time and not having adequate dynamism of development. There were several suggestions for its further development from the staff in charge as well as from others who have used it in the past. All of them said that it was an excellent based for developing it and making its material widely available by using the dissemination technologies like SOCHARA's website.
- (3) Excellent place to be for the "starters", those who need basic understanding and motivation. It not only inspires, but gives lots of ideas about what they could do in their work. Several of those who have been inspired by it told that they have been using their learning in their professional work. But some respondents attached a rider attached to it; that one grows over it fast once the basics are learnt, and despite getting inspiration from it they would not like to work there. One respondent said that there is some amount of paternalism and he liked it very much in the beginning, but thereafter found it difficult. Despite such criticism aired very forcefully or as a side remark, there was a general consensus that the CHC has done its work as catalyst and motivator the best, and almost all of them attributed it to the personality of and capacity to stir critical thinking by Ravi and Thelma. In many ways the respondents attributed this strength to individuals rather than to the organisation - a few even going to the extent that these individuals will keep doing so irrespective of the existence of the CHC. The flip side of this strength was that there was better appreciation of it by those who gained by "passing through" CHC, by collaborating with it from outside as consultant or as a part of team engaged in some exciting programme or project, than by those who actually worked for some time there. Other reasons given for not feeling like working there were that they did not have capacity to be motivator, it was not an institution where professional contribution would be appreciated, it was too demanding in terms of commitment while they could go only to a limited extent in that direction (one said that its value system is "too harsh and rigid") and so on. Only one of the individuals at the periphery of the CHC said that he would not mind working for some time as staff in the organisation.
- (4) Community orientation of the first several years was mentioned as the strength but some others were feeling concerned about reduction in the community orientation in last few years. Interestingly, those who felt that the future of CHC was in undertaking more research and policy advocacy did not mention much about the reduction in community

orientation but those who felt that it should go back to the original work of training of NGOs were emphatic in saying that the direct work with the community has suffered. The some respondent with the latter view went to the extent saying that the NGOs that were close to the CHC have moved away though not broken away from it, the change was dictated more by the change in the orientation of the leadership – read, Ravi and Thelma – than the change in the priority at the ground level. They also felt that the current priorities are gradually turning its strength in community work into weakness. This group suggested that CHC should opt for a mix of consistent community work and institutional development, and should have less concern for organising "events" than actually forging alliance based on common work.

(5) Lack of administrative and programmatic decentralisation. Everything is lump together as one whole and as a consequence there is less initiative from below, the division of labour is nebulous and not open to specialisation. There is less sensitivity to the fact that all individuals may not have enthusiasm for all activities, or they are attracted to a part and not the whole. On probing, I was told that there is some degree of division of labour and specialisation already there but there is a tension related to accepting as a correct process – there is constant looking back about the desirability of such development thus making it very tentative and not allowing it to settle down. Along with this there was a concern for taking too many issues – the desire to respond to as many requests as possible rather than focusing on the programmes at hand and doing best in a focused manner.

On the administrative part, some members of the SOCHARA and some of the trainee fellows felt that it relies too much on "inspiration" and "individual motivation", and they opined that as organisation grows, that is bit difficult to sustain – leads to some unevenness in administrative management. Some suggested more formalisation of management; others suggested weeding out of "bad" management practices. By "bad" they mainly meant practices that curb autonomy of the professional staff, some participation of the staff in decision-making, and some decentralisation at the team level.

(6) There was lots of appreciation of the work of networking. Almost all felt that such networking initiative of so many years was a real plus point, and it has made many organisations conscious about their need to do work in the field of community health. At the same time, they and others felt that networking on the long-term basis would yield better dividends if the networking is combined with three important "in-house" functions or works, viz. (a) capacity building within the staff of the CHC, (b) some outstanding outputs from the CHC staff, and (c) CHC having its own field area of work. They felt that by networking the CHC had contributed a lot, but beyond a point its moral authority in the network was non sustainable if it did not have its own development and team of staff that is seen to be good work of its own. Two former senior staff members felt that excessive networking sometimes made the leadership ignore the in-house capacity available, it also made them to take less risk with the in-house staff by giving them opportunity to make mistakes and learn. Another respondent felt that intellectual and

moral authority of the CHC in such, network came from only a couple of CHC persons (Ravi and Thelma) and so the organisation was appreciated less than the individuals. In their absence, the networks did not take others representing the CHC so seriously and that was frustrating for the staff. And such professional staff needed time and space to come out with their own out puts before they were recognised in their own right.

- (7) One weakness that was articulated by several individuals former staff and others at periphery - was lack of following up good initiatives. For instance, the contribution made by the CHC in the task force report of Karnataka was highly appreciated, but at the same time not doing enough to follow up its implementation by undertaking its own independent policy research and using other advocacy opportunities (like media, seminars, conferences, legislative assembly questions etc) with such data, was characterised as major weakness. Some of these people felt that in past several such good initiatives from the NGO sector have not achieved desired goal because of lack of generating pressure for implementation - "comparatively easy to change policy, difficult to get it implemented". So more needed to be done on the implementation. One strong supporter of the CHC from the periphery (who also expressed his desire to work there some time) said that in the Karanataka health policy work, somehow an image is created in the media that CHC was too friendly with the government, and he recommended that our policy be to "hit them hard (for inadequate implementation) and yet getting our things done by them". He also felt that the CHC was great initiator but not so good in sustaining and concluding the initiatives. The attributed this to insufficient attention to or failures in organisational development and in-house team building.
- (8) A few respondents were concerned about the fact that there was no clarity on the "CHC's identity". "Is it a campaign team, a scientific team; a platform for few individuals or an organisation/institution?" Here too the emphasis was on what the CHC did in-house being as important as what it did outside.
- (9) There was very high appreciation of the contribution made by the CHC in building Jan Swasthya Abhiyan, People's Health Movement secretariat, International networking and campaigns, its role in People's Health Assembly, its media profiling of the PHM, and so on. One person described such contribution as "simply great". Generally, the feeling was that it has done a lot in strengthening such movements, particularly PHA and PHM. However, this work of last few years has also attracted some criticism four persons felt that CHC has become more international oriented and thus neglected work in Karnataka and India.
- (10) I met individuals connected to environment and disaster management movements and organisations. From both currents I received very high appreciation of the contribution made by the CHC, and they demanded more such work from the CHC so that these movements could build their capacity on health issues, in providing health care and in undertaking research.

(D) PROGRAMMES AND IMPACT – CONTRIBUTION OF THE CHC/SOCHARA IN VARIOUS FIELDS. IMPACT

Many of the major responses about CHC/SOCHARA's impact have been covered in the critical remarks on the its strengths and weaknesses. It must be re-emphasised that most of the respondents were very clear about its general impact. The differences or criticisms were usually with regard to the extent or degree of impact. Some key criticisms were based on the assertion that the impact was great, but its organisational capacity to sustain the impact in order to affect a major or long-term change was limited.

In addition at least on two issues, the environment and disaster management, I could meet the individuals and organisations concerned and could get first hand information on the way the contribution of the CHC was appreciated. The third category of work was on the NGO training and I could meet individuals from three NGO or NGO-networks who testified on the positive impact of CHC's training work on the capacity building for undertaking community health work and in brining community health on their priority agenda. It should be noted that the CHC training has helped both the health NGOs as well as non-health NGOs.

The third source of my information for understanding impact is based on meeting some community level workers of another NGO collaborating with the CHC project. Interestingly, the project work of the CHC on different issues taken up in last few years is normally done in collaboration with some community-based NGOs, usually not having health as its priority area of work. The CHC does not believe in establishing its own direct community work but believes in doing it in partnership with an established community level NGO. This provides them with good base for intervention and reduces duplication of work of another organisation and at the same time helps in building capacities of the community based organisation that is going to continue its work in the community even after the CHC project gets over. I met community level workers collaborating with the CHC in its project on alcohol and found that the partnership was well established and there was mutual trust. However, I also found that this limited the amount of innovation in the approach and strategy that CHC could take up as ultimately it is required to implement its project within the organisational constraints of the existing NGOs.

As a part of the review exercise, the SOCHARA/CHC sent out a questionnaire to large number of individuals in the country. Some of their responses testify to the impact made by the CHC's work. Some relevant responses are given below:

Impact and recognition as a centre:

- "It is an important centre for community health in India".

- "Despite ... bleak scenario of voluntary organisations, the CHC is an outstanding example (having) continued to serve the PEOPLE's sector in spite of considerable difficulties. The CHC has played a seminal role in advocacy not only at the people's level, but also at the State, Central as well as International levels, especially in the WHO. ... The CHC now claims both national and international recognition. Their efforts need greater acknowledgement and support".
- "CHC has been the most active group in critiquing and advocacy in medical education."
- CHC has been able to create a platform to view health as a justice issues. provides opportunity to learn to integrate the social, economic issues with promotion of health.
- Has symbolized ... (as) an organization truly dedicated to taking up causes and spreading awareness on public health issues and problems in our country. Over the years has maintained its credibility and integrity and therefore lay-persons have been able to use information, views, messages on issues, expressed by CHC with complete confidence.
- CHC has documented effectively in a number of areas. has raised its voice on many issues to be heard. The follow through has not been focused enough to produced specific results. Appears to be capable of being India's best advocacy organization, yet is involved in too many areas to produce effective results.
- I trust CHC to represent my/our concerns when it works at policy level or at a global level. ... it epitomises a belief that you don't have to become big to do something big. And that professionalism has to be maintained even at NGO level. Its greatest strength lies in preventing people from feeling threatened in a network their networking skills are excellent.
- CHC counter balances the commercial aspects of community health. ... gives a
 forum to people who view health through an alternative perspective and gives them
 opportunities to prove their point of view. provides some ethical values to people

Its contribution to the other NGOs

- If I could achieve something to promote community health (in my organisation), it was mainly due to the contribution from CHC and all those connected with it. The very concept of community health was emerged with the support of CHC.
- CHC was almost like a ready recknor for the latest on medical or community health information. Showed me the value of low cost teaching aids, especially the posters and songs. CHC means "friends" who are always willing to help during

a training programme and to share their knowledge. ... a good sounding board to test new ideas.

Motivating and inspiring individuals

- At the beginning CHC was a mentor. I was feeling lost in a new field and CHC was able to show that values could be applied "even" in this (my) "speciality". During my post-graduate CHC was a senior friend and a colleague. One could rely on CHC even when medical colleges and community health departments were getting institutionalised. ... CHC is like a reference point its attachment to ideals is consistent.
- CHC has been an inspiration, calling me back to my own commitment to people especially those whoa re on the fringes of society. It has provided a sounding board for my own doubts, questions, and search for ways to move forward in my path. It also been a partner in the wider effort to bring in values of cooperation, justice and peace in our country / world.
- CHC has meant to me a refuge "a place to recharge" a place to visit when spirits are down (but not out); to understand that "we are not alone" that there are others who also are constantly questioning, "trying to understand" fighting for rights for the "voiceless" adding agendas if need be but never "shying from the truth". It has also helped me to "have faith in fellow human beings".
- CHC members provided me valuable mentorship and counselling. They helped shape my understanding of community health and develop a broad, holistic, interdisciplinary perspective on health and medicine.
- The core team of CHC and many friends at CHC have been a 'landmine' of shift in my paradigm of thinking, viewing, believing and acting.
- personally, CHC gave immense opportunity and help to understand the concept of Community Health.
- CHC has been a source of inspiration to keep my passion for helping people help themselves alive.

I also had an opportunity to go through one independent review of the work of CHC in the Women's health training programme (see Jandhyala Kameshwari, "An assessment of programme in Karnataka, 23rd-28th February, 2001). The CHC acted a lead or nodal NGO in Karnataka. The report states that, "Generally the partnership between a nodal agency and other NGOs has been seen in a positive light. All the partners felt that they have been allowed to retain their individual flavour in the implementation of the programme. By and large the management and coordination of the programme has been smooth."

Although there is no need to discuss the contribution made by the CHC in the Health Task Force of Karnataka and in the drafting of its report as the same are well-known, it must be noted that this intervention in the policy making at the state level was a tremendous success in bringing about the impact of its work in last five years. This task was carried out with lots of commitment and effort, and the individuals I interviewed were highly impressed by the performance of the CHC in this field. Another work of the CHC mentioned by respondent was on influencing the medical education at the health sciences university of the state.

It must be noted that the study of the impact of work or programmes require more rigorous efforts. One needs to go into each programme and not only look at how well they were conducted by the CHC, but also examine its objective impact in improving health or meeting other objectives and also how the recipients or beneficiaries appreciated them. Such detailed examination of the programmes was not possible in this review.

(E) QUALITY OF WORK UNDERTAKEN

I did not have time during the review process to objectively assess the quality of work in the randomly selected programmes or projects. Indeed such assessment would be a task in itself. Hence, this review does not have much – indeed almost nothing – in assessing the quality of work undertaken by the CHC.

I indeed ask this question to many individuals I interviewed, particularly those who are not directly involved in working at the CHC. The quality of these responses also did not convince me to come to any reasonable conclusion about the quality. The responses were varied but quite instructive:

- The leading individuals are intellectually very good and whenever they have taken up research-based work, the outcome has been excellent. There was high appreciation of quality of such research-based writings. Some individuals expressed disappointment that they have not done enough research, systematically published their work in peer-reviewed, indexed journals nationally and internationally and thus not done enough to influence the professional public health community.
- A few individuals from NGOs where the CHC had organised trainings in the past were interviewed and their general comment was very positive about the quality of training. They showed more concern about the quality of follow up, as they complained that CHC is taking so much work that it does not have sufficient time to follow up.

- Two types of critical comments were received on the quality of work in the networks and the work at the community level. The first was that somehow there was more orientation to number of events rather than what each event was achieving. Thus it needed more rigorous, high quality and clearly defined intervention in the network related work. One person said that good networks cannot be built by "flying in and flying out". The second was that the CHC must strike direct roots in some community, build some good work and experience in working at the community level and do some demonstration of translating their ideals into reality at micro-level. According to this view, such approach would take the quality of their training one step ahead.
- One person made comment that while lots of documentation of work was carried out, but it is very excessive and not systematic. As a consequence, one does not find systematically designed and regularly updated training manuals on some very important subjects coming out of the CHC. He lamented that an organisation with training at the high priority agenda should have gained good name by now in providing such training manuals. However, he was quick to add that that did not mean that trainings provided by the CHC were not of high standard but that it should have done something more systematic to ensure that such training courses were documented in manuals, thus providing much better guidance to trainers.

(F) FINANCIAL POSITION AND SUSTAINABILITY

As explained in the section on organisation, the financial position of the CHC has considerably improved in last few years. It doubled its income in last three years and its annual turn-our is about half a crore rupees. A concern was raised that much of the income was from grants, and many such grants had come for specific projects, and that it does not have enough money in its corpus funds and reserves. So there was also a concern for its sustainability – with an assumption that if there is more annual budget, the sustainability is more difficult.

I did not have detailed discussion on this with many individuals – not at all with anybody on the financial statement of accounts of the SOCHARA, but with few individuals on the issue of sustainability. So most of the points given below are my own comments.

(a) The excessive concern for the corpus funds should not be there as there are organisations with less corpus funds and higher annual turnover than the SOCHARA's have been able to sustain themselves. Besides, with the low-interest rate regime in force and with almost no chance of high interest rate times coming back, the income from the interest of the corpus would be so low that one would need very big amount in the corpus to earn adequate interest.

- (b) Unlike in the past, there is relatively more emphasis on the monitoring and evaluation by the funders and there is also more demand for focused work. The positive side of such demands is that they force the NGO not to keep doing anything and everything that comes in its way, but do better planning and have long term focused work. If such situation is alright for the CHC, its capacity to attract fund is still very good.
- (c) Several respondents made a strong plea that CHC should explore possibility of raising funds from the public and private sector corporate houses and their philanthropic organisations. In principle it should be possible to raise such funds if there is no unacceptable strings attached to them. Particularly efforts need to be made for increasing corpus funds or for getting endowments that could sustain some of its activities.
- (d) Induction of competent professionals in the team would help in the fund raising too. Firstly their presence would make the organisation more attractive for providing project-based work, and secondly these professionals in a course of time would be able to attract funds for their own work.
- (e) One viewpoint was that the CHC did not have to struggle too much so far for funds as it had funders who were very committed to it and its requirement of funds was modest. It also did not create non-moveable assets and thus remain somewhat tentative. This has, according to this view, made the CHC somewhat less dynamic (lethargic) in fund raising. It would be more dynamic in that field if it creates stakes in terms of non-moveable properties (its own office building, for instance); and also has responsibility of supporting a larger team of professionals. In fact, some amount of insecurity related to funds was considered better situation than having it easily as that often robs away the organisation's dynamism.
- (f) Since the turn over of the SOCHARA has considerably increased, there is a need to develop some expertise in the management of finances. Gradually both in-house and consultant-based expertise in finance management would be needed for efficient utilisation and creation of reserve Funds created for various core activities by accumulating surplus money in specific Funds.

In essence, organisational expansion – in terms of human power and work/activities – bring about more responsibility at the level of finances. In the present context of dearth of good NGOs, it is not impossible to sustain work of good NGO provided one plans well for fund raising, focuses work in the key priority areas, professionalise its working and give sufficient attention to the outputs and impacts.

DISCUSSION ON SOME CRUCIAL ISSUES OF PRIORITY IMPORTANCE

(1) CHANGING VALUE SYSTEM:

Two milestones - the registration of independent society in 1991 and the change in direction in 1998 – are impacting in many ways the foundational philosophy and the value system, and that is making some of the society members concerned. They are more concerned because further consolidation of the course could lead to major change in the foundational philosophy and the value system. This issue needs very explicit discussion within the organisation. It is not sufficient to argue that the developments since 1991 have not seriously impacted the philosophy and the value system. The following points need to be clear in the minds of the members – particularly those who are associated with the organisation since its inception.

The period 1984-90 is cherished as "golden-age" because it was formative, idealistic and the most dynamic phase. The 1991 change was supposed to formalise and integrate those values and ethos in a formal and independent organisation. However, it seems that the society gave less attention to, or needs to appreciate, the objective impact that the formalised organisation brings on the value system and ethos.

First of all, the formalised legal system creates both stakes and responsibilities. Not just individual's likes and dislikes, but the presence of organisation needs to be taken into consideration more and more.

Second, there is pressure to expand the public space in the organisation and demarcate it from the founding individuals' private space.

Third, it inaugurates the institutionalisation of the organisation. I think this is hardest to accept, because if the founding philosophy and values are strongly against the "institutionalisation", or attaches premium on "de-institutionalising" just in the same way as one attaches philosophical and political importance to "de-professionalisation", "de-mystification", "de-bureaucratisation" and so on, the organisation goes through a phase of denial ("we are an organisation but not institution", and a phase of accommodation ("we have institutionalised a bit but there is absolutely no change in our original philosophy and value system").

Fourth, it makes it urgent to rationally understand the relationship between the "society" (SOCHARA) and its "functional unit" (CHC). I feel that this relationship is not as seriously discussed as necessary. Often the society is seen as the upholder of the philosophy and the value system. The functional unit, as its name suggests, is the one that operationalises the practical decisions and carries the burden of living that philosophy and the value system. This does not mean that some of the society members do not get

involved in providing lead and direction, but that the essential burden of operationalisation is collectively on the functional unit and not on the society.

Fifth, the establishment of the formalised unit brings into the relationship another force, the paid as well as honorary staff of the organisation. It is this group of people and the way they work that remains at the centre of discussion on success and failure of implementing ideals. Despite all idealism, one needs to accept that once we have employees, we become employers. For activists entering into the running of paid full time organisation, it is very difficult to accept the reality of the employer-employee relationship. Over and above that, it also brings about hierarchy. The most important challenge for a sensitive voluntary organisation is not to strive for the utopian state of the elimination of the hierarchy, but for how to have hierarchies without hierarchical relationships.

I think it is necessary to look at this dynamic of development in order to understand the stress that the original or founding philosophy and value system keep experiencing. The semantic of terms may not be useful because each one may define "institution", "bureaucracy", "hierarchy", etc. differently. What is essential is the acceptance of the fact that in the formalised paid organisational structure, they are present; the only thing that we can do is to make efforts to give them different form, a more humanistic form. In the relationship between the society and the functional unit, we need to pay attention to two processes: (a) the functional unit should never be allowed to become the utilitarian appendage of the legal unit, the society, and (b) put in place the formal structure and processes of autonomy and empowerment for the functional unit(s) and the individuals working there. Attention to these two aspects is important simply because the society and the functional unit exist in power relationship and the society being a legally empowered body, always has more power than the functional unit. The issue of ethics in the structure of relationship needs to be addressed here.

It is often argued that certain values are eternal and must be upheld under any circumstance and organisational form. Here, we need to filter out the secular ethics from the individual morality. The latter is important for each individual and it is bound to be different for each depending upon the cultural, religious and other upbringings, but the former is the one that deals with the standard of conduct in the secular and public space and hence needs to be continuously contextualised. Moreover, we need to discuss this the idea of comparing the present with the past. Why do we assume that the idea and philosophy we started with ware qualitatively superior/better than what we have on the ground today? Perhaps it makes better sense to understand evolution of the ideals simply because there is always continuity of certain elements and the change in others. The elements showing continuity are also not eternal, and simply because they survived do not make them eternally ideal. A reason for that could be that they are kept alive artificially, but have lost the actual base within a majority of the society members and the staff. Those who have not survived should also not be seen as dispensable simply because we may think them important to make practicable.

The only suggestion that I can give is that the SOCHARA/CHC need to have very hard and realistic look at the philosophy and value system of the organisation. There is a possibility that it may become an endless discussion, but that should not deter it to have appreciation of the philosophy as it is presently practiced and not get carried away by the philosophy as it is idealised.

(b) ORGANISATIONAL STRUCTURE AND PROCESSES

One of my strongest feelings is about the structure of the organisation. I narrated some aspects having bearing on the structure in the previous point; here they are developed further. Several issues need discussion:

First, the process of organisational change seems to have started in the CHC but not reflected in the SOCHARA. This is a very paradoxical situation simply because the changes introduced since 1998 in the CHC came from the decision of the SOCHARA. Perhaps the members have not fully appreciated or understood the meaning of the changes. The change in the CHC is that since 1998 the process of institutionalisation and professionalisation has been augmented. Correspondingly, there is little attention paid to the changing role of SOCHARA. We need to face the question – if the CHC institutionalises or reaches a higher level of institutionalisation and professionalisation, what would be the role of SOCHARA?

Second, the first two (1984-1990 and 1991-1998) phases of the organisational development, the SOCHARA was a support network nurturing few individuals who had made commitment to work differently, be a sounding board and generator of the ideas. In many ways, much of the organisational work as against the programme-based work were centred, around SOCHARA and the CHC was just a functional unit. This system has continued even now, and to my understanding, one of the strongest criticisms of some of those who worked in the CHC in last five years implicitly is in relation to this system. This does not mean that there is absolutely no participatory system. On the contrary, most of them did describe it as participatory system. However, the problems I found were more with the content and context of participation, because participation does not automatically lead to democratic and empowering system. So we need to discuss the participation and decision making in the areas that matter, the areas that have formal power sharing arrangements, rather than looking at the participation in formal sense and often in the softer areas.

Three, the executive/managing committee of SOCHARA is by law and in effect should function as the Board of Trust or Governing Board of the CHC and not as the executive body. In a way a perusal of the minutes of the executive committee shows that it is in fact moving in that direction but without discarding its executive functions and creating legitimate and formal body of the staff to devolve those functions. It is absolutely essential that the staff, by having circumscribed and devolved formal executive functions

learn to govern the organisation and learn to evolve its own development plan. Presently such processes are there but at the informal plane, and that is making many individuals tentative in committing themselves to the processes.

Four, this would necessitate the demarcation of role/functions, powers and system of accountability between the staff body, the coordinator, the executive committee as governing body and the general body meeting. Given these structures, one would also need the meeting places – where they are able to jointly meet, consult each other and iron out differences from time to time. I believe that the EC and the GBM should act as policy making bodies, peer reviewers, sounding boards and refrain from directly exercising executive function unless absolutely essential or when there is a course correction found to be necessary.

Five, the SOCHARA needs tighten its norms for membership and reconsider its earlier decision to increase numbers. It must be kept in mind that CHC is no longer a small organisation – its financial turn over has increased several times as compared to early and mid 1990s – and there are stakes involved. The current practice of accommodating individuals in the SOCHARA if they cannot continue to be a part of the CHC must stop. It must also overhaul its membership by keeping in mind those who are genuinely active – not in general as a part of network or ideology-sharing but specifically for the CHC/SOCHARA – and those who share the vision for the future of the organisation.

Six, the CHC needs to be given a more systematic and formal shape. The CHC cannot be governed only using the rules and regulation of the society, but it also needs a separate administrative rules and structures. I am sure that there are administrative rules, salary scales and other things existing as a part of the administrative orders adopted by the EC from time to time. But this is not sufficient – they need to be brought together, openly debated, modified and in consultation with the staff adopted jointly by the EC and staff.

(c) INSTITUTIONALISATION:

V

The most intriguing aspect of the CHC/SOCHARA for over years for me has been its concept of being facilitator and catalyst organisation and not being an institution. I have made lots of efforts to understand this concept as applied to organisation, but not sill understood fully. So if my comments betray my ignorance, I beg apology in advance.

I received a very consistent (very few people doubting this aspect) response from all over the country from those who associated with the CHC for short duration as a part of network or visitor to the CHC, and then kept in touch and remained in active contact. All of them told me about how they felt inspired, how they could get some vision and how such association impacted their decision about involving themselves in community health. However, some more discussion brought out several issues that are worth pondering about. First, there is a mixing up of the individual's personality and the

organisation. Some of these individuals were very appreciative of individuals but not so much of the organisation. Particularly Ravi Narayan was identified as highly suitable person as mentor, facilitator and the one who could provoke them, but not the organisation as such. I know that individuals give shape to organisation and sò they cannot be completely separated. But if the unevenness of the development between the individual and the organisation keeps widening, the ups and downs, the changing priorities etc of the individual can have sharp impact on the organisation. Secondly, it is very evident that with the gradual withdrawal of Ravi Narayan, there is corresponding change in the way the organisation is playing the role of the facilitation and being catalyst. This is based on my conviction that any organisation, having basic dynamism and social commitment, at some level acts as catalyst and facilitator. Thirdly, the organisational role as facilitator often depends upon how professionally well it functions in providing training, undertaking research and in advocacy. Its work on health policy and research, have those components, but they are still under-developed. One of the reasons for the under-development is that it is not able to find suitable and modified organisational role as catalyst and facilitator; and stop looking back as more personalised approach that was there in the informal phase of the development of organisation.

Fourth important issue to ponder over is the kind of needs and demands that are now emanating from the NGOs/CBOs and public health bodies (including professional bodies and medical colleges/university). In the 1980s and early 1990s the CHC was acting as a catalyst and facilitator in a different social and political environment than is doing now. From health as being community health activity – the paradigm shift that is well documented by the CHC – it has acquired some additional meaning, one of them is the also being a right and political process. The health as a right's issue was not as prominent earlier as it is now. Besides, the NGOs are undergoing rapid changes. The impact of economic reforms on the NGOs is enormous. I have a feeling that the list of what is to be catalysed and facilitated has expanded considerably and within that the socially relevant research, the policy advocacy, monitoring implementation of policies and impacting mainstream have emerged as newer areas having direct connection to the developmental process.

WAY FORWARD

What is the best way forward for the CHC? Answer to this became more difficult as I progressed in the review than I had anticipated at the time of starting the work. I am giving here a very brief and tentative view, but it can be modified and elaborated in the course of discussion with the SOCHARA/CHC in coming time. Besides, issues and ideas expressed in the previous section – some in very provocative way – provide lots of material for discussion and decision-making.

Three alternatives kept coming back in discussion: (a) Make a retreat, go back to pre-1998-9 situation and continue doing what the CHC did between 1984 and 1998. The recent changes are institutionalising the organisations, divorcing it from the community work, making it more research oriented, expanding its strength and making it financially non-sustainable, and so on. (b) Build on the great achievement of last 20 years, half-baked institutionalisation has created more problems so it would be better to do institutionalisation in the planned but bold way, preserve some of the values and ethos, and chart a course towards establishment of a good community health institution. (c) The CHC should be closed down.

The last position was not explicitly taken by anybody, but some individuals indirectly mentioned such possibility. The factors that prompted such response were: (1) institutionalisation would be a worst option than the closure, (2) unable to carry on because the core team is tired, burnt out or has changed its direction.

So essentially the views largely revolve around the first two alternatives. The first alternative was articulated by a minority of the informants while a big majority talked in terms of institutionalisation.

My own view on the subject is very clear. I feel that institutionalisation is not only the correct option but perhaps also the only practical option available. The only other practical option is closure. The first option is not practical at all, as there is no core group to undertake work in the manner required. The best way out would be go for institutionalisation while making efforts to preserve as much of the values and ethos as possible. While institutionalisation will add new priorities, it should also strive to preserve in suitable form the present work of motivating and inspiring individuals and NGOs to work in the field of community health and be committed to social paradigm.

I think the present initiative on the community health fellows, trained in the CHC and in several community health NGOs in different parts of the country, has a great potential to initiate systematic institutional work – training, research, community work – in people oriented community health. Given its broad canvass and people-orientation, by making one of the basic components of the institution, it will also help in preserving many values and ethos so dear to the organisation. Such work will also help the CHC in bringing its

network partners to share the work - as it is already doing by placement of fellows in different community health organisations.

Another area of high potential is development of systematic and rigorous research work – the policy research, health system and operation research, and general social science and public health research in health and health services. The socially relevant research with high professional quality can give good support to the movements as movements can use such material in their campaigns. The advocacy work based on such research could be complement the efforts of the movements.

Organisational Reviews of SOCHARA-2005-Dr.Amar Jesanis Review

COMMUNITY HEALTH CELL BANGALORE

REPORT OF THE REVIEW

Amar Jesani Mumbai

2005

TERMS OF REFERENCE

A team of two external persons were supposed to undertake this review, but one of them could not join the team. Thus, with the cooperation of the team members drawn from the SOCHARA, this review was completed.

The Terms of Reference for the review are very broad and all encompassing. Although they provided free hand to reviewer, all issues in the terms of reference could not be adequately dealt with in the review process. The Terms of Reference were as follows:

- 1. The philosophy in founding the Community Health Cell. The objectives at that time. Modifications of the objectives what, why, when? The present objectives. To what extent have these objectives been achieved?
- 2. The organizational structure of the Society (CHC). Is this optimal to achieve the objectives? Modifications, if any, needed to achieve the objectives better. Recruitment of Staff, training and re-training. Staff development programmes and their usefulness. Staff turnover, Staff satisfaction. Is the organization democratic / decentralized in its functioning? Is there a system of planning, monitoring and evaluation of the functioning of the Society and taking action on the findings?
- 3. Strengths, weaknesses, constraints and opportunities. Have the strengths and opportunities been utilised to achieve the objectives? How have the constraints and weaknesses been reduced / overcome?
- 4. Values and life styles of the Society members and team. Did they have any impact on the functioning of the Society and on other organizations / people? If yes, how?
- 5. Important programmes of the Society (CHC) and their impact local, state, national, international. Involvement of the Society in advocacy and networking with other organizations governmental and non-governmental; experiences and learnings from them.
- 6. Quality assurance in the activities of the society. What are the procedures in place to assure quality? What steps are needed to assure better quality?

- 7. Society (CHC) as a learning organization. How has the Society (CHC) utilised its programmes for learning by the members / staff and in creating awareness leading to action among the people on the health related problems?
- 8. Contributions of the Society (CHC) to equity, social justice, environmental and gender issues, intersectoral action, community organization, mobilization and participation and empowering the people, especially the disadvantaged.
- 9. Contributions of the Society (CHC) towards health planning and policy formulation of the state / country. Involvement with the Panchayati Raj institutions at the district, Taluk and village levels.
- i0. Have there been innovative, creative contributions made by the Society (CHC)? If yes, what is their impact?
- 11. Education/training: what has been the involvement of the Society (CHC) in training and education in Community Health? Public Health? Is there a need for greater involvement? If yes, how should this be done?
- 12. Management of finances of the Society (CHC). How can we ensure financial sustainability in the long run?
- 13. Factors, which facilitated the Society (CHC) to work as a team. Suggestions to enhance teamwork.
- 14. Recommendations for improved functioning of the society and suggestions for new directions.

The report is divided into the following sections:

- Terms of Reference
- Methodology
- Findings pertaining to Terms of Reference and any other relevant observations
- Discussion on some crucial issues in the priority concerns of the organisations
- Suggestions for the way forward

Acknowledgement: My sincere thanks to all who cheerfully spared time to share with me their experiences with and the views on the CHC, at my convenience. My thanks also to the staff of the CHC who made my stay and travel in Bangalore comfortable.

METHODOLOGY:

- 1. The SOCHARA made available the documentation of last 20 years, starting from it inception 1984. The documentation included reports and publications of the CHC, from 1991 onwards the minutes of the meetings of the SOCHARA and the executive committee minutes, the financial information of last five years, the documents pertaining to work plans, the previous review of 1990 and 1998, various writings related to the CHC and its work, the newsletters of the CHC, rules and regulations of the society and so on. All of them together run into over 1000 pages of documentation. The reviewer spent lots of time going through the documents, though selectively, in order to get a fair idea of the mission and history of the organisation.
- 2. An internal review of the CHC by the staff was undertaken between April and November 2003 in five meetings. A draft of the internal review report was made available.
- 3. A mailed survey of opinion of members of the SOCHARA and associates; was undertaken by Dr. Mohan Issac, president of the SOCHARA. 27 individuals responded to this questionnaire. A summary of their responses was made available to the reviewer.
- 4. Starting from January 2004 at the World Social Forum, the reviewer conducted a series of interviews with the individuals presently working at the CHC, those who have left the organisation, those who associated with their work in some capacity, some of the members of the SOCHARA, some individuals and organisations who have associated with the CHC/SOCHARA from time to time in collaborative work and one meeting with the Bangalore based field workers involved in field based project of the CHC. Totally over 40 persons were interviewed, some of them in more than one sitting while some were interviewed for only few minutes. Two were interviewed on email and telephone.

A brief note on my experience in the review process: A few important issues must be put on record so that the findings and the over all report of the review is better appreciated:

(a) I know CHC for last more than 20 years now. I have been its admirer and at the same time, as it is my researcher's temperament, its critic. One's respect, personal friendship

with the leading group of the individuals, etc could become some handicap in objective assessment of the task at hand. I did feel some conflict of interests or to put it better, some amount of confusion and tension, and emotional turmoil while doing this work. It often slowed me down, and at least once made me to question myself the wisdom of accepting this work.

- (b) My work was made bit more difficult by the fact that many of the informants or respondents whom I interviewed were also known well to me, though not as well as Ravi and Thelma are. They trusted me and tolerated my way of interviewing. I often became very provocative, taking position of devil's advocate in order to make the informant give the best response on the topic. They mostly tolerated this, and gave me as frank information as possible. More than once I was told that they were giving some sensitive information or view simply because they trusted me, or thought that at least I would bring it make note of it in my report. I do not know how far I have succeeded in giving representation to such points, but surely such information made me to work and think overtime to judge about how to assess and interpret such information.
- (c) Lastly, I noticed discrepancy in the responses given by individuals to me and in their opinion given in writing to the organisation. This was partly due to the fact that in personal discussion one tends to elaborate and explain better than in writing brief responses to questions. But in four cases the there was major variation in the content, making me uneasy about what to use as authentic. Ultimately I decided to use the information provided to me in interview or on email as authentic position of the individuals and I have used the same in the report.

FINDINGS IN RELATION TO TERMS OF REFERENCE

(A) PHILOSOPHY AND VALUE SYSTEM OF THE ORGANISATION, VALUE AND LIFE STYLE OF MEMBERS:

These aspects of the CHC/SOCHARA are considered to be its greatest strength. On scanning through the documents from the very inception of the organisation, there is constant explicit commitment to certain type of the organisational philosophy and the value system. Under the rubric of philosophy and value system one finds several things mentioned. The philosophical understanding of voluntarism and its necessity, the way one looks at the health issues - the social paradigm of health, the appreciation and faith in collective community actions, participatory way of functioning, non-hierarchical relationship, commitment to equity and empowerment, and so on. My first discovery while interacting with many individuals during the review was that these terms were used by most of them, but their meaning was understood differently or not understood at all. A part of the problem is that these terms are very general, with omnibus meanings. Voluntarism, participation, non-hierarchical relationships etc. need rigorous discussion and consensus development on how they are operationalised in the CHC's internal functioning, work and in its relationship with other organisation. Keeping this in mind, I probed only few elements of philosophy as they were viewed as well as perception of their actual operation at the organisational level.

Voluntarism:

I got different meaning of voluntarism from the SOCHARA members who are not working in the CHC than those individuals who work or worked in the past as full time staff. This was in a way natural and found so in many NGOs. The SOCHARA members are either professionals involved in their own work or come from more institutionalised NGO background or are retired from some such work. On the other hand are those staff members of the CHC, who are not or were never a part of the SOCHARA. With a few from each category I had some discussion on this aspect, with the rest such issues came up by chance or I was enlightened indirectly.

I could discern three levels of understanding of the voluntarism. The first level was more at the individual level, wherein I was told why it was necessary to get involved in some voluntary activity while being engaged in one's own mainstream work. The justification for that ranged from religious to simple need to derive satisfaction and give back something extra to the society. At this level, there was deeper commitment to the individual morality. The second level was more political, and associated it with the need for social change. The voluntarism was to undertake activities, both professional and political, that could lead to some impact on changing, for better, the lives of the deprived. And third level was more pragmatic, and looked at the voluntarism as a part of more satisfying career choice. At this level the responses ranged from the idea of assisting those who were doing good work, to attraction for involving in organisation that was not bureaucratic, allowing some initiative and experimentation of new ideas. No individual responded only at one level, all of them used points that partially overlapped at least with one more level. Interestingly, one relatively new staff member felt very sad that in the NGO sector the staff were becoming more of full time functionaries and losing their spirit of voluntarism. The voluntarism as non-remunerative, altruistic and purposive action came more from those who did not depend upon the CHC for their basic survival or who had other sources of income.

At another level, there appeared to be some amount of conflict between the work as professional commitment and voluntary activism. The professional staff, most of them interviewed not presently working with the CHC, expressed more dissatisfaction to voluntarism that misguidedly reduced the professional commitment to work and ideological orientation that prevented balanced appreciation of evidence. On the other hand, one former professional staff and one present staff lamented about increasing orientation of the CHC to research, projects and professionals at the detriment of voluntarism and activism. These two diametrically different perceptions flow from the dilemma of transiting the CHC to be an institution in last five years.

My comments: The voluntarism in terms of organisational activities is evidently very high – and acknowledged by all, irrespective of the views expressed above. This is because of its foundational principle of being catalyst. As a consequence, last two decades of the organisational work show tremendous awareness of responding to disasters – both natural and social, responding to smaller and rural organisations – whether working as organised groups or as informal voluntary groups on a wide variety of issues – health as well as non-health, professional support to various social groups and movements, participation in democratic rights and human rights

movements and groups, etc. etc. Such activities were evidently taken up irrespective of having specific projects on such subjects and at the risk of over-burdening the staff with multiple activities. Thus, irrespective of how individual members of the organisation perceive voluntarism, one gets strong impression that organisation as such is not driven only by the funded projects but by certain commitment to voluntarism.

Participatory:

Similarly, the appreciation of the term participation was different among the SOCHARA members from the staff, and within staff there were perceptible difference between the administrative and non-administrative staff. Before I go into details of responses, it must be said again that discovery of differences is not new; it has been there in most NGOs. There is bound to be variation in the understanding of the initiators of the NGOs and those who join later on, the variation is also related to one's ideology, with the position one has in the organisation and the aspiration. What is important is the consciousness that such participatory method is considered good and desirable, and such consciousness was very strong among all interviewed.

The members of the SOCHARA either looked at the participatory functioning as the most suitable way or they assumed that that is how, broadly, the CHC is functioning. Within the CHC, the participation is looked at as ethos and process; and not as systematic component of organisational structure. At the heart of participatory processes and structures is the willingness to promote participation, so in a way it is difficult to judge whether one should rely more on processes or structures. However, a combination of the two is an ideal situation but difficult to sustain.

In the CHC I discovered that all people I met testified to the participatory functioning of the organisation. The responses ranged from defining participation as consultation by the seniors with juniors to participation in decision-making. The former was stated by all while the latter was mentioned by only a few persons. The critical elements in my discussion with the staff on issue of participatory functioning were high level of appreciation for discussing issues with as broad a layer of individuals as possible, so much so that there were criticism of being too consultative and thus wasting time in meetings on one hand, and on the other hand some disquiet on the way decisions were made, the criteria used for decisions taken, opinion of the person not finding echo in the decisions, etc. However, there was general appreciation of the fact that some space exists

in the organisation to question decisions or have a discussion on the subject. Some individuals in discussion mentioned their unhappiness about certain decisions but at the same time were very clear in their appreciation of openness and humility that exists in the decision- making bodies.

My comments: Overall, I found very strong commitment - both in ideology as well as practice, to the principle of participation. This internal principle is very important because it helps in making the external health programmes related work more participatory, and the acceptance by the new staff the political philosophy of participation and democracy becomes easy. Since this is one of the most cherished and practiced principle of the organisation, it needs to nurture it with all care. In the future development of organisation, it should keep in mind and consciously prepare to tackle three problems that often impact the internal participatory methods of organisation. One is the problem of time as it takes longer time in doing work, and so issue of work efficiency will keep cropping up. And here one needs to create structures that encourage participation but at the same time facilitates timely decision-making. Another problem is of the quality - an issue often raised by professional staff as participation by wider group could mean incorporation of many views. In certain types of works, the democratic decision does not mean adherence to high quality. Thus, one needs to work hard on separating out technical work from organisational policy making - in the former the issue of democracy is not high while in the latter it is. In each, different type of competency is needed, and so one needs to work on developing them. And third problem is the reluctance of professional and senior staff to provide democratic participatory space to others. The professional staff often believe that high technical competence automatically gives them high competence in deciding organisational policy matters and hence they do not like their decisions being questioned or their opinion on organisational matter treated on par with the opinion of other staff.

Political philosophy:

There are two essential elements among others that characterise SOCHARA/CHC's political philosophy, viz. **community orientation and social paradigm of health**. Both these elements are very broad, their meaning need to be upgraded based on the accumulation of empirical data and their practical application tested in specific contexts. Going through the work of last two decades, I get an impression that the CHC has operationalised its philosophy in three major ways:

- a. Promoting and providing inputs to the NGOs and individuals for voluntary action, for undertaking different kinds of work at the community level and by motivating them to deepen their commitment to community work. The CHC functions related to catalyst role, networking, grassroots (community-based NGOs and others) training etc, fall in this category. However, it must be noted that the CHC has not opted for its own long-term area specific community work.
- b. The social aspects of illnesses, social-economic conditions affecting health and illnesses, promotion of healthy practices, etc. have been taken up both for research as well as educational campaigns and training.
- c. While general critique of the health service system and commitment to primary health care were integrated in the social paradigm from the beginning, it did not have systematic programme of research, participation in policy making and advocacy. In last few years, the CHC has made transition from generality of critiquing health system to touching basic contours of the system and design its research and advocacy plans around them.

Generally, there seems to be a dynamic development of political philosophy – from a voluntarist critique and civil society efforts; to training and consciousness-raising; to a more system research and change approach. If one takes this dynamism as a break from the past than one is likely to conclude that CHC has radically changed its philosophy, but if one looks at it in a more <u>integrative manner</u> than it can also be said that the CHC is making efforts to strike balance between the three. It is not possible to pass definite judgment on the situation as of now, the dynamic of further development in coming time would make clear the real trajectory.

While some may see evolving as radical change in priority, I believe that evolve one must. There is no doubt that health and health service system is more complex and cannot be simplistically explained. The terms such as de-professionalisation needs to be examined more closely and weighed against the strategy of regulated and ethically committed profession. Similarly, demystification needs to be related to people's and patients' right to information and patients rights within the health system. Thus, while the basic political philosophy of the SOCHARA/CHC is not outdated, the need for its dynamic interpretation and application in changing situations must be appreciated and should be looked at as a positive part of the CHC.

As against this interpretation of mine, there are few strong critical remarks on the political philosophy needing mention and discussion. These remarks can be grouped in two categories. **The first category remarks** show extreme alarm on the CHC fast discarding its "community orientation" "training role", "grass-roots activism" etc in favour of the "health policy" orientation. **The second category of remarks** are from other extreme, show dissatisfaction over the CHC's refusal to shed its "ideology" in favour of "evidence-based public health", refusal to change the language and priority of work, and criticise the CHC for having half-baked, hesitant (vacillating) approach to professionalising its work. Interestingly, the SOCHARA members are divided on this issue – a few making remarks in each category, but the former staff members from professional category (except one) and some trainees all made comments belonging to the second category.

My comments: Indeed, the political philosophy will be more under scrutiny in coming time. It therefore makes necessary that the integrative character of development is emphasised. More so because in any organisation where the "action-based community work" and "intellectual/academic research" work co-exist; there are often practical organisational problems in balancing them. These problems often get expressed as differences for the simple reason that the "action" staff are often reluctant to read research findings and take care to qualify their statements or tone down their rhetoric. The "research" staff on the other hand are too reluctant hastily generalise, are cautious in their criticism and value "objectivity" more than taking political position. The action-staff would demand "evidence" for their political positions from research; while research staff would find it difficult to do "research" where conclusions are already derived, positions taken and campaign initiated. On the other hand, this uneasiness in orientation to work is also found in the differing needs for administrative support. The research normally needs more skilled or semi-skilled persons as support staff while the action projects would be having more unskilled or street-smart persons in the administration. In research projects the administration is normally trim and the need for administrative support is episodic depending on the work phase of the project; while in the action-based work the administrative staff is more populated and support need is constant and even rapid response needed as crisis and emergencies are many.

In short, translating political philosophy into the work of the institution takes place by different routes in research and action; and both have implications for the kind of

administrative structure one would need. The most important issues in the political philosophy for the organisational work are: (a) how to ensure that political positions are not treated as dogmas and final truths; but as dynamic process needing constant reinforcement by generating the evidence and hence providing the strong foundation for respect for research in the institution; and (b) how to ensure that the "action" is not seen as an end in itself but also a learning process, and thus, regarding action as integral part of the broader agenda of research for generating evidence for the political philosophy.

Others issues related to value system:

Talking to some of the senior members of the SOCHARA I was deeply impressed by their concerns such as commitment to such mundane things as simplicity and cleanliness, readiness to do any work, the concept of living wages – looking after the needs rather than greed, strong concern for reducing gulf between the intellectual/specialised and manual/unskilled works, not allowing the ratio of remuneration to the lowest and the highest category of staff to exceed 4, non-hierarchical relationship and functioning. All of them, I am told, are parts of the foundational values of the organisation, and efforts have been made to operationalised them over all these years.

Evidently, operationalisation of such values was not found to be so easy. In last 20 years they were experimented, discarded or modified. For instance, the idea of reducing the gulf between intellectual and manual work is not attainable in any organisation unless we are able to create condition where basic minimum education and skill of all staff is same and very high. Such situation may provide an objective basis for not having division of labour in the traditional way (manual vs intellectual). Overcoming such division of labour through voluntarism in an organisation is not only unsustainable, it could also make organisation authoritarian by forcing those who are not convinced about it. Thus, certain values may look attractive in terms of personal morality, it is difficult to make them ethical code of the organisation without creating pre-condition for making them practical and sustainable.

While I think that value such as promoting equity by ensuring appropriate ratio of basic pay between the lowest and the highest salary is both appropriate and to certain extent sustainable, we need to review it regularly to ensure that organisation does not lose good professional due to that policy. The staff and ex-staff members of the CHC are divided on this issue. The professional staff is critical of this policy as they find that it is a hindrance to paying higher salary to them, the staff at the lower

level find it a good policy as they get salary at the level higher than available elsewhere. This criticism of the operationalisation of value CHC considers important is going to only increase.

The sustainability of this value is directly proportionate to three critical factors: (a) Having senior professional staff with commitment to working at low salary or they have other family sources not requiring good salary. (b) The CHC is looked at and used only as the administrative support base of for the otherwise full-time employed professionals in the SOCHARA and thus the CHC not having any paid full-time professional staff. (c) By technologically upgrading the work system so that the low paid non-professional staff is not required.

All three options are difficult ones. In the (a), almost all NGOs have found difficult to get professionals not needing "decent" salary. Adhering to this factor has either made the founders as the only professionals in the organisation or they have attracted only the spouse of well-paid professionals or businessman looking out for semi-voluntary employment or they have attracted retired professionals. This inevitably pushes out the professionals hailing from lower strata. Such individuals would be there to use the organisation as stepping stone for higher jobs. The strategy (b) would change the CHC from functional centre of the SOCHARA to its administrative centre. And (c) would make the CHC without peons/office assistants and secretaries, thus demanding technological up-gradation – a debatable value in itself in the SOCHARA.

I found the issue of technology, location and space as value related considerations as part of value debate in the SOCHARA/CHC as somewhat misplaced and extreme. I believe that practical considerations rather than moral should be applied on these issues. The politics of technology or ideological underpinnings of technology and technological change should be separated from the appropriate practical use of technologies and space.

Lastly, the issue of life style of individual members is problematic. There are over 30 members of SOCHARA, and then we have staff members of the CHC. There is no way to find a uniform consideration in the way each member lives his or her life. There are also variations in the extent of social and family support each one enjoys, as that could be important consideration for taking risk in life. And at another level, it is difficult to determine the appropriate standard or level of life style that could be adequate for the

value system of the organisation or for the simple middle class living in present-day urban jungle of India.

Summing up:

Issues related to philosophy are not easy to resolve. More so if the philosophical considerations and values; are eclectically put together. Somehow I kept getting a feeling that the list of values to be followed is too long, too eclectic, not having a coherent structure or being part of one theoretical position. This was less problematic when the organisation was small, was trying not to become an institution, did not require more professional staff for undertaking projects, etc. For at the time, the value system was judged more in terms of its founder's or Ravi/Thelma's value system rather than value system of all members and staff. With the SOCHARA growing into big organisation (over 30 members) and expansion of staff and work of CHC, the longer list of values and philosophical considerations is going to keep creating problems. By narrowing down the focus and ambition of the CHC it may be possible to provide better coherence to value system and bring down number of values to be universalised within the organisation.

Lastly, it must be kept in mind that all values cannot be and should not be legislated as rules within the organisation. Just as some people call laws as minimum ethics, the rules of the organisation should also be looked at as minimum value or only those values necessary to be universalised for the socially useful and efficient functioning of the organisation. The rest should be left to the commitment and goodness of individuals.

them opportunities to prove their point of view. \dots provides some ethical values to people

Its contribution to the other NGOs

- If I could achieve something to promote community health (in my organisation), it was mainly due to the contribution from CHC and all those connected with it. The very concept of community health was emerged with the support of CHC.
- CHC was almost like a ready recknor for the latest on medical or community health information. Showed me the value of low cost teaching aids, especially the posters and songs. CHC means "friends" who are always willing to help during a training programme and to share their knowledge. ... a good sounding board to test new ideas.

Motivating and inspiring individuals

- At the beginning CHC was a mentor. I was feeling lost in a new field and CHC was able to show that values could be applied "even" in this (my) "speciality". During my post-graduate CHC was a senior friend and a colleague. One could rely on CHC even when medical colleges and community health departments were getting institutionalised. ... CHC is like a reference point its attachment to ideals is consistent.
- CHC has been an inspiration, calling me back to my own commitment to people especially those whoa re on the fringes of society. It has provided a sounding board for my own doubts, questions, and search for ways to move forward in my path. It also been a partner in the wider effort to bring in values of cooperation, justice and peace in our country / world.
- CHC has meant to me a refuge "a place to recharge" a place to visit when spirits are down (but not out); to understand that "we are not alone" that there are others who also are constantly questioning, "trying to understand" fighting for rights for the "voiceless" adding agendas if need be but never "shying from the truth". It has also helped me to "have faith in fellow human beings".
- CHC members provided me valuable mentorship and counselling. They helped shape my understanding of community health and develop a broad, holistic, interdisciplinary perspective on health and medicine.
- The core team of CHC and many friends at CHC have been a 'landmine' of shift in my paradigm of thinking, viewing, believing and acting.

- personally, CHC gave immense opportunity and help to understand the concept of Community Health.
- CHC has been a source of inspiration to keep my passion for helping people help themselves alive.

I also had an opportunity to go through one independent review of the work of CHC in the Women's health training programme (see Jandhyala Kameshwari, "An assessment of programme in Karnataka, 23rd-28th February, 2001). The CHC acted a lead or nodal NGO in Karnataka. The report states that, "Generally the partnership between a nodal agency and other NGOs has been seen in a positive light. All the partners felt that they have been allowed to retain their individual flavour in the implementation of the programme. By and large the management and coordination of the programme nas been smooth."

Although there is no need to discuss the contribution made by the CHC in the Health Task Force of Karnataka and in the drafting of its report as the same are well-known, it must be noted that this intervention in the policy making at the state level was a tremendous success in bringing about the impact of its work in last five years. This task was carried out with lots of commitment and effort, and the individuals I interviewed were highly impressed by the performance of the CHC in this field. Another work of the CHC mentioned by respondent was on influencing the medical education at the health sciences university of the state.

It must be noted that the study of the impact of work or programmes require more rigorous efforts. One needs to go into each programme and not only look at how well they were conducted by the CHC, but also examine its objective impact in improving health or meeting other objectives and also how the recipients or beneficiaries appreciated them. Such detailed examination of the programmes was not possible in this review.

(E) QUALITY OF WORK UNDERTAKEN

I did not have time during the review process to objectively assess the quality of work in the randomly selected programmes or projects. Indeed such assessment would be a task in itself. Hence, this review does not have much – indeed almost nothing – in assessing the quality of work undertaken by the CHC.

I indeed ask this question to many individuals I interviewed, particularly those who are not directly involved in working at the CHC. The quality of these responses also did not convince me to come to any reasonable conclusion about the quality. The responses were varied but quite instructive:

- The leading individuals are intellectually very good and whenever they have taken up research-based work, the outcome has been excellent. There was high appreciation of quality of such research-based writings. Some individuals expressed disappointment that they have not done enough research, systematically published their work in peer-reviewed, indexed journals nationally and internationally and thus not done enough to influence the professional public health community.
- A few individuals from NGOs where the CHC had organised trainings in the past were interviewed and their general comment was very positive about the quality of training. They showed more concern about the quality of follow up, as they complained that CHC is taking so much work that it does not have sufficient time to follow up.
- Two types of critical comments were received on the quality of work in the networks and the work at the community level. The first was that somehow there was more orientation to number of events rather than what each event was achieving. Thus it needed more rigorous, high quality and clearly defined intervention in the network related work. One person said that good networks cannot be built by "flying in and flying out". The second was that the CHC must strike direct roots in some community, build some good work and experience in working at the community level and do some demonstration of translating their ideals into reality at micro-level. According to this view, such approach would take the quality of their training one step ahead.
- One person made comment that while lots of documentation of work was carried out, but it is very excessive and not systematic. As a consequence, one does not find systematically designed and regularly updated training manuals on some very important subjects coming out of the CHC. He lamented that an organisation with training at the high priority agenda should have gained good name by now in providing such training manuals. However, he was quick to add that that did not mean that trainings provided by the CHC were not of high standard but that it should have done something more systematic to ensure that such training courses were documented in manuals, thus providing much better guidance to trainers.

(F) FINANCIAL POSITION AND SUSTAINABILITY

As explained in the section on organisation, the financial position of the CHC has considerably improved in last few years. It doubled its income in last three years and its annual turn-our is about half a crore rupees. A concern was raised that much of the income was from grants, and many such grants had come for specific projects, and that it does not have enough money in its corpus funds and reserves. So there was also a concern for its sustainability – with an assumption that if there is more annual budget, the sustainability is more difficult.

I did not have detailed discussion on this with many individuals – not at all with anybody on the financial statement of accounts of the SOCHARA, but with few individuals on the issue of sustainability. So most of the points given below are my own comments.

- (a) The excessive concern for the corpus funds should not be there as there are organisations with less corpus funds and higher annual turnover than the SOCHARA's have been able to sustain themselves. Besides, with the low-interest rate regime in force and with almost no chance of high interest rate times coming back, the income from the interest of the corpus would be so low that one would need very big amount in the corpus to earn adequate interest.
- (b) Unlike in the past, there is relatively more emphasis on the monitoring and evaluation by the funders and there is also more demand for focused work. The positive side of such demands is that they force the NGO not to keep doing anything and everything that comes in its way, but do better planning and have long term focused work. If such situation is alright for the CHC, its capacity to attract fund is still very good.
- (c) Several respondents made a strong plea that CHC should explore possibility of raising funds from the public and private sector corporate houses and their philanthropic organisations. In principle it should be possible to raise such funds if there is no unacceptable strings attached to them. Particularly efforts need to be made for increasing corpus funds or for getting endowments that could sustain some of its activities.
- (d) Induction of competent professionals in the team would help in the fund raising too. Firstly their presence would make the organisation more attractive for providing project-

based work, and secondly these professionals in a course of time would be able to attract funds for their own work.

- (e) One viewpoint was that the CHC did not have to struggle too much so far for funds as it had funders who were very committed to it and its requirement of funds was modest. It also did not create non-moveable assets and thus remain somewhat tentative. This has, according to this view, made the CHC somewhat less dynamic (lethargic) in fund raising. It would be more dynamic in that field if it creates stakes in terms of non-moveable properties (its own office building, for instance); and also has responsibility of supporting a larger team of professionals. In fact, some amount of insecurity related to funds was considered better situation than having it easily as that often robs away the organisation's dynamism.
- (f) Since the turn over of funds of the SOCHARA has considerably increased, there is a need to develop some expertise in the management of finances. Gradually both in-house and consultant-based expertise in finance management would be needed for efficient utilisation and creation of reserve Funds created for various core activities by accumulating surplus money in specific Funds.

In essence, organisational expansion – in terms of human power and work/activities – bring about more responsibility at the level of finances. In the present context of dearth of good NGOs, it is not impossible to sustain work of good NGO provided one plans well for fund raising, focuses work in the key priority areas, professionalise its working and give sufficient attention to the outputs and impacts.

DISCUSSION ON SOME CRUCIAL ISSUES OF PRIORITY IMPORTANCE

(1) CHANGING VALUE SYSTEM:

Two milestones - the registration of independent society in 1991 and the change in direction in 1998 – are impacting in many ways the foundational philosophy and the value system, and that is making some of the society members concerned. They are more concerned because further consolidation of the course could lead to major change in the foundational philosophy and the value system. This issue needs very explicit discussion within the organisation. It is not sufficient to argue that the developments since 1991 have not seriously impacted the philosophy and the value system. The following points need to be clear in the minds of the members – particularly those who are associated with the organisation since its inception.

The period 1984-90 is cherished as "golden-age" because it was formative, idealistic and the most dynamic phase. The 1991 change was supposed to formalise and integrate those values and ethos in a formal and independent organisation. However, it seems that the society gave less attention to, or needs to appreciate, the objective impact that the formalised organisation brings on the value system and ethos.

First of all, the formalised legal system creates both stakes and responsibilities. Not just individual's likes and dislikes, but the presence of organisation needs to be taken into consideration more and more.

Second, there is pressure to expand the public space in the organisation and demarcate it from the founding individuals' private space.

Third, it inaugurates the institutionalisation of the organisation. I think this is hardest to accept, because if the founding philosophy and values are strongly against the institutionalisation", or attaches premium on "de-institutionalising" just in the same way as one attaches philosophical and political importance to "de-professionalisation", "de-mystification", "de-bureaucratisation" and so on, the organisation goes through a phase of denial ("we are an organisation but not institution", and a phase of accommodation ("we have institutionalised a bit but there is absolutely no change in our original philosophy and value system").

Fourth, it makes it urgent to rationally understand the relationship between the "society" (SOCHARA) and its "functional unit" (CHC). I feel that this relationship is not as seriously discussed as necessary. Often the society is seen as the upholder of the philosophy and the value system. The functional unit, as its name suggests, is the one that operationalises the practical decisions and carries the burden of living that philosophy and the value system. This does not mean that some of the society members do not get involved in providing lead and direction, but that the essential burden of operationalisation is collectively on the functional unit and not on the society.

Fifth, the establishment of the formalised unit brings into the relationship another force, the paid as well as honorary staff of the organisation. It is this group of people and the way they work that remains at the centre of discussion on success and failure of implementing ideals. Despite all idealism, one needs to accept that once we have employees, we become employers. For activists entering into the running of paid full time organisation, it is very difficult to accept the reality of the employer-employee relationship. Over and above that, it also brings about hierarchy. The most important challenge for a sensitive voluntary organisation is not to strive for the utopian state of the elimination of the hierarchy, but for how to have hierarchies without hierarchical relationships.

I think it is necessary to look at this dynamic of development in order to understand the stress that the original or founding philosophy and value system keep experiencing. The semantic of terms may not be useful because each one may define "institution", "bureaucracy", "hierarchy", etc. differently. What is essential is the acceptance of the fact that in the formalised paid organisational structure, they are present; the only thing that we can do is to make efforts to give them different form, a more humanistic form. In the relationship between the society and the functional unit, we need to pay attention to two processes: (a) the functional unit should never be allowed to become the utilitarian appendage of the legal unit, the society, and (b) put in place the formal structure and processes of autonomy and empowerment for the functional unit(s) and the individuals working there. Attention to these two aspects is important simply because the society and the functional unit exist in power relationship and the society being a legally empowered body, always has more power than the functional unit. The issue of ethics in the structure of relationship needs to be addressed here.

It is often argued that certain values are eternal and must be upheld under any circumstance and organisational form. Here, we need to filter out the secular ethics from the individual morality. The latter is important for each individual and it is bound to be different for each depending upon the cultural, religious and other upbringings, but the former is the one that deals with the standard of conduct in the secular and public space and hence needs to be continuously contextualised. Moreover, we need to discuss this the idea of comparing the present with the past. Why do we assume that the idea and philosophy we started with ware qualitatively superior/better than what we have on the ground today? Perhaps it makes better sense to understand evolution of the ideals simply because there is always continuity of certain elements and the change in others. The elements showing continuity are also not eternal, and simply because they survived do not make them eternally ideal. A reason for that could be that they are kept alive artificially, but have lost the actual base within a majority of the society members and the staff. Those who have not survived should also not be seen as dispensable simply because we may think them important to make practicable.

The only suggestion that I can give is that the SOCHARA/CHC need to have very hard and realistic look at the philosophy and value system of the organisation. There is a possibility that it may become an endless discussion, but that should not deter it to have appreciation of the philosophy as it is presently practiced and not get carried away by the philosophy as it is idealised.

(b) ORGANISATIONAL STRUCTURE AND PROCESSES

One of my strongest feelings is about the structure of the organisation. I narrated some aspects having bearing on the structure in the previous point; here they are developed further. Several issues need discussion:

First, the process of organisational change seems to have started in the CHC but not reflected in the SOCHARA. This is a very paradoxical situation simply because the changes introduced since 1998 in the CHC came from the decision of the SOCHARA. Perhaps the members have not fully appreciated or understood the meaning of the changes. The change in the CHC is that since 1998 the process of institutionalisation and professionalisation has been augmented. Correspondingly, there is little attention paid to the changing role of SOCHARA. We need to face the question – if the CHC institutionalises or reaches a higher level of institutionalisation and professionalisation, what would be the role of SOCHARA?

Second, the first two (1984-1990 and 1991-1998) phases of the organisational development, the SOCHARA was a support network nurturing few individuals who had made commitment to work differently, be a sounding board and generator of the ideas. In many ways, much of the organisational work as against the programme-based work were centred, around SOCHARA and the CHC was just a functional unit. This system has continued even now, and to my understanding, one of the strongest criticisms of some of those who worked in the CHC in last five years implicitly is in relation to this system. This does not mean that there is absolutely no participatory system. On the contrary, most of them did describe it as participatory system. However, the problems I found were more with the content and context of participation, because participation does not automatically lead to democratic and empowering system. So we need to discuss the participation and decision making in the areas that matter, the areas that have formal power sharing arrangements, rather than looking at the participation in formal sense and often in the softer areas.

Three, the executive/managing committee of SOCHARA is by law and in effect should function as the Board of Trust or Governing Board of the CHC and not as the executive body. In a way a perusal of the minutes of the executive committee shows that it is in fact moving in that direction but without discarding its executive functions and creating legitimate and formal body of the staff to devolve those functions. It is absolutely essential that the staff, by having circumscribed and devolved formal executive functions learn to govern the organisation and learn to evolve its own development plan. Presently such processes are there but at the informal plane, and that is making many individuals tentative in committing themselves to the processes.

Four, this would necessitate the demarcation of role/functions, powers and system of accountability between the staff body, the coordinator, the executive committee as governing body and the general body meeting. Given these structures, one would also need the meeting places – where they are able to jointly meet, consult each other and iron out differences from time to time. I believe that the EC and the GBM should act as policy making bodies, peer reviewers, sounding boards and refrain from directly exercising executive function unless absolutely essential or when there is a course correction found to be necessary.

Five, the SOCHARA needs to tighten its norms for membership and reconsider its earlier decision to increase numbers. It must be kept in mind that CHC is no longer a small

organisation – its financial turn over has increased several times as compared to early and mid 1990s – and there are stakes involved. The current practice of accommodating individuals in the SOCHARA if they cannot continue to be a part of the CHC must stop. It must also overhaul its membership by keeping in mind those who are genuinely active - not in general as a part of network or ideology-sharing but specifically for the CHC/SOCHARA – and those who share the vision for the future of the organisation.

Six, the CHC needs to be given a more systematic and formal shape. The CHC cannot be governed only using the rules and regulation of the society, but it also needs a separate administrative rules and structures. I am sure that there are administrative rules, salary scales and other things existing as a part of the administrative orders adopted by the EC from time to time. But this is not sufficient – they need to be brought together, openly debated, modified and in consultation with the staff adopted jointly by the EC and staff.

(c) INSTITUTIONALISATION:

The most intriguing aspect of the CHC/SOCHARA for over years for me has been its concept of being facilitator and catalyst organisation and not being an institution. I have made lots of efforts to understand this concept as applied to organisation, but not sill understood fully. So if my comments betray my ignorance, I beg apology in advance.

I received a very consistent (very few people doubting this aspect) response from all over the country from those who associated with the CHC for short duration as a part of network or visitor to the CHC, and then kept in touch and remained in active contact. All of them told me about how they felt inspired, how they could get some vision and how such association impacted their decision about involving themselves in community health. However, some more discussion brought out several issues that are worth pondering about. First, there is a mixing up of the individual's personality and the organisation. Some of these individuals were very appreciative of individuals but not so much of the organisation. Particularly Ravi Narayan was identified as highly suitable person as mentor, facilitator and the one who could provoke them, but not the organisation as such. I know that individuals give shape to organisation and so they cannot be completely separated. But if the unevenness of the development between the individual and the organisation keeps widening, the ups and downs, the changing

priorities etc of the individual can have sharp impact on the organisation. Secondly, it is very evident that with the gradual withdrawal of Ravi Narayan, there is corresponding change in the way the organisation is playing the role of the facilitation and being catalyst. This is based on my conviction that any organisation, having basic dynamism and social commitment, at some level acts as catalyst and facilitator. Thirdly, the organisational role as facilitator often depends upon how professionally well it functions in providing training, undertaking research and in advocacy. Its work on health policy and research, have those components, but they are still under-developed. One of the reasons for the under-development is that it is not able to find suitable and modified organisational role as catalyst and facilitator; and stop looking back as more personalised approach that was there in the informal phase of the development of organisation.

Fourth important issue to ponder over is the kind of needs and demands that are now emanating from the NGOs/CBOs and public health bodies (including professional bodies and medical colleges/university). In the 1980s and early 1990s the CHC was acting as a catalyst and facilitator in a different social and political environment than is doing now. From health as being community health activity – the paradigm shift that is well documented by the CHC – it has acquired some additional meaning, one of them is the also being a right and political process. The health as a right's issue was not as prominent earlier as it is now. Besides, the NGOs are undergoing rapid changes. The impact of economic reforms on the NGOs is enormous. I have a feeling that the list of what is to be catalysed and facilitated has expanded considerably and within that the socially relevant research, the policy advocacy, monitoring implementation of policies and impacting mainstream have emerged as newer areas having direct connection to the developmental process.

WAY FORWARD

What is the best way forward for the CHC? Answer to this became more difficult as I progressed in the review than I had anticipated at the time of starting the work. I am giving here a very brief and tentative view, but it can be modified and elaborated in the course of discussion with the SOCHARA/CHC in coming time. Besides, issues and ideas expressed in the previous section – some in very provocative way – provide lots of material for discussion and decision-making.

Three alternatives kept coming back in discussion: (a) Make a retreat, go back to pre-1998-9 situation and continue doing what the CHC did between 1984 and 1998. The recent changes are institutionalising the organisations, divorcing it from the community work, making it more research oriented, expanding its strength and making it financially non-sustainable, and so on. (b) Build on the great achievement of last 20 years, identify its strengths and build it as institution in a planned but bold way, preserving some of the values and ethos, and charting a course towards establishment of a good community health institution. (c) The CHC should be closed down. This position was not explicitly taken by anybody, but some individuals indirectly mentioned such possibility. The factors that prompted such response were: (1) institutionalisation would be a worst option than the closure, (2) unable to carry on because the core team is tired, burnt out or has changed its direction.

I do not think that the third option should be entertained at all. It would be the biggest disappointment if decision to close down an organisation after it has done tremendous work in last quarter century. I also do not believe that there is a dearth of new generation of committed professionals to carry on with the work of the organisation. Hence, the choice is between the option (a) and (b).

Here too, I feel that while it may be useful analytically to dichotomise between being organisation but not institution and the strength of being catalyst as compared to weakness in becoming institution; I do not see such dichotomised relationship between organisation and institution; and in being catalyst and institution. For me all organisations are different kinds of institutions, and all good institutions must provide inspiration to those who work there and others so they are also catalyst in certain ways. Institution building does not mean that the organisation should become too big or should stop having ideals and should stop inspiring.

Concretely, institution building is a process that (a) changes mind set of group governing it from seeing the organisation as temporary to permanent entity; (b) makes the organisation more stable and giving look of permanency, (c) increases the role of organisational system so that it does not rely too heavily on one or few individuals for its survival, for good functioning or for its value orientation; and lastly (d) provides continuity by creating its own image that helps in attracting and retaining right kind of individuals for perpetuating its work.

This process need not take place in one place, in one building with over-centralised bureaucracy or the organisation having only one priority. The process may take place in several decentralised centres with one governing entity coordinating and providing guidance to such process.

Recommendations:

During my interaction with various people from SOCHARA and the CHC, I did find some strong differences in perceptions – at philosophical/political level and in actual work – and they are to some extent reflected in the report and also discussed. Some views may appear very extreme, yet I think there is maturity and the scope within the organisation to make adjustment and continue with the process started in 1998 for building institution.

I am not going into details of changes to be made in administration, process of organisational functioning etc as recommendations on them are already in the text of the report. I will write only on few points related to the institution or organisation building.

(1) While lot is said about bringing back the spirit of first decade of CHC (1984-1993/4), it seems to be more nostalgia and "manner" of making points. The real tension appears to be on how to strike balance between the "action" work in the community and the "intellectual" work of research and the "campaign" work of advocacy. This balance is not easy; as it seems that various actors involved in this process have strong views, one of them being that orientation towards research is shifting focus or priority from and perhaps detrimental to the action or community-based work. These views need to be reconciled, and the appropriate place for all three components must be found under the larger framework of the SOCHARA.

(B) ORGANISATIONAL STRUCTURE

The factor of structure is very important in keeping organisation alive to newer challenges, impersonalise it by making it a public space and by ensuring a system of participation. My first impression of the structure was that it was very weak and traditional. Later, my detailed examination of it only provided part confirmation of my feeling. It is not surprising that unconventional thinking and work by NGOs in our country are often carried out in an organisational structure that is very conventional. But this produces imbalance and keep creating its own crisis. So one needs to pay more attention to the structure and be innovative in evolving something more appropriate to the work for which the organisation is created.

Another important fact is the organisational processes, and there is dynamic relationship between the structure and processes. Those who do not see structure and processes as inter-dependent, normally pay more attention to processes rather than structures. Besides, structures would be virtually empty and useless if there are not good processes to make them workable. The problem with the emphasis on the processes without structures is that they could appear and get perceived more as top-down, benevolent and paternalistic. The structures with good processes help in making the power-relationship explicit and good structures could help in distributing power in such a way that it allows more initiative and development of new leadership or political voice.

The organisational structure of the SOCHARA/CHC is very simple and based on the legal requirement of the society. In that sense the organisational decision making structure is basically that of society rather than CHC. The general body of SOCHARA elects the executive committee and the secretary to the executive committee also works as coordinator/director of the CHC, the functional unit of the SOCHARA. Since within the CHC the structure is only around the job designation or position accorded to each staff member, the participatory functioning and participatory decision-making are left to the processes sustained through coordinator's initiative.

General Body:

All members of the SOCHARA constitute the General Body. It has 34 members. For last few years the SOCHARA has been making lots of efforts to expand its number by

motivating individuals to join the society. The membership appears to be drawn from three constituencies. The first one is its core-constituency made up of those who have been associated with the society from its inception or for very long time. The second constituency from where members are drawn are the peer and network groups, the long time supporters and participants in the training and other programmes. The third section is made up of the former CHC staff members, trainees, associates and others.

The annual general body meeting of the society, as compared to the number of members, is not well attended. A quick look at last ten years of the annual general body meetings show that the attendance was from 60% to 30% of the total membership. The core team of 7 to 10 individuals has been consistent in attending the meetings and also in sharing the responsibility as Executive Committee members. This consistent low attendance could have been one reason why the SOCHARA tried to recruit more individuals in its general body as members in last few years. However, the attendance has not improved.

The efforts to get more people involved and take responsibility in running the society are laudable. In every organisation there is always time when one needs to think in terms of getting fresh blood and new ideas. However, it needs to be kept in mind that such initiatives must be well planned and membership offer should be based on mutual compatibility as appreciation of the responsibility for being a member. Besides, in a society having lots of people who are otherwise very busy in their own profession and activities, it will be impossible to find a time convenient to all for the meeting. So a smaller body would provide more flexibility in arranging meetings at the convenience of all. Thus, it would be much better to look for replacement of members who are retiring and not able to take more responsibility and the new entrant's membership must be accepted only on the promise of discharging some minimum responsibility. The individuals living far away from Bangalore should be offered membership only on making arrangement for financing the participation of the individuals for the meeting.

There is one more reason for exercising caution in expansion of membership. The SOCHARA/CHC are not activist organisations, though some amount of activism they undertake as a part of their activities. They are essentially institutions or establishments with full-time jobs at stake, high budget raised through grants and stakes in terms of at least moveable properties, instruments, books and so on. Add to that an impressive history of twenty years of work. For such establishment it is necessary to ensure that its chief governing body is trim, active and involved. There are also examples – several of

them in Western parts of India – where the establishments run by societies have been taken over by the members who made slow but deliberate entry.

Thus, those members not meeting minimum requirement of discharging responsibilities should be allowed to drop out and the entry may be restricted to only those who make commitment to provide minimum inputs in the society's work.

Executive Committee:

The executive committee is the real day-to-day decision making body. It is exclusively made up of the members of the SOCHARA elected on this body at the AGM and has tenure of three years. With strength of seven members, it is natural that a big majority of the core and regular members of the SOCHARA work as EC members.

First of all, the attendance at the EC meetings is fairly good showing that the core-regular members of the SOCHARA are deeply interested in the work and welfare of the CHC and all other activities of the society. Second, the frequency of the meetings is as per the legal requirements. Minimum two meetings in a year do take place, in a few years the maximum number of the EC meetings is much higher. Three, the minutes of the meetings show that EC carries out a wide range of decision-making. It decides on all major policy issues related to the work of the CHC and the SOCHARA, receives reports of work carried out by the CHC and takes decision on it; and at the lower level takes or ratifies decisions on simple administrative matters like sanction or approval of rejection of leave application and other problems. Between two meetings, the secretary, who also works as the coordinator of the CHC, is empowered to take decisions on the routine matters and also take initiative, with the aid of staff and others, new activities; but the same are reported at the EC, discussed and ratified. The staff confirmed that usually the secretary consulted them on important matters and the office meetings were conducted before taking decision and so on. This indeed is a good practice, and works well in small organisations. However, the informal consultation with all, however regular, start bringing strains on the participatory methods in larger organisation for simple reasons that there is greater unevenness in qualification, involvement/commitment and relevant experience of the staff. Hence it is necessary to find a practical way out so that the participatory processes are not stopped and yet, the day-to-day decision making body assisting the secretary is compact, smaller and functioning regularly.

The EC as a decision making structure in the period between the General Body meetings seems to have worked well for the SOCHARA. The general acceptance of it in the staff of the CHC has something to do with the processes in which care is often taken to invite staff members for discussion during the EC meetings. At the same time in my discussion with a cross section of the staff and former staff members about it in last five years has elicited some responses that need to be addressed to. The administrative staff has been finding itself in some disarray of late because of the sense of insecurity generated by the uncertain future of the organisation or due to discussion on the re-organisation. Somehow, the message from the EC has not been clear enough to allay some of the problems of theirs or they are not able to articulate their problems or they are finding themselves not fully competent to the new tasks coming in the way. My collective discussion with them could not generate enough material to pin point the problems except a statement saying that they are not trusted enough, but their problems, if they are significant, are worth looking at. In any case more needs to be done to tackle this issue of trust as it has been articulated.

Some of the former staff members have also raised issues related to the considerations that go in making certain decisions. The former professional staff also aired some similar issues. One area they showed lots of concern was that criteria used for judging their competence and contribution. For instance, at least two former staff members said that one of the reasons they left was related to non-appreciation of their competence to represent organisation in meetings, particularly national and international meetings. They also raised issue that such decisions normally favoured the SOCHARA members for representing the organisation while they were actually working on the subject on which such meetings took place.

My comments: The critical remarks on the decision making process throw some light on the need to work out a structure that has formal representation of the CHC staff and at least strengthening the inter-phase between the SOCHARA and the staff. This issue will keep becoming critical as the CHC expands its activities (as it is doing now) and more professional staff keeps joining.

The CHC Staff:

There are several structural and functional issues related to the staff raised by individuals I interviewed. Most of these issues take into consideration only last five-years as they

seem to have come more forcefully with the expansion of the project based activities and community health training.

Two issues discussed above are found to be important. (1) The issues of formal representation of the staff in decision-making process to ensure that there is wider clarity and understanding of the decisions among the staff. This does not mean that informal processes of the consultation with the staff are weak, on the contrary, they are very much there and consultations and their democratic nature are acknowledged by most, but that has not overcome the uneasy feeling about that decisions and the justification for decisions taken. It might help to formalise those processes so that participation does not look selective. (2) Structurally it is important to demarcate the areas of direct involvement of SOCHARA members in the work of the CHC and the areas where the CHC-staff has full autonomy to represent organisation (CHC and not the SOCHARA) and autonomy to design and undertake activities. This demarcation should go hand-in-hand with the strengthening of the inter-phase between the SOCHARA and the CHC so that there is a formal forum for interaction and resolution of problems cropping up.

Other issues raised in interviews are as follows:

(a) Some of the former senior, professional staff has found the designations used problematic. The designation as Fellow was found to be less useful while working with the outside organisations and they felt that better designations are needed so that they could help them in facilitating their work.

My comments: This looks trivial issue, but I think designations could always be changed if there is a need or demand from the staff. However, care needs to be taken that the designations reflect the NGO or institutional character of the organisation and do not sound like corporate entities.

(b) The issue of right mix between the project work and general work underpinned some of the discussion. While nobody opposed the idea that project staff should also be undertaking other works, there was some amount of disquiet on how that could be achieved. Issues like the projects also flowing from the core concerns of the organisation, the mix should not be looked at administratively in terms of number of hours put in for each activity but in terms of the extent to work put in on the topic of the project beyond the work committed in the project proposal, how and who decides the work that is

project-based and general, etc were mentioned. This does demand not only some clarity but also consensus among the staff.

My comments: I was not surprised to find that there was a discussion about the project work and institutional work. It may not be possible to put such discussion at rest at all as most of the NGOs survive on projects and they do not have any permanent source of funds. But few measures might go a long way in reducing such discussion: (i) it is necessary to make sure that "project" work is not distinguished from the "institution" work. This could be done by ensuring or making it known that project is taken simply because institution wants to do that work; (ii) by appointing all staff as temporary institution staff and not as project staff, the work of project is only assigned or responsibility given to the particular staff; and (iii) performance evaluation is for the performance on all the tasks assigned.

(c) An indirect mention of the way projects are formulated and their connection to the overall plan of organisation development was made both by some SOCHARA members, peer-groups members and present and former staff. A muted concern whether the project would be taken on the basis of availability of money from the funders or they would be evolved as a part of the raising funds for the short and medium term activities planned was also raised.

My comments: There is no evidence and I am not convinced by the arguments that some projects were taken by the CHC just for getting funds. On the contrary, there is evidence to show that there is a lengthy process of developing action plan for the organisation, and thus some amount of planning in development of organisation. At the same time, there is need for more rigour in planning of the programmatic areas of the action plan. Perhaps writing of working or discussion papers for each programme of the organisation may be useful. Such working or discussion paper should do rigorous literature review to summarise the present state of knowledge on that programme, describe work done by the CHC so far in that field, provide rationale for the kind of work that CHC should be undertaking in the next five years and make suggestions about how practically it could be accomplished by converting into relevant project or projects and raising funds for them. This will provide not only an additional, intellectually more organised input to current efforts in the planning but would also satisfy the present critics on how and why project are being taken by the CHC. This may or may not stop such criticism, but the

minimum it can do is to provide strong political and public health rationale for the projects being pursued.

(d) Several people raised the issue of second-line leadership and lamented on the structures not being conducive to development of such persons. A few were outright looking for motives for "not allowing second-line of leadership to develop", while all others (big majority) were more understanding about the problems of developing and retaining second-line of leadership in the NGOs but wanted more reforms to ensure that such leadership develops at the earliest time. Interestingly both the groups generally were of the opinion that such leadership would evolve only through better planning, positioning of individuals in the organisation, provision of autonomy in work and more tolerance to different ways of doing things. The former on the other hand articulated need for more institutionalisation, representation in decision-making, professional approach to work and better salary structure to retain emerging new leaders, the latter group was more reticent in talking about such issues but wanted such second line to develop by paying extra attention to the task within the existing structures.

My comments: This is both a difficult issue and also a delicate issue in discussion. The NGOs in India a personality-based and not based on organisational system is an oftrepeated remark used both to describe as well as defame the NGOs. I am giving comments on the assumption that there is genuine problem in finding new leadership. Two problems often prevent the founding individual(s) from passing the organisational leadership into new hands: (a) lack of such individuals, or the right individuals not staying in the organisation for "long enough", and (b) fear whether in their absence the political commitment or idealism with which the NGO was started would be sustained by the new leadership or leader. The first problem in the context of the CHS has two dimensions. First, is there any individual or individuals in the SOCHARA ready to leave their current work and make commitment for at least five years to take leadership of the CHC? In my interaction with the SOCHARA members, I did not get any hint to this effect and so I assume that there is none. The second dimension is whether from the professional staff of the CHC it is feasible to nurture such leaders. At the time this review was carried out the CHC had lost most of the professional staff so it was difficult to say anything; but in general if conscious policy is pursued, it should be feasible to prepare new people for the leadership. Perhaps it may be useful to start experimenting by appointing one or two potential persons as deputy or join coordinators of the organisation with a proviso that after two or three years they would be replacing the coordinator. The

second problem of sustaining old idealism or changing the political direction of organisation is directly connected to the SOCHARA's capacity to provide political leadership rather than founding member's presence or absence. My suggestion would be to strengthen the political capacity of SOCHARA rather than being dependent on a few individuals for political correctlness.

(e) The coordinator has decision-making powers between two EC meetings, and some of the major decisions by the coordinator are reported to the EC, discussed and ratified. Much of the criticism on the decision-making of the coordinator reported was related to the style of functioning, and so comparison between the past and present coordinator, were at that level. While I did suspect some motives in some of the responses – particularly those that made comparisons, I chose not to confront but accept them at the face value, as it is always very difficult to have individuals with the same style. At least one former professional staff while airing criticism of style, on his own admitted to the humility and transparency, thus dismissing the ideas of motives.

My comments: My inference is that much of such criticism came because of three reasons: (1) the tension between direct organisational commitment and desire for autonomy at the level of work, (2) inadequate appreciation of the deadlines for completing tasks and accountability to the funders, and (3) strong disapproval of quick administrative measures without allowing the process of negotiation on the problem at hand. Structurally, one of the ways to reduce (they can never be fully stopped) such problems related to style is to have a small formal committee of drawn from the staff to assist the coordinator so that such tricky decisions have wider support within the staff and at the same time the coordinator retains both the veto power as well as emergency power to make decisions. My own feeling while going through responses on the organisational structure is that the complexity of the evolving work and organisation demands more formal involvement of the staff in the management of the organisation, more frequent meetings of the EC or the EC to act like a governing board and devolves the day to day executive powers to the coordinator with a staff committee to assist in the process. The minutes of the regular meetings of the committee could provide better insight to the EC about prioritising its intervention. This process could be a beginning of both more thinking in the SOCHARA-CHC relationship on the managing the staff-based organisation and promotion of the principles of participatory and self-management at the level of CHC. This would provide a meeting ground between progressive staff policies (rules and salaries) with the organisational management. It will also provide some alignment between the demand of commitment and political consciousness among the

staff from the SOCHARA and problems of working as employees in an organisation whose objective is to operationalise objectives and decisions of the SOCHARA.

Rules, Salary scales and financial position:

The rules and regulation governing the CHC are fairly elaborate and cover most of the essential requirements. There is healthy respect for labour laws – making provision for the social securities and staff welfare.

The salary scales are also better than the most of the community-based NGOs. One person from the NGO made a comment that they are high. A salary revision was carried out about a couple of years back. However, as mentioned in the discussion in the philosophy and values system section, there is definitely a tension between the commitment to equity and the salary expectations of the senior professionals, and that has resulted into loss of some professionals. Another tension mentioned by a former professional is about the parity of salary practiced between the social science professionals and medical/public health professionals. Third tension, reported by two individuals, is between the lowering of salary of seniors thus paying them less than "market value" while giving salary that is more than "market value" to lower level staff in order to meet the value of equity. The fourth tension, not mentioned by any respondent but implicitly present (and found to be a tension in other NGOs) is between emolument for those who involve themselves in community level work and those who do research and higher levels of training. The last two issues, equity and the action-research, are the most difficult to resolve and that is the reason why the action/community based NGOs are not able to build good tradition of rigorous research by retaining good researchers, and the research NGOs are not able to provide place of pride to action oriented community workers without violating principle of equity. There is no easy way out of the dilemma.

Unless an NGO keeps getting adequate number of highly committed professionals ready to work at relatively low salary (less than "market value" of their labour, or less than UGC scales of associate and full professors), it has struggled to retain good researchers. The supplementary ways in which relatively low salary is matched with retaining them, are providing them more autonomy, rapid career development and high profile, possibility of becoming coordinator of the organisation, allowing them to undertake private consultancy outside office hours (on sharing basis with the organisation or by allowing full benefits), and so on. That is making it possible for

them to have higher job satisfaction and other non-material benefit with possibility of getting material benefit by working extra in private time. They need to be looked at to understand the extent to which such strategies and other innovative strategies thought of are compatible with the value system of the organisation.

The financial condition of the society is in very good health. I had an opportunity to study the balance sheet of the organisation for the years 1999-2000 to 2002-3. The annual income of the organisation more than doubled in this period and number of activities for which funds are utilised has shown steady increase. I have not studied the books of accounts but based on the auditor's report and the details given in the balance sheets I feel that management of funds is done in a fairly good manner. There is no doubt that the CHC as an organisation has established a good financial base to take off in case it wants to make a transition to a more complex institution.

Other issues of structure and policies

(1) One former senior staff member expressed very strong feelings on the organisational and staff policies, particularly with regard to the professional staff. According to him, organisationally the CHC had become: (a) a nursery centre for fresh medicine graduates join explore the field of community health as a possible career, (b) a sabbatical centre for highly qualified professionals when they are on sabbatical period from the parent institutions for very short period of 6 months to 2 years, (c) Post disaster make-shift shelter for professionals who quit their jobs or had to shift to Bangalore due to untoward professional/personal distress, and they join CHC until they find alternative, and (d) Professional vruddhashram centre, as a good retreat centre (retired men's paradise) rehabilitating 60+ yrs retired professionals. I was not able to separate out humour from the serious point on my own, but soon I realised that this was a serious point as he went on giving few examples in each category to buttress his argument. Essentially he was arguing that there was too much reliance on stop-gap arrangements rather than building core professional group within CHC; and was arguing for development of an institution that provided opportunity to professionals both for doing something socially good as well as develop their career within the CHC.

My comments: All four categories – nursery, sabbatical, makeshift support and vruddhashram – are important ones for any institution. It must nurture new talent and thus it needs to be a nursery. The provision of time for reflection to those who are sabbatical would be a great input. Makeshift support to talented individuals is

not a bad humanitarian commitment. And lastly ensuring that a retired but dynamic and idealist individual finds a place to continue work is also a laudable objective. Hence, I have no problem if organisation is pursuing such policies. However, I also agree that they should not be pursued in lie of the work of building professional core or core faculty of the institution. An institution having stable core of professionals would be able to pursue these four categories of work with much more confidence and as supplement to the work carried out by the core; than the institution lacking such a core.

(2) In the appreciation of organisation, the personalities cannot be kept out because they both shape the organisation and provide it with public profile. More so in the case of the CHC as for outsiders, it has somehow got identified with Ravi and Thelma for very long time - and this despite the fact that they had taken sabbatical for considerably long time in 1990s. I has lots of difficulties during the interviews to separate out points made on the CHC as organisation and on both or one of them. As far as possible, I did ask for clarification but it was not possible always. When such clarification was sought, I had found that the issue pertained more to the individual than to the organisation or it was assumed that both were same. While this is not surprising, it makes simple issues more delicate than they ought to be. On the other hand, some of the respondents very forthright in making some strong comment on the place of Ravi and Thelma in the CHC. This was also natural because an association of such a long time was bound to personalise the place and the image of it. With that explanation, few strong points made are worth mentioning so that in future planning of the organisation they are kept in mind. Six out of all individuals interviewed (included three former staff members and three others) felt rather strongly that the CHC was a family affair and others had only temporary place there. There was also an indirect mention by a few others in terms of availability of "public" space within the CHC. At another level, several respondents positively appreciated (three even saying that they idealise them) Ravi and Thelma but were highly concerned about the future of the CHC if they burnt out, or decided to do something else. Such individuals usually also felt that for the sake of future, the SOCHARA should take the path of institutionalisation - as one respondent put it, "it is inhuman to keep expecting them doing the kind of work they have done in last 20 years". They felt that only institutionalisation could motivate some professionals to stay with the CHC for longer time and thus relieve Ravi and Thelma from all responsibility. Three of the six respondents who saw CHC as family affair imputed different kind of motives for not institutionalising; such as they were insecure, they could not work with equals, and so on.

My comments: I found the discussion on this topic difficult to handle. I know that committed individuals in the process of building institutions blur the distinction between personal space and office space, not because they want family to dominate office, but because in order to ensure that the organisation survives and function, they even give their family time to office and often make family to slog for the office. So on one hand there is high level of personal sacrifice involved in the mixing of family and organisation. On the other hand when survival crisis becomes a permanent one and the blurring of space between family and office also become regular, the problem like the one narrated from discussion become more visible and start becoming even deterrent to emergence of new independent leadership. It is indeed not possible for me to pass any judgment on this issue except to say that in order to get out of this situation, the CHC should be using its current good financial and organisational position to develop new leadership thus reducing pressure on Ravi and Thelma to continue providing additional personal support to the organisation. In addition, the suggestions made while discussing issue of developing new leadership may be used for overcoming this problem permanently.

(3) Although there is no evidence that the SOCHARA/CHC have connection to the Church or Church-based organisations, or that its policies and work have anything to do with religious activities, several persons, including a few members of the SOCHARA, talked about their unease or just mentioned that it had some Church connections. However, none questioned its secular credentials and did not make allegations on religious lines. The major concern shown was about the narrow-base such orientation was providing to the organisation. Yet, in my assessment of the work of the CHC and the number of people inspired and motivated by the CHC show that its base is much wider at national level. Perhaps their concern is about its direct interaction and network at the local level – Bangalore and rural Karnataka.

My comments: The organisations taking firm stand against religious fundamentalism and fighting against communal violence do invariably face criticism and attacks from the communal organisations. One way to manage this pressure is to ensure that one's activism is pitted against all religious fundamentalism and communalism; that such things are done in a very visible manner. The liberal Muslims have always felt pressure to shown equal enthusiasm to fight the communalism and fundamentalism within Muslim community. The CHC has done lot on this line perhaps it could be made more organised.

(4) Some disturbing comments were also received. A non-staff member who, while appreciating greatly the commitment to participatory way of functioning, informed that he had heard from others as well as from some junior and senior staff members that decision-making in the CHC was too centralised in the hands of one or two persons and that there was one individual pulling strings from behind those two decision-makers. However, he refused to give his source, and since no staff member mentioned it to me despite my probing, I was not able to validate this information. In another comment, a former senior staff member felt that organisational environment was not conducive to the articulation of problems of the staff as it was looked down upon as trade union activity, and as a consequence, some of the staff members could never make their grievances or views heard. He also felt that there was not much encouragement to bring together staff on non-work basis - like picnic, cultural events. At least two other persons - one former staff member and one who spent few months there getting initiated to community health made critical remarks of the issue of participation. One of them called the environment paternalistic, and thought that it was useful to begin with but as one grew on the job, it started stifling. Another called it paternalistic and condescending, and thus, participation was at the mercy of the need of the top leadership rather than as a need of the staff. These three and two others who had worked with the CHC (as staff or as trainee), and one senior staff member commented about the lack of autonomy in work, and that being justified as the need for participatory functioning.

My comments: The perception of the way organisation and its leadership are functioning are difficult to comment on. In the best of the situations, the individuals have made insinuations or thrown aspersion on characters of individuals. But these perceptions provide pointer to the need for refining structures of the organisation and for strengthening certain organisational processes. But this is easier saying than done. The best way of doing it is by making the constituency that is complaining – mainly staff – to sit together on their own and defining concretely the kind of professional autonomy they need; the way they want to do their own things, make mistakes and learn from them; and the kind of transparency they want in the organisational decision making. On the last issue, it may help if the decision making process is shifted from broadly participatory to making a staff committee specifically responsible for decisions taken.

(C) STRENGTHS AND WEAKNESSES

My notes on the interviews provide a very lengthy list of strength and weaknesses. I suspect that I was told more about weaknesses than the strength because – as one person put it – "it will be easy for you to put together strength because generally CHC has an excellent history, but there is less critical reflection on weaknesses as not many would be ready to be very frank about them or they just do not want to hurt". On the other hand, for each response on strength I found another response that characterised it either as weakness or recent erosion of the strength. As a consequence, it was not possible to separate out strength from the weaknesses and vice versa. In a way I felt that this was a much better situation, as it is not possible to look at anything in terms of only positive and negative, but identify positive as well as negative in each aspect of the work of organisation. Thus, given below are the issues raised and the range of responses characterising them as strength or weakness in a dynamic manner.

(1) The most important strength highlighted very frequently is its long tract record of work of last 20 years. Even those who left the organisation acknowledge the commitment and sincerity of the CHC though they have other criticisms of the organisation. This track record, its survival of two decades, the amount of inspiration it has provided to individuals and organisations, the support – both moral, intellectual and material – it has provided to otherwise weak movements within health sector, the interaction and networking it has promoted, made more and more people to look at the social aspects of health, the advocacy it has done on some crucial issues, the good will and respect it has gained in the circles of activists as well as policy makers, and so on – the list is too long to mention – have given the CHC a national profile and prominence. An overwhelming majority of the persons interviewed and those who responded to a questionnaire, including its critic, described this as the biggest strength of CHC, and a base and potential on which the organisation can embark on its next phase of development.

I fully agree that the CHC is at a stage when it can consolidate its national network and motivate it to make useful contribution in building an institution of learning and action at national level.

- (2) The documentation centre was seen as strength as well as weakness strength in the sense that it provides very valuable source, particularly on movements and works of NGOs, but weak because it looks frozen in time and not having adequate dynamism of development. All said that it was an excellent base for developing it and making its material widely available by using the dissemination technologies like SOCHARA's website.
- (3) Excellent place to be for the "starters", those who need basic understanding and motivation. It not only inspires, but gives lots of ideas about what they could do in their work. Several of those who have been inspired by it told that they have been using their learning in their professional work. But some respondents attached a rider attached to it; that one grows over it fast once the basics are learnt, and despite getting inspiration from it they would not like to work there. One respondent said that there is some amount of paternalism and he liked it very much in the beginning, but thereafter found it difficult. Despite such criticism aired very forcefully or as a side remark, there was a general consensus that the CHC has done its work as catalyst and motivator the best, and almost all of them attributed it to the personality of and capacity to stir critical thinking by Ravi and Thelma. In many ways the respondents attributed this strength to individuals rather than to the organisation - a few even going to the extent that these individuals will keep doing so irrespective of the existence of the CHC. The flip side of this strength was that there was better appreciation of it by those who gained by "passing through" CHC, by collaborating with it from outside as consultant or as a part of team engaged in some exciting programme or project, than by those who actually worked for some time there. Other reasons given for not feeling like working there were that they did not have capacity to be motivator, it was not an institution where professional contribution would be appreciated, it was too demanding in terms of commitment while they could go only to a limited extent in that direction (one said that its value system is "too harsh and rigid") and so on. Only one of the individuals at the periphery of the CHC said that he would not mind working for some time as staff in the organisation.

I feel that the strength of the CHC in terms of being able to inspire, motivate and create commitment among the young individuals needs to be harnessed by further strengthening its work in training of young doctors and others in public health. Its reakness in retaining professional staff needs to be overcome and several suggestions for the same have already been made in this report earlier.

(4) Community orientation of the first several years was mentioned as the strength but some others were feeling concerned about reduction in the community orientation in last few years. Interestingly, those who felt that the future of CHC was in undertaking more research and policy advocacy did not mention much about the reduction in community orientation but those who felt that it should go back to the original work of training of NGOs were emphatic in saying that the direct work with the community has suffered. The same respondent with the latter view went to the extent saying that the NGOs that were close to the CHC have moved away though not broken away from it, the change was dictated more by the change in the orientation of the leadership – read, Ravi and Thelma – than the change in the priority at the ground level. They also felt that the current priorities are gradually turning its strength in community work into weakness. This group suggested that CHC should opt for a mix of consistent community work and institutional development, and should have less concern for organising "events" than actually forging alliance based on common work.

My feeling is that it is very difficult to judge whether "new" work on health policy is "additional" or at the "expense" of ongoing community work. The work on health policy by the CHC, in strict sense, is not new, it only become better organised and consistent in recent time. Such work does make the organisation to divide time but that does not automatically mean that in absolute terms the community work has declined. What is more important for the institution is not to debate whether there is "shift" in emphasis from community work to health policy work, but to discuss how the research, action and advocacy are balanced to further the impact of the organisation. For me it was impossible to assess "impact" of the community work of the recent past. Such evaluation is of totally different kind, and demands good data of the base-line to make comparison. I did not want to pass on impression as evaluation, so I have avoided such inquiry. But I have no hesitation in saying that mere community work is going to be less effective and sustainable than the community work with strong research and advocacy component. Hence irrespective of whether the critics are right or wrong in asserting that the community work has declined, I would suggest that the CHC should go for a more balance approach among community work/action, research/training and advocacy.

(5) On one hand some members of the SOCHARA and some of the trainee fellows felt that CHC relies a lot on "inspiration" and "individual motivation", and that on its own such administrative methods were the best. On the other hand there was a feeling that when an organisation grows, it is difficult to rely only on inspiration and individual

motivation and that one needed better system of administration. Some pointed out as the weakness the lack of administrative and programmatic decentralisation, nebulous and not open to specialisation, kind of division of labour, is less sensitivity to the fact that all individuals might not have enthusiasm for all activities, and so on.

On probing, I found that there is some degree of division of labour and specialisation already there but there is a tension related to accepting as a correct process – there is constant looking back about the desirability of such development thus making it very tentative and not allowing it to settle down. The organisation needs to make peace at some level or clear misconceptions prevalent about the issues of specialisation and professionalisation as a part of integrated functioning of the organisation. Along with this there was a concern for taking too many issues – the desire to respond to as many requests as possible rather than focusing on the programmes at hand and doing best in a focused manner. This problem needs to be addressed by, as suggested elsewhere, relying more on the discussion papers and the plan outlined there and also by using some basic criteria on responding to requests.

(6) There was lots of appreciation of the work of networking. Almost all felt that such networking initiative of so many years was a real plus point, and it has made many organisations conscious about their need to do work in the field of community health. At the same time, they and others felt that networking on the long-term basis would yield better dividends if the networking is combined with three important "in-house" functions or works, viz. (a) capacity building within the staff of the CHC, (b) some outstanding outputs from the CHC staff, and (c) CHC having its own field area of work. They felt that by networking the CHC had contributed a lot, but beyond a point its moral authority in the network was non sustainable if it did not have its own development and team of staff that is seen to be doing good work of its own. Two former senior staff members felt that excessive networking sometimes made the leadership ignore the in-house capacity available, it also made them to take less risk with the in-house staff by giving them opportunity to make mistakes and learn. Another respondent felt that intellectual and moral authority of the CHC in such network came from only a couple of CHC persons (Ravi and Thelma) and so the organisation was appreciated less than the individuals. In their absence, the networks did not take others representing the CHC so seriously and that was frustrating for the staff. And such professional staff needed time and space to come out with their own outputs before they were recognised in their own right.

- (7) One weakness that was articulated by several individuals former staff and others at periphery – was lack of following up good initiatives. For instance, the contribution made by the CHC in the task force report of Karnataka was highly appreciated, but at the same time not doing enough to follow up its implementation by undertaking its own independent policy research and using other advocacy opportunities (like media, seminars, conferences, legislative assembly questions etc) with such data, was characterised as major weakness. Some of these people felt that in past several such good initiatives from the NGO sector have not achieved desired goal because of lack of generating pressure for implementation – "comparatively easy to change policy, difficult to get it implemented". So more needed to be done on the implementation. Such weakness in follow up was attributed to insufficient attention to or failures in organisational development and in-house team building. At the same time, I also found some differences in perceptions. The positive perception on the follow up was that on Karnataka health policy the follow up was more in terms of going along the government in making it to inaugurate changes and to sustain them within the government structures rather than being confrontationist. In any case, irrespective of the positive and negative perceptions on the follow up, it is clear that the way out it in having a policy of taking only certain number of initiatives and following them through; and in creating in-house organisational capacity to make that happen.
- (8) A few respondents were concerned about the fact that there was no clarity on the "CHC's identity". "Is it a campaign team, a scientific team; a platform for few individuals or an organisation/institution?" Here too the emphasis was on what the CHC did in-house being as important as what it did outside.
- (9) There was very high appreciation of the contribution made by the CHC in building Jan Swasthya Abhiyan, People's Health Movement secretariat, International networking and campaigns, its role in People's Health Assembly, its media profiling of the PHM, and so on. One person described such contribution as "simply great". Generally, the feeling was that it has done a lot in strengthening such movements, particularly PHA and PHM. However, this work of last few years has also attracted some criticism one repeated by some was; that it has become more international oriented than to the local work. I feel that its work of last few years in these fields and organisations is indeed a great achievement and so if there is a need to balance between the local and international then it can be looked into, but it should not over-react to the criticism and completely discard its international work.

(10) I met individuals connected to environment and disaster management movements and organisations. From both currents I received very high appreciation of the contribution made by the CHC, and they demanded more such work from the CHC so that these movements could build their capacity on health issues, in providing health care and in undertaking research. This indeed is a great strength of the CHC and it should find ways and means of sustaining it. It needs to be taken further at two levels, (a) by helping such movements to create capacities to undertake studies or investigations on health impact of environment and disasters, and (b) contribute to their work and movements by doing systematic research in health and environment and disasters.

(D) PROGRAMMES AND IMPACT – CONTRIBUTION OF THE CHC/SOCHARA IN VARIOUS FIELDS. IMPACT

Many of the major responses about CHC/SOCHARA's impact have been covered in the critical remarks on the its strengths and weaknesses. It must be re-emphasised that most of the respondents were very clear about its general impact. The differences or criticisms were usually with regard to the extent or degree of impact. Some key criticisms were based on the assertion that the impact was great, but its organisational capacity to sustain the impact in order to affect a major or long-term change was limited.

In addition at least on two issues, the environment and disaster management, I could meet the individuals and organisations concerned and could get first hand information on the way the contribution of the CHC was appreciated. The third category of work was on the NGO training and I could meet individuals from three NGO or NGO-networks who testified on the positive impact of CHC's training work on the capacity building for undertaking community health work and in brining community health on their priority agenda. It should be noted that the CHC training has helped both the health NGOs as well as non-health NGOs.

The third source of my information for understanding impact is based on meeting some community level workers of another NGO collaborating with the CHC project. Interestingly, the project work of the CHC on different issues taken up in last few years is normally done in collaboration with some community-based NGOs, usually not having health as its priority area of work. The CHC does not believe in establishing its own direct community work but believes in doing it in partnership with an established community level NGO. This provides them with good base for intervention and reduces duplication of work of another organisation and at the same time helps in building capacities of the community based organisation that is going to continue its work in the community even after the CHC project gets over. I met community level workers collaborating with the CHC in its project on alcohol and found that the partnership was well established and there was mutual trust. However, I also found that this limited the amount of innovation in the approach and strategy that CHC could take up as ultimately it is required to implement its project within the organisational constraints of the existing NGOs.

As a part of the review exercise, the SOCHARA/CHC sent out a questionnaire to large number of individuals in the country. Some of their responses testify to the impact made by the CHC's work. Some relevant responses are given below:

Impact and recognition as a centre:

- "It is an important centre for community health in India".
- "Despite ... bleak scenario of voluntary organisations, the CHC is an outstanding example (having) continued to serve the PEOPLE's sector in spite of considerable difficulties. The CHC has played a seminal role in advocacy not only at the people's level, but also at the State, Central as well as International levels, especially in the WHO. ... The CHC now claims both national and international recognition. Their efforts need greater acknowledgement and support".
- "CHC has been the most active group in critiquing and advocacy in medical education."
- CHC has been able to create a platform to view health as a justice issues. provides opportunity to learn to integrate the social, economic issues with promotion of health.
- Has symbolized ... (as) an organization truly dedicated to taking up causes and spreading awareness on public health issues and problems in our country.

 Over the years has maintained its credibility and integrity and therefore lay-persons have been able to use information, views, messages on issues, expressed by CHC with complete confidence.
- CHC has documented effectively in a number of areas. has raised its voice on many issues to be heard. The follow through has not been focused enough to produced specific results. Appears to be capable of being India's best advocacy organization, yet is involved in too many areas to produce effective results.
- I trust CHC to represent my/our concerns when it works at policy level or at a global level. ... it epitomises a belief that you don't have to become big to do something big. And that professionalism has to be maintained even at NGO level. Its greatest strength lies in preventing people from feeling threatened in a network their networking skills are excellent.
- CHC counter balances the commercial aspects of community health. ... gives a forum to people who view health through an alternative perspective and gives

(2) How should these three functions of the organisation be continued under one organisational structure of the CHC? To me this is a practical issue and not principled one. If the individuals running the organisation are able to respect all three functions equally and able to evolve an organisational structure that is conducive for coordinated functioning, they all could be done under the CHC. But any approach that unnecessarily pushes the researcher to constantly feel that because they are researchers they are elitist and to overcome their elitism, they need to compulsorily do some community work would create tension and may jeopardise the smooth relationship between the three functions. Same way, the arrogance of researchers attaching low importance or priority to the action based community work could lead to similar outcomes.

My suggestion would be to choose from two possibilities:

- (a) The CHC may be kept as one unit under one coordinator, but with functional and administrative decentralisation between the community-based training, campaigns and action on one hand and the research and public health training on the other. Each of these two arms could be headed by a joint/deputy-coordinator. This would promote division of labour and specialisation, but would have same administrative support.
- (b) Alternatively, the CHC could continue to function as the unit of SOCHARA for community-based training, campaigns and action with strong component of the work as catalyst etc. But the research and public health training may be separated out as another unit of the SOCHARA. This unit could be called by any appropriate name, but it will work separately from the CHC but will be supervised by the SOCHARA.

A BRIEF REPORT ON THE VISIT TO CHENNAI OFFICE OF CHC: 21 NOV 08

--K Gopinathan

Introduction

After the initial discussions with the Chennai Team in Bengaluru on 01.11.08, I had planned to visit Chennai on 14.11.08 (the date accepted by all) for further discussions. But this could not take place because of some urgent engagements of two of the members of the team on that day. Tried to advance the visit to 13 Nov 08 for the convenience of the team but had to give up owing to unavailability of train accommodation. The visit was then postponed to the last week of Nov (provisionally 27th) with the intention of meeting with all the members of the team for obtaining a common perspective of the situation. Later on, when contacted to confirm the date, it was informed that the team member who was away from the country will be back only on the 27th night and meeting with them on that day was not possible. The next day could not be confirmed. Moreover 28th was not convenient for me. The meeting with the other two members of the team was therefore fixed for the 21st Nov 08. Accordingly this visit was made.

Amir Khan met me at the train station and took me to Bala Mandir where my accommodation was arranged. We reached there at 8.45 am. The office of CHC team is located in the premises of Bala Mandir. Amir went to his residence for a wash after fixing the meeting time as 10.00 am. I requested him to inform Shalini about the same.

The Office

There are two rooms facing a narrow corridor. The rooms are with inadequate ventilation and light. One room is kept empty. It is difficult to enter the currently occupied room because the doors of it cannot be easily opened or closed. One of the doors does not open and the other opens little more than half just enough for a person to enter.

The rooms do not seem to have dusted or cleaned for days. Dust collected all over the tables, racks, files, chairs and other places of utility. Toilet area may not have been cleaned for weeks as it appears. There are cobwebs, insect nests (wasp), stain and so on.

It was informed that a lady working with Bala Mandir has been engaged to carry out the cleaning work—of the floor only. Dusting of tables/chairs/files/racks/cupboard/printed material kept on the floor has not been done for days as has been observed.

There are three office tables and three plastic netted chairs with steel tube frames. Of the three chairs one cannot be used for it has gone out of shape. Two tables are kept in the center of the room and the other in a corner.

There is a PC with a telephone and internet connection as also a printer. A few cups and steel plates are seen lying on top of an almirah.

A "COMMUNITY HEALTH CELL (CHC)" panel has been nailed to the door frame of the office facing the corridor. It could have been at the entrance of the building with full address indicating office hours (if it has to be considered a full fledged extension unit).

As is seen today at the most the present arrangement could be termed a meeting place. A lot of changes have to be effected to make it an extension unit of CHC (as I understand from the discussions with the team it is no more a project office).

Suggestion for improvement:

- 1. could engage someone to carry out dusting/cleaning of office/corridor/lavatory every day.
- 2. painting/coloring of office and corridor could be taken up
- 3. office door and other furniture may be got repaired

- 4. it would have been better to take the first room (at the entrance to the building) and the immediate second instead of the present second and third room. There are a total of four rooms, of which the first and fourth are vacant.
- 5. arrangements for adequate lighting of the rooms/corridor may be made
- 6. a name board indicating as extension unit of CHC with full address, office hours to be put up at the entrance to the building
- a full time assistant could be appointed to carry out office work including attending to enquiries, visitors and so on
- 8. the tendency of every team member opting for flexi hours of working to be curbed. Such facilities may be extended to most exceptional members of staff (a policy to be framed).

The Discussions

The discussions began at around 10.30 am.

Outcome of discussion in brief:

[the outcome mentioned herein is based on the response to questions put to the team. My suggestions are indicated in italics]

1. The office facilities available in the office are sufficient. However some improvement could be made in terms of upgrading the present PC, making available laptops, computer table (the present one is small and not comfortable), scanner and further furniture, appointing a full time office assistant.

HO to examine this issue.

2. The activities are in accordance with the plans made at the HO along with the team in Bengaluru. The staff development workshop is not of much use. It goes as administration related meeting. Individual-wise work is focused. Though the team has expressed the need to meet the seniors in the HO for sharing of experiences/ideas/plans while in HO, it was not possible. Nor attempted. Unavailability of time was stated to be the reason. However it is said that such meetings are taking place in Chennai (not mentioning with whom).

The members of the team together have to prepare a plan before making the visit so that it could be utilized profitably. This could include meetings with the seniors within and outside of CHC (an inadequacy identified) and the administrative team. For the purpose, if necessary, an extra day could be spent in Bengaluru.

3. The team is familiar with the objectives of SOCHARA. It is aware of the Rules, regulations, procedures and guidelines of the organization but not being strictly complied with.

Administration to look into this matter.

4. Rakhal is in charge of the Unit and he oversees the functioning. Amir maintains imprest cash. Activity report and statements of accounts are sent to HO separately. There used to be delay in attending to these but it has now been minimized.

It would be preferable to send the statement of account and the report of the activity/activities for which money had been expended, together. This will help in monitoring of the activities and of the related expenditure. [It is informed that the imprest amount sanctioned is Rs 10,000.00.]

5. The team informs that it contributes to the furtherance of the objectives of the Society in various ways at individual level—like participating in the program of a personal contact or helping a personal contact in preparing a document.

Attempts should be made to convert this personal contact in to organizational contact.

6. The team has been discussing the ways and means of generating funds for the activities of the organization.

This should be encouraged; guidelines to be framed.

- 7. With regard to a question on accountability nothing much was forthcoming. But the team understood the issues related to it.
- 8. The mode of communication is generally phone, meetings, occasional emails (between the members the team and among the team in HO). Similar means of communication is being followed while dealing with other contacts including government authorities.

For maintaining proper records, communication with external agencies should always be in writing especially so with government authorities, using organization letter pads. E mail communication with authorities should be followed by sending a hard copy.

There is a delay in crediting the salaries of two members.

The AO may look into this matter.

The discussions ended at 1.45 pm because Amir had to board a train at 2.30 pm to Erode for attending to some personal work. Shalini left the office by 2.30 pm after lunch to attend to some urgent official work being attended to from home. I remained in the office.

Closed the office door with the help of watchman Sri Kannan, locked the room and handed the keys to the office of Balamandir and left the place at 3.45 pm when Rajendran came to see me and take me to the train station.

Hyderabad **25.11.08**

COMMUNITY HEALTH CELL

TYPES OF EMPLOYMENT TO OFFER

An organization hires the services of persons for carrying out its functions on the following lines:

- 1. when a created position as per the requirement and as approved by the Governing Body and included in the budget estimates is notified for filling in; (permanent position)
- 2. when an existing vacancy has to be filled in; (permanent or temporary)
- 3. when a position is created to handle a specific project/assignment that had come up during the course of a financial year and not as a pre-planned and budgeted for but on an exigency basis; (may or many not be a permanent position in the long run but could be to implement a project for a specific period, say one year or two years or three years)
- 4. when a leave vacancy of a longer duration has to be filled in; (temporary)
- 5. when an additional hand has to be taken in to complete a time-bound task; (temporary short term)
- 6. when a part-time job has to be handled; (the job described/involved is permanent and ongoing were the appointee has to be present every day at particular specified hours but a full time position is not required to handle it)
- 7. on a contract basis for executing a specific task. It could be for a short period or long period. The aim is to reduce long term financial burden.

Methods of remunerating the employees:

1. Permanent:

A permanent member of staff is eligible to receive salary and allowances and additional allowances, if any, as per policies of the establishment; all the employee benefits, facilities, rights and responsibilities (of workers) as per law.

2. Temporary:

A temporary employee is eligible to receive salary and allowances, employee benefits, additional benefits as described in (1) above. Such employees may have been appointed to fill up a permanent vacancy in which case they are normally paced on the rolls of the establishment like that of permanent employees but their services are considered under probation period in the organization—ranging from six months to one year to two years. Their continuance in the service or otherwise at the expiry of their probation period depends on their performance during their probation.

However, at times the establishment hires the services of person/s on a temporary basis in anticipation of possible vacancies in that specific cadre in the future. Such employees may or may not receive full benefits, excepting those that are mandatory, and their regularization in the employment will arise only when post/s fall vacant. Otherwise their services will automatically get terminated at the expiry of the specified period or earlier as the employer deem fit. If the services are renewed it will be with new terms and conditions and normally such employees will have no right to seek regularization of their positions.

3. Ad hoc appointments:

Ad hoc appointments are purely temporary in nature and they are focus specific. This is being resorted to when an emergency situation arises where such appointments cannot be postponed. It is normally done while, say, providing relief to victims of calamities—natural or otherwise. Such appointees are paid consolidated salaries, more than that of a regular employee in the same cadre—could range from 15-25% more--with specific terms and conditions. This is because they do not come under regular employment of the organization and therefore they are not given the employee benefit of a regular employee. In other words higher emoluments are given as a means of compensating the loss in the form of other benefits. Moreover such appointments are terminable at any time during the period of employment—whether it is due to underperformance or abrupt end of involvement or any other reason.

Justification for higher emoluments:

Adhoc appointees invest their time and energy for the sake of their employers while not excepting the benefits being offered to regular employees. For instance, a regular employee is eligible to become a member of EPF, eligible to receive other benefits including gratuity (after serving the minimum required number of years for eligibility). PF is currently 12% of salary and gratuity 50% of salary for every completed year of service. Hence it is put as 15-25%. Suggestion: 15% minimum and from 16% up to 25% as negotiated.

4. Fixed term assignment:

At times the organization finds it difficult to identify a suitable person to handle a specific job because of unavailability of such candidates or because of the remuneration being offered is much lower than the market rate. Under such circumstances, it will become necessary to appoint persons (who fulfill the requirement of the organization) with negotiated terms and conditions that are different from the existing policies of the organization so that the programs of the organization may not suffer. Their remuneration shall be on par with market rate or somewhat near to it.

Fixed term assignments are normally offered to most exceptionally qualified, experienced and suitable persons [who may sometimes be invitees to take up such positions] at senior levels.

5. Contract appointment:

The organization may require the services of a person on a full time basis to undertake a specific job and the organization may make policies to fill in such vacancies on contract employment basis with fixed remuneration and specific terms and conditions. Their remuneration may be on par with similar cadres in the organization (or even below). The services of such appointees can be terminated if their performance is found not satisfactory. [This is opted mainly with a view to reducing the long term financial burden of the organization like gratuity, pension. Certain schemes like Provident Fund, employee insurance will however apply. Many organizations in the country practise this method of employment.

[such contract employee need not be a direct appointee but a person hired by another agency and deputed to the organization on specific terms and conditions for performing a desired task; in this case the employer of the contract person would be the agency who originally hired him/her and as such the compliance of laws relating to employees/employment will be applicable to that agency.]

6. Part time post:

It may be that the institution has a regular ongoing activity and to undertake the same a full time person may not be required but a person on part time would suffice. For instance teaching of local language to a group of students doing social work studies. In such situations the organization may appoint candidates to carry out this particular assignment on hourly or part time basis—say two hours a day or half a day per day. Their remuneration could be calculated on pro rata basis or 50% of the remuneration (all allowances included) normally paid to such a cadre plus 10-15% of pro rata payment or of 50% remuneration as the case may be as compensating differential to motivate acceptance of the job offered.

Part time employees are normally not eligible to receive any other benefits.

Justification for 10-15% increase:

Employees holding part time posts are not eligible to receive the benefits that are offered to full time employees. For example: EPF contribution or full travel allowance or paid leave of absence or any other schemes. At the same time such employees are also contributing to the efforts of the organization at a greater personal risk than others—when viewed their future.

--K Gopinathan Hyderabad 25 Nov 08

Organisational Reviews of SOCHARA-2008

by Organisational Review Committee

Mr.K.Gopinathan, Dr.Mohan Isaac & Dr.Mani Kalliath (SOCHARA members)

ADMINISTRATIVE AND ORGANISATIONAL REVIEW OF SOCHARA

PRELIMINARY

The Executive Committee of SOCHARA in its meeting held on 27 Oct 08 formed a Committee to conduct an Administrative and Organizational Review of CHC (as of now CHC is referred to as parent organization in order to keep the long standing identity though ideally it should have been SOCHARA).

The Committee consisted of Dr Mohan Isaac, Mr K Gopinathan, Dr Mani Kalliath. Dr Thelma Narayan and Dr H Sudarshan. It was decided at the said meeting that Mr Gopinathan be requested to do the ground work in consultation with Dr Mohan Isaac and other Members of the Committee.

[Mr Gopinathan has since accepted to be a part of the Committee and agreed to undertake the ground work related to the review with specific terms of reference.]

2: PRELIMINARY DISCUSSIONS

In connection with this review Mr Gopinathan visited CHC on 30, 31 Oct 08 and 01 Nov 08 and held preliminary discussions with Mr E Premdas (Coordinator, CHC), Dr Thelma Narayan and Dr Ravi Narayan (the two immediate past Coordinators of CHC), after which he framed a simple methodology for the proposed review. The methodology was:

- 1. Discussions with the current Coordinator and the two immediate past Coordinators of CHC
- 2. Interactions with a few members of staff two phases if necessary
- 3. Visit to Office of the CHC project in Tamil Nadu for interacting with the staff stationed over there for undertaking the activities and programmes of the organization
- 4. Review the functioning of the members of staff of the Tamil Nadu project, look at the systems and structure of the project over there and suggest possible changes in terms of its functioning and related matters

The first step the Committee took for executing the terms of reference, after holding discussions with the Coordinators (present and the two immediate past) was:

- to define Cell or Centre/Extension Unit or Extension Office or Field Unit or Field Office /Branch/Project Office
- b. to study the present system and structures of SOCHARA as they relate to—
 - --CHC (parent institution) along with CLIC
 - -- CPHE and its Field Resource Centre/s
 - -- Tamil Nadu project, the members of the team implementing the project and their relationship to the parent organization
- a. DEFINITIONS (for the purpose of arriving at an appropriate nomenclature for the functional structure of SOCHARA)
- --Cell or Centre or Wing is a Functional Unit of the organization created by the general body of the Society for effective attainment of a group of objectives or a particular objective.
- --Extension Unit or Office/Field Unit or Office: It is a place from where extended activities and programs related to a formal functional structure of the organization, established elsewhere for the attainment of a specific objective, are undertaken.
- --Branch: It is a Division of the Society from where, for operational convenience, it carries out almost all of its business activities, as they target a particular region or State or some arrangements like that, as per the policies and decisions of the parent organization.
- -- Project Office: It is an office from where a particular time-bound project is implemented.

3: REVIEW OF THE PRESENT SYSTEM AND STRUCTURE OF SOCHARA

The general body of SOCHARA is the supreme authority. The general body consists of a ordinary members; b. ex-officio members; c. institutional members; and d. honorary members. Ordinary members, Ex officio Members and Institutional Members have voting rights.

Every year the general body with voting rights elects office bearers and members of the Executive Committee, except the Secretary, from amongst themselves during the annual general body meeting. The Executive Committee consisting of President, Vice President, Treasurer, Secretary and 3 Members looks after the work of the Society.

The Executive Committee appoints a Coordinator for the Society who shall be an ex-officio member and shall be the Secretary to the Executive Committee. The Coordinator, who is a paid functionary, coordinates and manages the activities of the Society under the superintendence and control of the Executive Committee.

The Coordinator is also the CEO of the Society.

The Society has established one Functional Unit called Community Health Cell to promote and conduct all its aims and objects and activities. The Society has been appointing Coordinators for the Cell, whenever required, to manage and coordinate the affairs of the organization. It now has a simple structure with one Functional Unit headed by a Coordinator.

The organization structure as of now:

General Body

Executive Committee

Coordinator for Community Health Cell (who is also the CEO of the Society and Secretary to the Executive Committee)

Sub Functional Units (with personnel linked to them)

- --Community Health/Public Health Action, Training and Networking
- -- Community Health Library and Information Centre (CLIC)
- --Public Health Policy and Advocacy (now named Centre for Public Health and Equity)
- --Support services (administration and accounts)

SOCHARA registered on 16 April 1991 at Bangalore is a legal entity under the Karnataka Societies Registration Act, 1960. For the purposes of governing the organization, SOCHARA follows the said Act and the Rules thereon (as amended from time to time).

The Society has framed its own Service Rules/Guidelines related to its staff functioning, leave policy, salary policy, accounts and finance, staff benefits (in service and retiral).

4. DISCUSSIONS WITH (A FEW) MEMBERS OF STAFF

Members of staff are overworked. There is inadequacy of staff both in Bengaluru and Chennai. AO is over burdened.

Chennai team is doing good except in the case of timely reporting of activities and sending in of the statement of accounts though improvement has been shown over the past few months. Administrative support except providing office facilities not being extended to Chennai team. Activities of the team in Chennai are in line with the plans made in consultation with the Bengaluru team, deviations if any being communicated over the phone. Visit of head office team to Chennai office rare. The team in Chennai contributes to the furtherance of the objectives of the Society in the form of extending support to like mind individuals and agencies. Such support, however, is at individual level. The team is discussing various ideas for generating funds for the activities of the Unit.

There is an efficient administration team but communication among them is poor because of which delay takes place and needs reminders. Administration needs to be pro active.

Upgrading of skills and developing/acquiring new skills would be of value.

There exists communication gap among the members of the team leading to dissatisfaction. Every member of staff knows the rules, regulations, procedures/guidelines of the Society but sometimes not being followed in toto. Known contacts are more acceptable to the team.

There is a need to strengthen the functioning of CLIC and widen its scope.

The Chennai team's communication with its contacts in Tamil Nadu—government and others—are in the form of email and verbal. And among the team members it is through phone and occasional emails.

There is a need to share ideas/plans/experiences with the seniors at the HO.

SUGGESTIONS FOR IMPROVEMENT/CHANGES

- 4.1 A job assessment could be carried out and determine the number of additional members of staff to be inducted—temporary or permanent or part time as the case may be.
- 4.2 Delegating authority at various levels will solve some of the problems. By so doing delays can be checked, communication gap bridged, responsibility owned, delays curtailed, efficiency improved and effectiveness felt.
- 4.3 Communication with all the contacts should ideally be conducted by using office letter pads. Email communication may not be given the due importance especially by government authorities unless the communicating organization is known to them. If the organization has to be recognized and show its presence in a given area communication on letter pad would be of great help. The Chennai team may look into it.
- 4.4 Upgrading of skills and encouraging acquiring of new skills for the members of staff may be thought of. This will be of use to both the employee and the employer especially at this point in time when the institution is in the process of widening its operations.
- 4.5 The senior members of staff may spare a little bit of their time with juniors for sharing of ideas/plans/experience. Planning a meeting with them in advance would be of help so as to have a relaxed discussion. The Chennai team could stay an extra day in Bengaluru for the purpose whenever they visit the HO.
- 4.6 Currently the Chennai team is utilizing the rented office premises--that too partly—at the most as a team meeting venue. This should not be so if we have to treat it as an Extension Unit of CHC. The team should follow office working hours and at least one of them should be available in the office to attend to enquiries and making the presence of the organization felt. [With regard to flexi working hours being followed by the team a policy has to be framed.]
- 5: REVIEWING THE CHANGES IN THE WORK AND PRESENT SYSTEMS AND STRUCTURES OF CHC AS THEY PERTAIN TO: CHC ALONG WITH CLIC; CPHE; CHC's TAMIL NADU PROJECT EXTENSION UNIT

5.1 COMMUNITY HEALTH CELL AND ITS STANDING IN THE EYES OF THE LAW

Community Health Cell (CHC) is considered parent organization. Technically and administratively it is different. It cannot be called the parent organization because it is SOCHARA which established Community Health Cell (refer aims and objects of SOCHARA—3.1.j.). Community Health Cell has no legal standing but the Society has. The Coordinator is the CEO of the Society and not the Cell. It is SOCHARA which has been granted FCRA Number. Income Tax authorities see SOCHARA as the organization. So is in the eyes of the Registrar of Societies.

Currently CHC is the one conducting all the activities for achieving the aims and objects of the Society.

In the circumstances a separate independent Functional Unit cannot be formed within CHC. If it is formed it can be considered only as a sub-unit of CHC. Therefore, CHC to be considered one of the Functional Wings of SOCHARA to carry out specific objectives.

Implication 1: To suitably amend the Memorandum of Association of the Society

5.2 CLIC

At present CLIC is a part of CHC. However, if major part of its currently available resources are to be utilized by another independent Functional Wing, say, CPHE it could be made a part of it (CPHE). Over a period of time—may be a year or two--CLIC could be made an independent Wing for by the end of this period it will be known as to how things are shaping. Widening the scope of CLIC, upgrading the skills of its team, introducing technology to its functioning and bringing in expertise could be thought of. It is not advisable to immediately start a separate Wing for CLIC as the collection now is smaller, the activities are not even minimal, technology related programs have yet to begin, suitable leader is not in place to oversee the functions of a contemporary information center and on top of these, its sustainability and viability cannot be visualized right now in the absence of a proper study on the matter.

It is for the EC to decide as to which Functional Wing will run CLIC based on proportion of utilization as mentioned above. Upon such a decision, the member of staff currently with CLIC will be attached to the Wing which has been specified to run it. The budget for CLIC will be prepared by the new Wing. The other Wing may be asked to contribute a certain amount of fund to the development and running expenditure of CLIC.

A Library Committee could be formed to support the functioning of CLIC.

Implication 2: Policy decision on the running of CLIC including financial and administrative input

5.3 COMMUNITY HEALTH CELL EXTENSION UNIT—TAMIL NADU

For the last three years CHC has placed three members of its team in Chennai to carry out similar activities as that of in Karnataka. This indeed is a good move--to expand its operations nationally. Since the team is conducting activities that are similar to CHC in Bengaluru, it can be considered an Extension Unit. However, before formally naming it an extension unit or otherwise, it is necessary to examine the functioning of the team posted over there.

The team for Tamil Nadu based in Chennai functions in the following manner. There are three members in the team each one doing his/her own assignment on a flexi-time basis (has flexi functioning been allowed by CHC or approved by EC?). A two-room office with basic infrastructure facilities has been given in the premises of Kamaraj Trust in Chennai (6 kms from Chennai Central). The members of staff do not appear to be working from this office regularly. It is—one room only--at the most utilized as a meeting place for the team on Tuesdays and Fridays as can be inferred from the discussions. One of the members of the team is purported to be going to this office everyday at flexi hours and another member going thrice a week. The members are in touch with each other almost everyday communicating their whereabouts and activities.

[K Gopinathan visited this office in Chennai and had discussions with two members of the team. A separate report on this visit has been given to the Coordinator of CHC.]

If the arrangements made in Chennai are to be treated in line with an Extension Unit it is necessary that the office is made functional as per rules of SOCHARA. One of the aims of creating an extension unit outside of the main functional unit is to show the presence of the organization in a specified place/territory. If all the members of staff are carrying out their assignments on a flexi-time basis it will not serve this purpose. Also, it is difficult to monitor the activities of personnel with flexi working hours.

Flexi hours are advantageous to the employee concerned. It cannot be extended to all members of staff in an organization especially to those whose primary responsibility is to deal with government officials and other similar functionaries. In exceptional way only flexi hours of working can be extended.

Therefore, in order to name an Extension Unit of CHC in Tamil Nadu it is mandatory that the office over there functions during normal working hours. Otherwise the very purpose of locating an extension office in Tamil Nadu will be defeated.

[It has to be kept in mind that SOCHARA has been established with the aim & object of working with the people involved and interested in community health and development issues. The services of an extension unit should be made available to any body who approaches it—could be government or other agencies. This can be attained only by making its presence during normally accepted working hours.]

Structurally the Extension Unit will be seen as a sub-unit of CHC and as such it will be the responsibility of CHC—the functional wing—to allocate funds for running the unit.

Implication 3: To define Extension Unit and suitably amend the Service Rules to allow flexi working hours in exceptional circumstances.

6. CENTRE FOR PUBLIC HEALTH & EQUITY—FORMATION OF

It is CHC which has been undertaking the activities and programs related to the aims and objects of the Society. CHC has involved itself with various activities for the attainment of the aims and objects of the Society. However, owing to limited resources—human and financial—it could not engage itself actively for promoting certain priority objectives. A time has come to do that. Accordingly a new Unit and an Extension Unit within it with independency in functioning have been formed and started working with visible changes—both technical and administration-wise.

[Organizations adopt different structural patterns such as this at different stages of its lifecycle. It defines the reporting relationship, facilitates allocation of resources, delegation of authority and decision making. Such a Centre so created will also facilitate coordination and smooth intertwining of employees and communication and administrative systems of the institution.]

The newly formed units and sub units have now to be formalized with the necessary changes in its working, reporting relationship, delegation of authority, allocation of resources, decision making etc. While so doing there will be a few implications. Those implications have to be overcome appropriately for the smooth functioning of the members of staff and the systems thereby. The expected implications are given below:

Implication 4: Need to amend Memorandum of Association of SOCHARA

One of the Aims and Objects of the Society is "to have a Community Health Cell to promote and conduct all the above activities". Here "all the above activities" means the aims and objects. It is clear from the Memorandum of Association that Community Health Cell is a functional wing of SOCHARA, through which the Society hopes to attain its aims and objects. Therefore, creation of a Centre independent of CHC invites amendments to the Memorandum of Association specific to creation and running of different Wings.

Specific Units within Wings could however be formed since such formations are for operational convenience only.

Units within a Wing do not require amendment to the Memorandum of Association as they are formed for operational convenience. However, it is advisable to state the same in the Memorandum of Association if such Units are to be formed outside of the jurisdiction of the Registrar of Societies, Bengaluru District under whose seal SOCHARA has been registered.

6.1 STRUCTURAL AND ADMINISTRATIVE CHANGES

Implication 5: A leader to head the newly created Wing

A separate Functional Wing to promote a specific objective requires a leader to head it. Such a leader should atleast be equal in ranking in comparison with the leader of the other Functional Wings. The EC to decide on the rank considering the technical expertise required of this position.

Implication 6: Change in roles of positions—amendments to the Rules and Regulations of the Society

In accordance with the Rules and Regulations of the Society, the Coordinator of CHC is the ex-officio Secretary to the EC and also the CEO of the Society. In order to pave the way for formalizing the Centre as an

independent Unit, it is necessary to suitably amend the Rules and Regulations of the Society as they pertain to ex-officio members and the Secretary to the EC as also the CEO.

Suggestion 1: The Secretary to the EC could be an elected office bearer as in the case of the other members of the EC. The leaders of different Wings will report to him/her.

Suggestion 2: A CEO could be appointed by the EC to manage and coordinate the functions of different Wings. This official could be the exofficio Secretary of the Society.

Suggestion 3: The leaders of different Wings could act as Exofficio Secretary in turns to the extent of fulfilling the legal formalities pertaining to the Society. The structural reporting could however be to the President or CEO as the EC deem fit.

6.2 CHANGES IN ADMINISTRAIVE SYSTEMS INCLUDING PERSONNEL ATTACHED TO EACH WING

Change 1: Functional independency and delegation of authority

Each Wing to be given functional independency within the aims and objects of the Society and along with it the necessary authority to carry out the work to be delegated. This will sooner or later will call for creation of subunits within the Wing and as a process toward it administrative changes are to be effected. They could be: a allocation of funds to each Wing; b. authority to the leader to manage and control the funds earmarked; c. appointment as a member of the team of the Wing an official to keep books of accounts of funds (appointment could be through skill development of an existing member of staff or through induction of a new one) allocated.

Change 2: Budgeting and Account keeping of allocated funds at different levels—role of central administrative team vis-à-vis Functional Units.

Currently CHC is supported by an Administration & Accounts team led by an Administrative Officer. This is a centrally functioning team extending support to all the Wings of the Society with additional hands, if required, and with changes in the roles and responsibilities of certain functionaries in the team. For example: The services of Administrative Officer will be available to all the Wings and therefore he/she will be responsible for all the administrative aspects of the Wing—not the day today work of the Wing—while he/she will have a senior official at the central level to coordinate account related matters with all the Wings. Each independent Wing will need to have its own Accounts Assistant to look after the Wing's accounts functions. Accounts functions for each Wing will be decentralized but reconciliation/compilation of each of them will take place periodically at central level. So is finalization and reporting.

An internal auditor should be employed to audit the accounts at various levels.

6.3 STAFF POLICIES, SERVICE RULES AND REGULATIONS OF THE SOCIETY

The staff policies, service rules and regulations framed by the Society shall be applicable to all its employees and all the employees are bound to abide by them.

6.4 SALARY POLICY

Change 3: Special remuneration for special categories of staff

An organization takes to creation of separate divisions/wings/branches/units--as they be called--to carry out certain specific objectives. To handle the work involved for achieving those objectives it may become necessary to induct subject experts/specialists. Unlike general experts or non technical personnel it may not be easy to find them and hire their services for the organization with a lower remuneration compared to the market rate. In order to attract such talents and retain their services at least for some time, the organization may have to pay higher remuneration to those specialists compared to generalists. However, it may not be possible for an organization like SOCHARA to make different salary policies for its employees working in its different Wings in view of its employee-friendly ethos and values. Therefore, the higher remuneration could be in the form of, say, teaching allowance, allowing acceptance of consultancy fee, sanctioning sabbatical for earning extra income.

6.5 FINANCIAL MANAGEMENT

Change 4: Constitution of Finance Committee

The volume of funds being handled by the Society is expected to rise upon creation of independent Wings. The EC is, therefore, required to constitute a Finance Committee (FC) whose primary function will be to review the financial position periodically, advise on revenue generation, investment and other matters related to finance/finance management.

The Members of the Finance Committee shall include, apart from nominated/coopted members, the Treasurer, the CEO/Secretary, Heads of each Wing and the Adminstrative Officer. The FC will be a sub-committee of the EC.