NOT TO BE QUOTED:
OR CIRCULATED

THE CHC EXPERIMENT

1984-1989

A REPORT

A.	Community Health Cell-An Overview	Thelma Narayan (TN)
B.	Net Working	Mani Kalliath (MK)
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D.	Rational Therapeutics and Drug Policy Issues.	Shirdi Prasad Tekur (SPT)
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A preliminary document for reflection with the wise council, associates and senior peers.

8TH JUNE 1990

A. COMMUNITY HEALTH CELL-AN OVERVIEW (T N)

1. The Beginnings:

The Community Health Cell 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. This was identified as an unmet need by 2 members of the initial team who had spent an earlier year (1982) travelling in many parts of India, reflecting with health and development groups. The CHC started with a small team of four, of whom, three had moved beyond a Department of Community Medicine of a Medical College.

2. Objectives:

The Main objectives of the Cell were:

i. To support NGO community health action,

ii. To provide a sound information base for voluntary health effort,

iii. To encourage groups:

- -To recognize the broader dimensions of health,
- -To see health as a process of awareness building and organization among people,
- -To a greater sharing among field workers and activists to build an understanding of process,
- -To see health efforts as part of a broad based movement 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 'people's health movement'.

For objectives (i) - (iv), the cell planned to relate particularly to groups in Karnataka, focussing specially on the needs of the underprivileged.

These objectives provided the broad approach of the cell and represented the understanding we had at that time. However we were open-ended in our approach and attempted to be responsive to emerging needs, learning also from this process. Hence the range and scope of our activities kept evolving and changing over the years.

v. Very early in the experiment the cell also accepted, for two years, the organizational and bulletin responsibilities of the Medico Friend Circle. This is 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 population in India, who are poor and under privileged. This additional objective took up considerable time and evergy of the group.

3. Methodology of Functioning:

i) An important component of the experiment was an attempt to develop an internal team process which would be more participatory, democratic and non-hierarchical. We had to continually work towards this as it challenged styles of functioning within each one of us which had developed in more structured situations.

ii) We also consciously attempted to play a facilitatory, catalyst role with the individuals/groups who approached us, trying to build solutions together through an exploratory process of dialogue, interaction and reflection. This demanded flexibility in out plans, work timings as well as in the issues we got involved in.

iii) However we did have to be selective, especially regarding issues which required more detailed or indepth involvement. For this we had regular internal team reflections to decide en priorities and directions.

iv) This experimental approach was made possible by establishing an integral link with a social action trust in Bangalore, which allowed us a creative autonomy and with whom we had negotiated a participatory form of governance. These senior peers also supported the cell as a sounding board and wise-council.

v) For the first 33 months the cell functioned from an informal base located in a private residence.

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vi) 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. We also identified the following needs which could be thrust areas for the future:

-Documentation,
-Communication and continuing education,
-Networking,
-Action research and
-More active linkages with Government.

vii) The Staff Training Phase (1986-87)

To equip ourselves further with certain skills members of the group spent a year undergoing further training. These were in the areas of low cost communication, personnel management and epidemiology. One of the members spent it as a sabbatical year exploring linkages between Agriculture, Health and Nutrition.

Considerable time was also spent writing up our experiences in the form of a report "Community Health-the search for a process". This was later circulated to many of our associates and friends inviting their reactions and comments.

viii). (1988-89) - The later Phase.

On regrouping at the end of 1987, the cell functioned from rented accomodation, centrally located in Bangalore. Here we had basic facilities for the office, library and also place for meetings and discussions. The growing team now included full timers and part - timers.

In 1988 we concentrated on:
-Building up our documentation cell and getting it more organized for easy accessibility,
-Networking with persons involved with community health action, involving them in various initiatives or responses of the cell,
-Exploring areas of research with NGO's, mainly in a supportive role,
-Preliminary exploration of management issues with some NGO's.

We also continued interaction with NGO's in community health.

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In 1989, the cell initiated greater focus on the following areas:

-Medical Pluralism,
-Health policy issues, and
-Social relevance in Medical Education.

4. The web of interaction:

Over the years the cell had the opportunity to interact with a wide variety of individuals and groups. Broadly these include:-

i) Individuals in search of greater social relevance in health work.

ii) Networking/issue raising groups like medico friend circle (mfc), All India Drug Action Network (AIDAN), Drug Action Forum-Karnataka (DAF-K).

iii) Coordinating agencies in the NGO sector, viz., Catholic Hospital Association of India (CHAI) especially with their Community Health Department, Voluntary Health Association of India (VHAI), Voluntary Health Association of Karnataka (VHAK), Christian Medical Association of India (CMAI), CSI Ministry of Healing and Asian Community Health Action Network (ACHAN).

iv) Health projects in rural areas, tribal areas and urban slums in Karnataka and a few in other states as well.

v) Development projects, networks and training centres, viz., SEARCH, Indian Social Institute (ISI) Bangalore and Delhi, Federation of Voluntary Organizations for Rural Development Karnataka (FEVORD-K) and Tribal Action Network Karnataka.

vi) Womens Groups, particularly in Bangalore and peoples science groups (KSSP and KRVP).

vii) Interactions with the Government of Karnataka, through the Consultative Committee on Rural Development and through discussions with the perspective plan committee. At the Central Government level also the CHC participated in meeting on primary health care system development for the Southern Region and another interacted with various advisers to the Planning Commission.

viii) Interaction with a few funding agencies, e.g., Misereor, Cebemo, OXFAM and Action Aid, sharing perspectives on Community Health in India.

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As a response to the very wide range of requests, these interactions took shape through informal individual/group discussions, field visits, workshops, editing and publishing of a monthly bulletin, lobbying, planning of communication and learning material, formal and informal training sessions, reviews, evaluations, planning and policy meetings.

5. Range of issues explored in Community Health:

i) One of the main areas was developing oan understanding and a perspective of community health based on the rich experience of groups responding to health needs in different situations in various parts of India.

A critical analysis of the prevailing health care delivery system was developed by interactions with numerous individuals/groups especially with the medico friend circle and also through publications on the subject.

Some related areas were:

-Interactions between community health and community development,
-Approaches to starting community health programmes,
-Evaluations of community health programmes,
-An overview of the community health effort by the NGO/Voluntary sector in India-their projects, training programmes, resource research centres.

ii) Other more specific aspects of community health that we were involved with included:
Tuberculosis control, Leprosy control including rehabilitation, school health, Mother and Child health, Natural Family Planning and population issues and study of the National Health Policy and Government Health Services.

iii) Rational Drug Policy issues and Rational Therapeutics was an area to which we gave much time. We participated with others in discussions identifying the role of hospitals and technology in community oriented health care in conditions prevailing in India.

iv) An area of special interest has always been the training of health personnel. The cell conducts a training course in Community Health and Development during the formation period of the Franscican Brothers of Jyothi Sadan. We facilitated a workshop of graduates

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from a Medical College who were on a rural placement scheme in order to get feedback regarding medical education as well as on their experience in peripheral hospitals. We participated in a dialogue of community health trainers organised by VHAI and one of our members was on the VHAI educational council.

Interest in social relevance and community orientation of medical education which was our focus while in the medical college was rekindled as we made some contributions to the mfc Anthology, entitled 'Medical Education Re-examined' (now in the press).

v) Management issues in Health Action for NGO's were also explored. These included self sufficiency, team functioning, team development, inter personal relationships and personnel management.

vi) Newer areas of focus have been Medical Pluralism, Women's Health issues and Community Health in slums.

6. Summing Up:

The CHC study-reflection-action experiment has helped in the emergence of a perspective on Community Health in India, stressing the need for a Paradigm Shift-from a medical model of health concentrating on a package of services provided to the community to a social model of health focussing on enabling/empowering communities to look at health as a right and responsibility. A number of key issues have been identified crucial to emerging process of community health. These have been described in a series of publications (see list elsewhere in the report). The CHC through this open ended experiment provided support to various emerging action initiatives and has helped to sharpen the perspectives of those with whom it has worked in partnership.

Keeping the concept of the epidemiological triad, i.e. Agent, Host and Environment in mind it can be said that in philosphical terms CHC has functioned as an indirect Agent for social change focussing on health issues and providing technical support, perspective planning and problem analysis with all the Hosts - medical and non-medical it has been in touch with. All these hosts including doctors, health and development activists and others are working on

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the environment making it more just and humane by tackling the socio-economic, cultural-political and ecological issues that have caused the situation of under privilege and marginalisation in our society-using health as an entry point.

However the entire process has been two ways-with the CHC team not only providing support but also learning and enriching its own perspectives in the process.

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B. NET-WORKING (M K)

During the years of functioning of Community Health Cell, CHC developed links with many health resource people in Karnataka. There was no forum where people could attend as individuals rather than as representing institutions. So net-working was started as a attempt to bring together individuals in the field of Community Health, to exchange ideas and facilitate interactions which could result in working together among such individuals. Eight meetings were conducted by CHC for the past two years. The earlier ones were full day affairs and later on become half day sessions.

MEETINGS

(1) First Meeting was held on Sunday, the 7th February 1988.

The goal was:

1. Get to know each other and our work.
2. Hear about ideas and experiences in the field of health and development.
3. Brain storm about the ideas presented in the CHC report.

Fifteen people attended, shared their activities and plans. It was conducted in an informal, exploratory, participatory way. A letter was drafted by the members to the newspapers regarding Mysore University stopping publications of the book "Where there is no Doctor".

(2) Second Meeting was held on 6th March 1988

Twenty members participated which included eleven new members. Ten out of the eleven were doctors who had gone in their work beyond the traditional role of the doctor. The meeting focussed more on community based health action. The issues that emerged were:-

1. Socio-cultural-political understandings in health work.
2. Multi sectoral approach that was needed.
3. Health was lesser priority among people as compared to land ownership, wages etc.
4. Awareness creation to demand collectively right to health.

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The actual plans that arose were the following:-

a) To study priority issue in health in Karnataka.
b) Document the health status of people of Karnataka.
c) Undertake a study on Government Primary Health Care System in Karnataka.
d) Explore integration of systems of health.
e) Prepare a memorandum to be submitted to the committee on university health sciences.

(3) Third Meeting was held on 23rd April 1988

Thirteen members were present. The goals of the meeting were the following:-

a) To collate information of activities and realities of Primary Health Care in Karnataka.
b) To look at the pattern and distribution of Government as well as Non Government Organisation's health services.
c) To collate Non Government Organisation's experiences as a feed back for health policy makers.

SUMMARY OF THE DISCUSSIONS

The Primary Health Care System is functioning poorely; the budget was inadequate; professional consciousness was poor; people's involvement was poor; planning was defective; all efforts were geared towards curative expectations; there was no awareness at the Government level about ground realities. The consensus of opinion was that alternative approaches need to be explored, health personnel needed training and awareness building, there was need for improving monitoring and evaluation. Participants felt NGO group needed to give active feed back to the Government. It was felt that groups with credibility could initiate a dialogue with Government which could later be even at the district level.

(4) Fourth Meeting was held on 5th December 1988.

Fifteen Members were present and they shared their experiences in community health action. It was decided to establish formal contact with FEVORD-K and VHAK so that individuals in the network could offer support to these association of projects in Health and Development.

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(5) Fifth Meeting was held on 21st July 1989.

Twenty eight Members were present, which included health committee members of FEVORD-K and CHAK Executive Committee Members. This was so as to enable them to share their plans and network members could offer support. This meeting was visualised as a step towards evolving the future activities of the net work amd moving it from a net work of individuals to a forum of individuals and associations. The out come of the meeting were the following:

a) The net work to take the name of Community Health Forum.
b) The next meeting was to be held under the auspices of FEVORD-K, VHAK where the dialogue would continue.

Following themes were suggested as focus for subsequent meeting:

a) Integration of Traditional systems of medicine.
b) Functioning of Government health system at the Primary Health Care level.
c) Exploring health priorities in Karnataka.

The forum would function in an informal way and common actions would take place through the existing co-ordinating agencies like VHAK, FEVORD-K. It was decided that CHC would facilitate next two meetings and beyond December 1990, the forum needed to evolve its own directions and organising structure.

During afternoon session discussions were held to evolve a training strategy in Kannada for grass root activities.

Sixth Meeting was held on 5th September 1989, at Vidya Deep.

During this meeting the viability and the future directions of the forum was discussed but it ended inconclusively. Subsequently a questionnaire was circulated by Smt.Vanaja Ramprasad and Sri.Mani Kalliath to forum members to clarify their perspectives and expectations so that fruitful discussion could be held about the future of the forum.

(7) Seventh Meeting was held on 11th December 1989.

Responses of 14 respondents to the questionnaire was discussed.

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Their views were as follows:

a) Forum was seen as place for sharing of ideas and experiences so as to evolve a wider perspective.
b) As an opportunity for working together and for supporting grass root organisations.
c) As a forum of support to each other and for learning from each other.

The majority wanted the forum to be informal without a definitive common ideology and manifesto or binding actions. The membership could be open and the forum could respond/dialogue around different needs. Many wanted the involvement of members and responsibilities to be rotating some of the problems based on the two year experience were identified as membership mostly from Bangalore, lack of continued involvement and commitment, differing levels of awareness among the participants and the bias towards only particular actions.

During the meeting it was decided to get the views of the remaining members since only half the number had responded.

Eighth Meeting was held on 3rd February 1990.

The attendance at this meeting was poor and sufficient interest did not seem to be there among the members. Only one of the remaining members had responded. It was decided to continue at present only as a discussion forum with a member offering to lead a discussion or presenting his/her experience for collective reflection each time. Paresh Kumar suggested that he would like to share about his experiences in teaching Medical Sociology at the next meeting. The meeting was fixed for 12th March 1990 but could not take place due to a VHAK-FEVORD-K dialogue with Government arranged for the same day.

The experience of Networking has been discussed by the CHC team over the last few months. The positive features were:-

i) It was a good opportunity to bring together most of our contacts who are providing individual support to community health action.

ii) There was evidence that some degree of working together and

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interactions have taken place beyond the framework of the meetings called by CHC.

iii) In addition CHC team were able to involve many of the network associates in their initiatives. However there was an apprehension that the experience had some negative features as well.

iv) Networking was not seen as a need by itself and

v) There did not seem enough energy in the group to sustain the process, if the CHC stopped facilitating the meeting as a group. The net work was also perceived as just one more thing dto do.

vi) Experience of trying to link the network of individuals to ongoing coordinating groups like FEVORD-K and VHAK were also not successful.

Even if the network of individuals were to metamorphose into a discussion forum entitled Community Health Forum, the organisational dynamics and continuity of the forum remained an open question.

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The CHC team has now decided to circulate a summary of the questionaire survey and a list of all the potential network associates to all concerned and to let individuals in the group take further initiative beyond June 1990.

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3. TRAINING - FORMAL AND INFORMAL (M K)

The CHC team did not plan to get involved in formal training at the start of the experiment. Moving beyond a medical college, it focussed its attention on individuals and project teams sharing and learning in informal, mutually supportive ways.

In the first phase 1984-1986, it did participate in a few sessions in ongoing training programmes organised by Community Health training centres or NGO resource groups.

In 1988 at the begenning of the Phase 1988-89, the CHC team decided to respond to a request by the Franciscan Brothers (Jyothisadan) to coordinate a training in Community Health and Development integrated with their formation studies. The team agreed to be involved so that members of the CHC team would continue to improve their training skills. The CHC team also decided to use this opportunity to experiment with more participatory approaches focussing on small group work, pulling in methods and 'interactive' and problem solving approaches. As this experience evolved, the CHC team also undertake a few shorter workshops for voluntary agencies using similar approaches.

Some details of the dynamics of the Jyothisadan Course and the workshops for Karnataka groups (VHAK - FEVORD) and Tamilnadu groups (OXFAM) are given to highlight the approach and the process.

3(a) JYOTHI SADAN BROTHER'S TRAINING

Background

Upto 1984 seven brothers had attended the community health workers course of St.John's Medical College which is for three months.

In the same year a workshop for formators on 'social Apostalate of the Church' was held under the auspices of CNFCE attended by the formator of Jyothi Sadan also, in which the importance of Health/Development dimension in formation training is emphasised.

In November 1984 a refresher course for the seven CHWs were organized with the help of CHC, Prof.Rama Rao and the community medicine faculty of St.John's Medical College. Based on the reflections and recommendations of these brothers it was decided to integrate community health training into the scholastic studies.

Follow up planning was done by the CHD section of CHAI, Prof.Rama Rao and CHC and in 1986-87 the training was co-ordinated by CHAI-CHD team. In 1987 due to certain circumstances this training did not take place but the brothers were sent for the two weeks Deacon's course at St.John's Medical College. In 1988 CHC took over the co-ordination and 1988 and 1989 has been done by CHC.

The Community Health Training of 1988, 1989 Batches Included the Following phases

a) Phase I of Theory and discussions with both the senior and Junior batches totaling about 30 scholastics spread over a period of two months.

b) Thalavady rural camp (1988 batch)

c) Phase II - two weeks intensive course at CHC for the senior batch of ten brothers (1988 batch).

d) Rural posting to Manantavady,(1989 batch) and

e) Phase II- an intensive course at Jyothi Sadan for the Juniors. (1989 batch)

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CONTENT OF THE COURSE: This has evolved through the 1988-89 Experience as follows:

Phase I (a) The first two weeks of the course is spent exploring the meaning of Community, Health, Development and evolving a social analysis using case studies, audio visuals, simulation games and other participatory methodologies. The course outline is built in a participatory way. Introduction to low cost media and skill training in street theatre, poster making and puppetry was also included.

Phase I (b) Human Biology, Ailment management, First-aid, Leprosy and Alternative Systems of Medicine and overview on MCH and nutritions, communicable diseases and Environmental Sanitation.

Phase II Rural postings for the brothers in a rural area/tribal area to study and understand the development and health dynamics of the community.
During the rural postings, visits were made by CHC team emembers and associates to the rural camp to facilitate, concurrently, their understanding of the experience. When they get back they make a presentation on the experiences of the rural posting using techniques of street theatre and other media apart from group reports.

Phase III Community health situation analysis, simulation game on poverty, Drug issues, working with the community, Mother and child health, communicable diseases, visits to health programmes Health education methodologies, mental health, school health, community based rehabilitations and evaluation of the training.

METHODOLOGY:

It was attempted to reduce didactic lectures as much as possible and to use participatory methodology. However with a large group of 25-30 trainees this was not always easy. Methods used to facilitate the training include usage of simulation games, case studies, discussions following a slide presentation, demonstrations, visit to projects where the community health concepts were put to practise and written assignment to be completed by the trainees, individually and in groups.

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EVALUATION

Evaluation was done both to assess individual and group learning and to assess the content, the process and the participation. The certificate of participation was presented at the graduation function of these scholastics.

FUTURE OF THE TRAINING PROGRAMME

With changes taking place in the goals of CHC the co-ordination of the training programme will in future be done by the staff of Jyothi Sadan itself.

The course methodology, curricula and resource person's list would be made available to them. In addition St.John Ambulance First-Aid Course, and the two weeks Deacon's Course of St.John's Medical College are also recommended which would give additional experience and an official certification as well.

AN OVERVIEW

The Community Health Course at Jyothi Sadan Centre is among the first of its kind attempting to incorporate this subject as an integral part of formation. The focus is on the social model of health not just a medical model. The course supports the new direction taken by many religious including the Franciscan brothers in their social appostolate, which is now gradually moving from institutional responses to more community based responses.

For the CHC team it has been an interesting experience in promoting participatory learning and using small group and interactive approaches. The team have also tried to involve many of its associates from the network, to pull in their field experiences and perceptions for the benefit of the course participants.

3 (b) 'PARTICIPATORY LEARNING' WORKSHOPS

CHC has tried to encourage a more 'participatory learning process' in workshops, facilitated by the team on Community Health and other topics. The participatory ethos is promoted by involving the potential participants in planning through a questionnaire; by redefining the orthodox division between participant and resource persons so that every person is also accepted as a resource person, giving priority to field experience and lessons learnt from it; using small group and interactive approaches in the workshop discussion; evolving follow up plans with the participants. The workshops, then become a part of an emerging process rather than just an adhoc event. Two such, recent workshops in 1989 are analysed in a tabulated form to highlight the process and the experience.

COMMUNITY HEALTH WORKSHOPS

SUBTITLES	KARNATAKA GROUPS (FEVORD-K/VHAK)	TAMILNADU GROUP (OXFAM)
BACK GROUND	FEVORD-K members expressed a need work-shop resulted out of the facilitation of CH forum meant to be a preliminary to developing a training programme for incorporating health in their activities.	OXFAM Director discussed their initiatives in Tamil Nadu, in health and development and the need to help their partners gain a wider understanding of community health and demystify health actions. Decided CHC would contact partners so that no expectations of/from Funding Agency develops.
PREPARATION	Resource persons met, questionnaire sent to member organisation, response collated. Invited senior staff for two days.	Questionaire sent to 15 organisations. Decided to invite from each organisation a decision maker, a grass root worker.
PARTICIPANTS	60 members from 40 projects participate	About 35
NO. OF DAYS	2 days	3 days
RESOURCE PERSONS	FEVORD-K Health Committee/ CHC Team/ C.H.Forum resource people	CHC Team/Vanaja Ramprasad/Dr.Benjamin and OXFAM staff
LANGUAGE	KANNADA	TAMIL
QUESTIONAIRE	Regarding health problems, solution tried, Government resources available.	Regarding health problems, solution they have tried, obstacles and causes for failure, extend of utilization of Government and local resources.
OTHER MATERIALS	Different types of communication materials were gathered.	Different types of communication material gathered.
WORK SHOP	After introduction of members and introduction of human contents were-Health problems of communities/solutions/ activities tried, usage of Government facilities and how to improve/understanding of health.	Content: 1.Understanding of health and community health 2. Understanding and prioritizing health problem 3. Understanding malnutrition 4. Understanding health education 5. Government resources 6. Sanghams.

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SUB TITLES	KARNATAKA GROUPS (FEVORD-K/VHAK)	TAMILNADU GROUP (OXFAM)
METHOD	a) Through small group discussions and presentation and consolidating in the large group. b) Audio visual presentation on thought provoking themes.	small group discussion and presentations in large group. Simulation game on poverty to understand malnutrition. Learning health education through material produced by participants. After the first day course planning most of the workshops was done in a participatory way. Daily evaluations done.
SUMMARY	Available in workshop report.	Summary of workshop available.
OUT COME	Decided following areas need to be stressed in subsequent workshops. 1. Health Education/Awareness 2. Cooperate/pressurize Government health 3. Local activists need to be trained/no need of doctors. 4. Nutrition 5. Health as a movement	Participants decided to have a follow-up workshop organized by themselves for, -Sharing of resources among themselves, -especially in traditional systems of medicine. -Greater utilization of Government resources -Share experiences of greater community participation in health. -Evaluating their work by themselves
EVALUATION	It was experienced as a very useful workshop. Participants recognized a lot of their activities were health promoting. Decided to meet again to outline training programmes for two years in a participatory way.	During daily sessions-were about content, methodology, materials and whether meeting up to expectations. Regarding method of conducting workshop majority felt it was participatory. <u>General Impression</u>: First effort by Shirdi, Mani and Gopi to facilitate a participatory workshop-there is a need for greater co-ordination and pre-planning among us.

D. RATIONAL THERAPEUTICS AND DRUG POLICY ISSUES. (SPT)

CHC's role in the area of Rational Therapy and Drug Policy issues has been primarily catalytic.

The starting point was a group discussion organised by the Science Circle of the Indian Institute of Science and led by Dr.Zafrullah Choudhary of Gonoshasthya Kendra, Bangladesh on "A people oriented Drug Policy" in December 1983. CHC-MFC facilitated the visit and prepared a background file on Gonoshasthya Kendra Project and Bangladesh for circulation.

The annual convention of the Catholic Hospital Association of India on the same topic was facilitated by CHC in November 1984. Preparation for this convention was through three earlier workshops with over 20 people who were trained as resource persons to facilitate group discussions during the workshop. The drug issue was explored in this convention through an exhibition, small group discussions, paper presentations, street theatre, slide-show and also liturgy. A special issue of the magazine 'Medical Service' was also edited by CHC.

At the mfc Annual Meeting on Tuberculosis at Bangalore in January 1985, the All India Drug Action Network also organised its meet. CHC invited some of its contacts to this meeting and the idea of DAF-K was born. Two or three associates of CHC took up the challenge to evolve a forum of individuals and groups interested in promoting Rational Drug Policy and rational therapeutics. This issue was further explored in meetings with doctors, health workers, development activities, consumer groups and persons interested in this in Karnataka.

As the Drug Action Forum evolved CHC team members participated in the core group and CHC was made a document resource centre for it. The subsequent involvement of CHC in Drug Action work has been primarily through the evolving initiatives of the DAF-K.

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and were in favour of involved action alongside these discussions. The next two meetings are centred around this aspect, when the study group plans to visit two centres where medical pluralism is being practised and areas ofstudy could emerge from these interactions. One is a charitable clinic on Bannerghatta Road, and another, a community health program off Kanakapura Road, which is just starting.

Another area of action envisaged was the preparation of short course on herbal therapy for common ailments to be imparted to members of FEVORD-K groups who plan to incorporate 'health' in their development activities. This is still under discussion and will be part of a larger training programme on Health for Development activists.

Members of the study group have been attending various workshops and conferences like:-

*The Holistic Health Workshop-Bangalore
*The National Convention on Traditional Medicine and MCH-New Delhi
*The Tribal Medicine Workshop at Heggana Devana Kote (VHAK)
*The National Workshop on Medicinal Plants at Dharwar
*The IASTAM Conference at Bombay.

In addition to the above activities of the study group CHC team members have also explored this dimension of Medical Pluralism in many other ways which include,

* A training in Acupressure for minor ailments for community health workers in B.R.Hills. (SPT)
* A two part article on 'Medical Pluralism' to begin a dialogue on this theme in the medico friend circle bulletin (RN)
* An exploration of the role of Tibetan Medicine and the possible areas of integration during a CHC team assessment of community health priorities in Tibetan settlements in Karnataka (SPT)
*.Participation/facilitation of a 4 day short course on orientation to Medical Pluralism in the MSC Community Health Course at the London School of Hygiene and Trppical Medicine in 1987. (RN)

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Over the years the initiatives of the CHC in the production of background materials and audio-visual aids on the theme have included:

a) A slide set with audio on the Drug Policy of India called "Ramakka's Story" with media unit of the CNFCE.

b) Special bulletin, issues:

   i. Bulletin of Sciences (Science Circle, Bangalore)- 1984.
   ii. mfc bulletins November 1984 and December 1985.
   iii. "Rational Drug Use" in Health Action, August 1988 (A H.A.F.A. Publication)

c) Resource file on Bangladesh experience, in co-ordination with I.S.I. Bangalore and Science Circle.

CHC has also been a resource person on Rational Drug Policy at the St.John's Diploma Course in Health Care Administrative and a resource centre for articles (by journalists) on drugs in newspapers and also related articles in consumer columns on "mosquito repellants", "Cosmetics" etc.,

Members of the CHC also participated in workshops of the Drug-Action Forum of Karnataka, like

*Drug workshop (3 days) for voluntary agencies in the health sector in Karnataka.
*One day workshop on Drug Policy and Rational Therapeutics for students at Mysore from the Medical, Pharmacy and Ayurvedic Colleges.
*Seminar on Rational Drug Policy for members of Indian Institute of Science and Factory and Industrial Labour Welfare Officers-a group called'Scientists and Engineers for Peace'.

Contacts with consumer forum like 'Grahaka Jagruthi' and Science Forum like 'The K.R.V.P.' have also been made.

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' form a major component of health care at all levels and are an important part of

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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, accessability, 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.

E. STUDY GROUP-INTEGRATION OF TRADITIONAL SYSTEMS OF HEALTH CARE (S P T)

The idea of a study group (consisting of professionals from various systems of health care and those practising medical pluralism) to get together and discuss scope, areas and possibilities of "Integration" took off at a formal meeting on 6th March 1989 at CHC. There have been regular meetings since then (10 so far) and this is an attempt at putting the process on paper.

Initial meetings were mainly centred around discussing the scope, capabilities and need for such a group, and the activities which could help clarify the goals of individuals and the group. The active promotion of Traditional Systems of Health Care by networks like LSPSS, VHAI and individuals and organisations who were integrating at practical levels was considered worth studying together. Towards this end, all material available about these efforts was collated and in addition a compendium of addresses was made.

A need was then felt to understand the basic/underlying philosophies of various systems to find areas of integration. Three meetings were devoted to understanding these aspects from presentations on the philosophies of Ayurveda and Homoeopathy which were the dominant non-allopathic systems in prevalence.

Since all the members of the study group were interested in "Integration" towards a practical, workable objective, the training manual for the CHW published by the Government of India, where simple remedies from systems like Ayurveda, Siddha, Unani, Homoeopathy and Naturopathy were advocated for use, was the next objective of study. Only Ayurveda and Homoeopathy were studied again, basically for lack of Unani and Siddha practitioners in the group. Efforts are being made to expand the group to include members of those systems also.

A few members of the group felt uncomfortable with just discussions

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* Promotion of the concept of Herbal Medicine and an exhibition on this topic during the CHAI Annual Convention on a 'People Oriented Drug Policy'. The resource persons for these were Fr.Joseph Chittor and Sr. Innocent of Gudalur.

* Introduction of a short course on orientation to minor ailment treatment by alternative systems of medicine in the Community Health Course at Jyothisadan. (SPT)

* Peer group support to the evolving plans of the Traditional Systems unit of Voluntary Health Association of India, New Delhi.

F. MANAGEMENT AND TEAM BUILDING PROCESS OF CHC

K Gopinathan

F(1) MANAGEMENT DYNAMICS

I. Background

CHC was formed by a small group in 1984. The main objective of CHC was to build up an overview of community health by interacting with various groups including individuals involved in community health work in Karnataka. We decided to play a catalyst role. We did not want to create one more centre nor start a project of our own. Additional responsibility was to undertake the organizational functions of a national body called 'medico friend circle' for the initial two years.

II. Link up

CHC was linked to STAND (Student Training and National Development) Trust initially and now to CNFCE (Centre for Non-Formal and Continuing Education) Trust, both Jesuit Social Action Trusts, headed by one of our wise counsel, Fr Claude D'Souza, with autonomy to function on our own.

III. Accommodation/base

For the initial period of two and a half years the Cell functioned informally from Koramangala. As we grew in number, in 1987, we moved to a centrally located place in the city (Holy Cross Brothers, St Mark's Road) on a rental basis. In this place, though we established basic office facility, library and documentation centre and a place for meetings and small group discussions, we preferred to consider it a contact point rather than a formal institution.

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IV. Funds

Funds required for the Cell were received through the CNFCE Trust. CHC team prepared the budget annually and the proposal was submitted through the Trust. Periodical statements of accounts were submitted to the Trust. The expenditure incurred under various heads during the period January 1984 to December 1989 were as follows (rounded off to nearest rupee):

1.	Meetings	2,700	0.5%
2.	Staff Development	2,740	0.5%
3.	Office expenses and others	5,760	1.1%
4.	Educational Materials	7,890	1.5%
5.	Office equipment	13,160	2.5%
6.	Travel	13,900	2.6%
7.	Honoraria	16,875	3.2%
8.	Postage/stationery/ telephone/xeroxing	29,000	5.5%
9.	Furniture	30,800	5.8%
10.	Rentals	49,175	9.2%
11.	Salaries	3,60,800	67.6%

Total...Rs.5,33,000

Average monthly expenditure Rs.8880 (calculated on 5 years expenditure, 1 year being training period for staff)

The expenditure on Books and Educational Materials was low because we received a lot of materials gratis. The expenditure on travel, meetings was also low because we received support from many local institutions and projects. The overall emphasis of the experiment was to establish a <u>low cost</u> ethos and seeking available support, facilities or resource materials from other organizations and centres--in short tapping all the available local resources without duplication.

The total (Rs.5,33,000) represented actual funds received. It is difficult to compute all the materials resources we were able to tap from local institutions and associates as well as coordinating agencies and others.

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V. Documentation/Library

We brought together more than 1500 books and reports on various subjects like agriculture, appropriate technology, child health, community health, education, drugs, environment, medicine, traditional medicine, occupational health, nutrition, management etc. Apart from this we received over bulletins, newsletters, journals and magazines--both national and foreign. We are also members of the DOC POST service (articles, paper clippings) of CED, Bombay. The Documentation Centre was managed by a part time team member.

VI. Management

We managed our own affairs through an experimental participatory, non-heirarchical team decision making process.

We identified three senior persons as our Wise Counsel to share our plans and ideas with a view to getting their feed back. They were a sounding board and we met them informally as and when required and formally atleast once or twice a year. Though we governed our own affairs this arrangement enhanced our own accountability.

F(2) TEAM BUILDING PROCESS

An important dimension of our experiment was our attempts at evolving a team process based on our past experience. Even during the years in St John's Medical College, there had been attempts at such a process through a series of annual reflections termed "staff development workshops". The process at that time was only partially effective because of various factors such as too large a team with divisions of status, prestige, professionalism etc. However, the earlier process was encouraging. Since ours was a small but heterogenous team

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we experimented with this idea further using participatory, non-hierarchical, equitous, collective, functional (leadership) method.

We discovered that having worked in an institutional set up in which much of these divisions--professional/non-professional; thinker/worker; medical/non-medical; technical/non-technical; intellectual/manual--are entrenched, we ourselves had internalised some of these values. Just a desire to wish them awaywas not enough but had to be confronted and changes in attitude to be gradually accepted.

We believed that team work was greatly helped not just by participatory decision making process but by also internalising the whole value system into the social/economic relationships within the team.

We also believed that every member of the team was important and was responsible for the achievements and failures. Collectivity in our efforts had to be recognised and enhanced.

A brief account of how we functioned keeping in mind the above team building process are given below:

1. We saw that as far as possible, all the team members were involved in the planning and decision making process. Each one's suggestions and ideas were sought and utilised.

2. Responsibility was shared by each team member, in accordance with his capability.

3. Regular sharing of experiences (after attending a meeting, workshop etc) was done. This has encouraged learning from each other.

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4. Initially two levels of salaries were fixed for more experienced/less experienced team members. Annual increments, TA/DA were equal for all members so that over a period of time there was a move towards greater equity.

5. Team concept was emphasised in correspondence and interactions with contacts. All team members could sign for CHC team and CHC contacts and associates were encouraged to interact with all the team members.

6. The team had regular meetings to review progress of work; to consider new assignments and requests; to fix responsibility for each function; to fix a time schedule for completing the work.

7. Plans were made in such a way that they were flexible to meet emergencies.

8. We believed in delegation of authority accompanied by responsibility and accountability.

9. Additional team members were recruited in consultation with the team.

10. The new younger members of the team were given an orientation to the programme, the ways of functioning and staff relationship after joining.

11. Staff development programme to all staff was encouraged. Staff were encouraged to attend courses of long duration, short duration and workshops, seminars etc. Participation in various initiatives of the CHC, even if not primarily involved, was also encouraged.

12. The team supported individuals needs and ideas at both professional and personal levels.

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13. The team also supported movement from office based skills to NGO oriented skills, ie., staff who joined as support to office work were encouraged to develop skills that would be supportive of field based NGOs.

14. Review of each one's effectiveness was done informally with a view to help him/her improve performance and feed back was provided. Personal hindrances to performance was sorted out with the help of colleagues through non-threatening discussion.

15. All team members could seek the help of their colleagues in undertaking an urgent or difficult task.

16. In addition to full time and part time team members the network of associates facilitated by the CHC were also encouraged to participate in various initiatives and responses. During this participation no difference was made between team members or associates in terms of sponsorship, TA/DA or making available facilities of the Cell. This flexible approach to non-team members enhanced collectivity.

17. Locally available NGO resources were utilised for the various programmes and initiatives to reduce expenses as well as to build contacts and promote collectivity.

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Some positive features that contributed to the team building process

1. The group was small
2. The group had sufficient time for 'participation' especially in the initial years.
3. There was trust in each other's ability, involvement and commitment.
4. Members were known to each other for a long period of time.
5. All were in one way or the other experienced in group effort.
6. The members had no professional ego
7. The members had interest to participate in the experiment.
8. The team had openness in communication.
9. Even before forming the team, a few members of the team had established wider personal contacts in India. This was shared with all the team members gradually and the contacts were deepened.
10. We have received support from many groups irrespective of their ideological differences ie., the team received acceptance and encouragement.

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Problems and some issues for further thinking

While the overall experiment was very satisfying for the team, the participatory management process was not always easy nor ideal. Many problems were experienced and issues faced, which are listed:

1. Participation is time consuming and time demanding. It brings pressure on an individual to cope with the demand as well as delays the timing for response by the group.

2. Sometimes certain ideas/suggestions were accepted by the team without going into detailed discussions due to shortage of time or urgency of the matter, ie., because of the demands on a catalyst group full team participation was not possible always in every decision.

3. Attendance at meetings, workshops was encouraged but it was doubtful if equal interest was shown by all the team members in participating at such events. This showed that though opportunity may exist in a group process but it may not always be exploited by individuals.

4. Sometimes too much time was spent on discussing minor issues/experiences. This led to unnecessary delays in the work.

5. Providing equal salary/increment was not realistic. Some team members received less and some more than what was offered in the open market for their skill. In the latter case it has raised expectation of team members. Conversely some team members expected more out of others. Unmet expectation was an unovoidable problem.

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6. We had team members from part time associates to full timers. Among part time associates, we had one who comes every afternoons, another who comes in alternate weeks. This flexibility lead to delayed decision making. Creative participation from all members of the group cannot be sought in such a flexible circumstances. This forces the full timers to take more decisions.

7. The team became involved in wide ranging areas without considering the availability of time. This reduces the time to share experiences of individuals.

8. CHC had no projects of its own. The experiment was based on catalyst support to ideas/projects, initiatives of others. This lead to a feeling of lack of 'continuity or concreteness' in the work for some team members. Since processes which we facilitated ultimately depended on the motivation of the CHC partners, there was some dissatisfaction with lack of follow through or follow up.

9. Unless there is a personal level contact with various groups, utilising locally available resources does not work well. Though it reduced duplication and brought down supportive costs for the experiment, the liaison work required was time consuming.

10. We are yet to clarify certain issues like what is the idea behind staff development? Is it for the individual only or for both the individual and the organization as well?

    We gave a lot of freedom in the choice which was not always related to the emerging needs in the process.

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Finally an objective description on the successes and failures of our participatory management process and the features of the non-hierarchical, equitous, collective and functional leadership style is yet to be adequately documented. Different team members experienced different phases. Each one came with different previous experiences or expectations on 'participation'; hence the evaluation of the process by each is different. We have to consider ways by which a more 'objective' evaluation of this dimension of the experiment is made possible before we can present definitive conclusions.

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G. A SWOT ANALYSIS (R N)

Though reflecting on the past year and planning for the next has been a continuous cycle in the CHC experiments, the CHC team, since July last year has been reviewing the experiences of the last five years to explore the strengths and the weaknesses, the opportunities and threats that were part of this process.

While some members of the team have been part of the process since the beginning, others joined later in the experiment and hence the perceptions and experiences were different. Like most processes there have been varying phases of intensity and challenge and periods of uncertainty as well. The purpose of the informal team discussions was to build up some consensus of the main experiences inspite of the varied experiences and expectations. The SWOT listed below represent the key issues.

G (a) Strengths/Opportunities

G (b) Weakness/Threats.

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G (a) STRENGTHS/OPPORTUNITIES

* Established a 'live' contact with individuals, groups, project teams, activists, resource centres, coordinating groups and networks, trainers, policy makers and research groups involved in Community Health in India, in the 1980s.

* Participatedin various ongoing and emerging initiatives in India at different levels and in different capacities especially with mfc, CHAI, VHAI, AIDAN, CMAI, CSI, VHA-K, FEVORD-K, ISI's and ACHAN.

* Have provided a 'Peer Group' support to a large number of individuals and groups interested in exploring Community Health Action in India particularly in the South.

* Have reached out to a wide variety of individuals and groups of various ideological orientation and have managed to establish credibility through the open ended dialogue.

* The CHC Team has managed to do all its work in the last five years through a process that was relatively non-institutional, low cost, facilitatory flexible, open ended and supportive available resources for a wide variety of activities and facilities was tapped from the local network of training and other centres.

* Team relationships and group process were given much importance during the experiment and CHC was able to establish a non heirarahical work culture supported by personal interest in each other's work, regular feed back and participatory decision making within the constraints of time and our flexible management style. Staff development was also emphasised and supported. We attempted to grow beyond the divisions that divide our present organisational ethos, e.g. professional-non professional,

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medical-non medical, technical-administrative, superior-inferior and so on and build a collective style of functioning, focussing on CHC Team and not individuals.

* Used every opportunity at Bangalore/Regional/National level to bring together individuals and groups irrespective of ideological and constituency differences, as long as they shared and interest in Community Health. While the long term effect of this effort may be difficult to measure, this stimulation to 'networking' has generally been in a positive direction.

* At a conceptual level we have tried to take community health beyond the orthodox medical model, characterised by a providing ethos and structured by just technological and management innovation to an alternative social model characterised by an enabling/empowerment ethos and structured by socio-economic-cultural-political realities. A series of issues have been identified and highlighted that strengthen the process dimension of community health action.

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G (b) WEAKNESSES/THREATS

* Due to the open ended catalyst ethos the diversity of issues explored and the varieties of initiatives in which we were involved were very large. New members of the team were often at a loss with this diversity.

* The follow up on ideas/processes generated by our interactions depended entirely on the CHC partner because we wished to remain in the role of the catalyst only. This did result in a growing feeling of lack of continuity, consistency and 'concrete' action among many CHC team members.

* The focus was on the Community Health action initiator and not the people/community in which health action was initiated. Some of us did feel that we were losing primary contact with the reality of working with the people. In the initial years since we were basing our work on a decade of intensive field experience in St.John's, this was okay but from a long term point of view this did seem a growing lacunae in our work.

* The load of requests and the demands on us increased rapidly with out increasing credibility. This affected both the quality of our response as well as reduced the time available to us to grow as a team in our group/collective analysis and understanding. There was need therefore for a greater focus, better time management and a more organised style of response and follow up which was not always possible.

* We were rather idealistic about our initial 'salaries' and security system. While at individual level (free lancers) it may be possible to function in this way. It is not viable when a team is being built and supported while we did become a little more realistic by the end of the experiment there were tunes of insecurity for different members of the team. Also for such a

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type of work to be effective there has to be viable base with basic facilities and this always needs an additional, core support which is continuos.

* Just as in the case of the community we needed to be able to reach those who need us most and could not reach us or afford us so easily. There was therefore an increasing need for discernment and 'prioritization' to ensure that we do not respond in our overall enthusiasm to those who make greater demands on us but have resources to seek elsewhere as well. This was not always an easy decision.

* While we realised that there was a need to remain small so that our responses could be flexible, diverse, creative and need based we scould not completely get rid of some degree of routinization, stereotyping and formalization. This balance was not always easy to maintain especially since it was inevitable with the growth in demands on the cell. We did attempt a concurrent critical review of this dimension but were not always successful in preventing it.

* While we did manage to build up a management and work ethos which was relatively more participatory, non heirarchical and creative than that prevailing in established institutions and systems it was not also always ideal nor easy. A wide range of factors affected this process, including personality and styles of functioning of team members, expectations and styles of CHC-contacts, the haziness between individual responsibility and the collective, and the problems of confusion between equity, equality, equal opportunity and responsibility. This led to the problem of unmet expectations among team members at different levels.

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H. ::LOOKING TO THE FUTURE::

* From July 1989 the CHC team began a series of internal reflections, 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 five years was also reviewed critically to understand various dimensions and learning experiences from the experiment. This reflective evaluation was also extended to initiatives such as the network, the integration study group, the participatory course in Jyothi Sadan and other initiatives which have a future beyond the CHC experiment.

* From January 1990, the CHC has moved into a post experiment transition phase when individual team members move on to more focussed goals and roles.

The overall conclusion is that the CHC needs to:

(a) Establish a more definitive, long term identity made possible by registering a community health trust or

(b) Negotiating a viable relocation with a larger institution or coordinating agency where much of the creative autonomy and style of governance is retained.

Alternatively individual team members, some or all may relocate or relink with other similar initiatives, and continue the work with a different base.

* In terms of focus, while open ended, catalyst, technical support role with NGO's has been very interesting and enriching, there is need to allow team members to initiate more focussed policy research efforts primarily under their control to enhance the long term commitment and work satisfaction of the team process.

* Policy research has emerged as an important priority area because this is a major lacunae in present day NGO/Volag efforts.

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There is need to take a reflective overview on the diversity of experience and the wealth of options that have emerged in NGO effort at the micro level and evolve large macro policy guidelines that can strengthen the 'Social Relevance' thrust' of the evolving National Health Policies.

*Building on the wealth of experience developed through its catalytic work the CHC team is now gearing up to this newly emerging focus in the coming year. Team members plan to focus on three key areas that have policy implications. viz.,

i) Community Orientation/Social Relevance in Medical Education

ii) Medical Pluralism and Child Health

iii) Community Health issues for Urban Slums.

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REPORT OF THE C.H.C. 5 YEAR REVIEW MEETING

Held on 8th June 1990

The C.H.C. Team met with their Wise Council, some associates and senior peers on 8th June 1990 to report on and discuss the C.H.C. study-reflection-action experiment between 1984 to 1989, and to clarify ideas on the future of the C.H.C.

The format of discussion was:

i) Presentations by members of the C.H.C. Team on different aspects of the experiment,

ii) Interactions on these with the group assembled.

The members who attended this meeting were:

1) Dr. C.M. Francis - Director, St.Marthas Hospital, Bangalore
2) Prof. George Joseph - CSI Ministry of Healing, Madras
3) Dr. D.K. Srinivasa - Professor of Community Medicine, JIPMER, Pondicherry
4) Prof. R.L. Kapur - Director, National Institute of Advanced Studies, Bangalore
5) Dr. Paresh Kumar - Department of Sociology, Mysore University
6) Dr. H. Sudarshan - Vivekananda Girijana Kalyana Kendra, B.R. Hills,
7) Ms. Maria Zillioli - Community Health resource Person, Mysore

The C.H.C. Team members present were:

1) Dr. Ravi Narayan
2) Dr. Thelma Narayan
3) Dr. Mani Kalliath
4) Dr. Shirdi Prasad Tekur
5) Mr. K. Gopinathan
6) Mr. John
7) Mr. Nagaraja Rao

Others who were invited but could not attend included:

1) Fr. Claude D'Souza (Centre for Non Formal and Continuing Education, Bangalore)
2) Fr. Percival Fernandes (Director, St.John's Medical College & Hospital, Bangalore)
3) Fr. B. Moras & Dr. Mario D'Souza(Administrator and Assistant Administrator, St.John's Medical College)
4) Fr. Thomas Joseph (Ex Coordinator, Community Health Department of CHAI)
5) Ms. Valli Seshan (Consultant, Development Trainer, SCI) &
6) Dr. Gerry Pais (Coordinator, DEED, Hunsur).

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The C.H.C. had developed a wide circle of associates and contacts in the last 5 years but a smaller compact, select group was invited for the review representing all the main sub groups of our circle/ network.

Thelma Narayan presented an overview of the CHC activities, dwelling on the beginnings of C.H.C., its objectives, methodology of functioning and the phases in C.H.C.'s development. She touched upon the range of issues explored in community health, as well as the individuals, groups and organisations with whom interactions took place. She summed up her presentation, stressing on the role of health and development-professionals and activists as agents of social change. Her presentation was animated by charts.

Mani Kalliath presented C.H.C.'s attempts at networking with individuals in the field of community health. He spoke of the positive as well as negative aspects, and the attempts to metamorphose the network into a Community Health Forum - the organisational dynamics and continuity of which were still somewhat unclear.

He also detailed the dynamics of the Community Health Orientation course for the scholastics of Jyothi Sadan, Bangalore (Franciscan Brothers) during their formative period. He also highlighted the approach and process of workshops conducted by C.H.C. for Karnataka Voluntary groups (organised by VHAK and FEVORD-K) and those for Tamilnadu groups (organised by OXFAM).

Shirdi Prasad Tekur presented the efforts in forming a study group towards Integration of Traditional Systems of Health Care. He outlined the dynamics of the study group meetings so far, and some aspects of the evolving process.

He also linked this to the C.H.C. efforts in promotion of Rational Drug Therapy at various levels, and with different groups and through different types of initiatives. The evolution of the Drug Action Forum of Karnataka from these efforts (which was now planning to register itself as a Society and had developed a core and working group of its own) were also highlighted.

K. Gopinathan highlighted the Management and Team building process of C.H.C., including positive and negative aspects and the problems and issues therein.

Ravi Narayan did a SWOT analysis of the C.H.C. process, thereby looking at the Strengths, Weaknesses, Opportunities and Threats in the functioning of the C.H.C.

In a look at the future of C.H.C. beyond the experiment, ideas about the future options available, the need for a long term identity, focus of activity, etc., were explored.

Each presentation was interspersed with discussions and, compiled below is a resume of the ideas, opinions and directions which emerged in the interactions at the meeting.

1) The need to maintain independence of C.H.C. Team to enable it to continue its flexible style of functioning was stressed. Registration as an independent Society was deemed necessary

However C.H.C. should continue interaction with all groups/ institutions with which it had established links and support their initiatives as a catalyst, while at the same time developing a sharper Policy Research focus in its work.

2) The range of issues and organisations which C.H.C. initiated and interacted with expressed the need for such activity in the Voluntary Sector. Even with the evolving research focus of the C.H.C., a continuing "open-ended" approach to fill a need was thought to be necessary and C.H.C. Team could keep this in mind while evolving their future plans.

3) The networking attempts and metamorphosis into a forum was appreciated. The need for a longer period of nurturing to get the Forum active was suggested. Also the need to open more channels of communication between the Forum members, e.g., through a newsletter or some such initiative was emphasised.

4) In the formal and informal training attempts, laying down of objectives initially and evaluation at the end against these objectives was to be considered. Also, the communication of ideas, such that the participants would "Learn to Learn" was to be further explored.

5) The formation of an independent Drug Action Forum of Karnataka implied a supportive and resource unit role for the C.H.C. in the area of Rational Drug Policy and Therapeutics.

6) In the continued attempts at fostering a study-group for Integration of Traditional systems of Health Care, the evolving areas of consensus, avenues for research and active involvement of larger groups in these activities was to be further explored.

7) The experiments with the team building process and participatory management seemed relevant for a small group. Its applications and utility in larger non-homogeneous groups was to be explored in the voluntary sector. This dimension needed continuing experimentation/adaptation in the context of C.H.C's own evolutionary process.

8) The salary/compensation structure evolved by C.H.C. was not consistent with outside realities, and hence unrealistic. A more realistic structure was to be planned for the future in the context of continuing long term involvement of team members in such a process.

9) In the evolving management style of C.H.C. there should be a continuing flexibility in staffing, linkages and project/ process evolution. This 'flexible' and 'adaptable' approach should continue to be stressed and further strengthened.

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10) Apart from continuing its catalyst role the C.H.C. Team should now seek support from organisations willing to collaborate with it on areas of mutual interest. This support could be financial as well so that C.H.C. could build up concrete local support also. . .

On the whole the review group was appreciative and supportive of the efforts made by the C.H.C. Team to develop a resource cell responding to the multi-dimensional needs of the evolving Community Health Action in India especially in the South. Most of the suggestions were however focussed on making the C.H.C. experimental process and structure more realistic in the context of Continuity and long term stability. While some formal structure and more focussed objectives were inevitable at this stage the group supported the continuing experimentation with ideas/attempts to build in a more participatory ethos in the work that would be supportive of community health cell's response to ongoing initiatives and emerging needs.

BEYOND THE REVIEW : MOVING INTO 1991

The 5 year (1984-89) Review Meeting organised by C.H.C. on 8th June 1990, with the wise council, associates and many senior peers, led to the identification of many ideas, options and directions outlined in the minutes of that meeting (enclosed).

In the period July-December 1990, the C.H.C. team has further explored these ideas and the following developments have taken place.

1. Registration of Society:

   A Society for Community Health Awareness, Research and Action is being registered with some of our associates/network agreeing to participate in the formalities. The C.H.C. will now be the functional unit of this Society.

2. Policy Research Focus:

   a) The Policy Research Focus had already been establised with C.H.C. and C.M.A.I. collaborating on a project to explore Community Orientation and Social Relevance in Medical Education. This project is also being supported by CMC-Ludhiana and CHAI with the additional participation of CMC-Vellore, CMC-Miraj and St.John's Medical College. This project initially was from April 1990 to March 1991 but will now extent till June 1991.

   b) Some policy research initiatives for 1991-92 are being explored with CHAI (Study of Church Health Sector), NIAS (Health Training of Panchayat Leadership and Building up of Decentralised Health Information System), VHAI and CMAI(NGO response to Educational Policy for Health Sciences Institutions).

3. Community Health Forum:

   A questionnaire on the scope/functions/objectives of the Community Health Forum which had been sent to all the members of the informal community health network was compiled. Dr. Shirdi Prasad Tekur of C.H.C. will now coordinate regular discussions/dialogue of the forum for a year starting from February 1991. The forum will focus on individuals not projects or institutions. The dialogue will be on special interest areas and initiatives.

4. The Community Health Course:

   While the remaining sessions of Phase II, for the 1990 batch will be completed by March 1991, the community health course at Jyothisadan is being reviewed systematically and the three year informal experience is being evaluated to draw up a more definitive curriculum with specific objectives and methodological guidelines.

5. Supporting Networks:

   The C.H.C. will continue to participate as resource in three

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networks in Karnataka - Drug Action Forum (Karnataka), FEVORD (Karnataka) and Voluntary Health Association of Karnataka. Dr. Shirdi Prasad Tekur will be resource person for the ongoing plan of regional workshops on Health for Non-Health groups.

6. Exploring Pluralism:

The study group experience is being documented and reviewed and the scope of integration of systems in an 'alternative medical curriculum' (ref: CHC/CMAI project) will be explored. The study circle has remained dormant since June 1990 due to changes in the personal work situation of many participants.

7. Documentation Centre:

C.H.C. had collected a wide variety of published and unpublished documents and reports, through its interactions, and initiatives with the NGO network in Health and Development. This entire collection has now been accessed/indexed and classified so that it is available for reference by researchers, action initiators and health activists. A guide to this collection is being prepared.

8. Participatory Management:

The participatory and flexible management style of C.H.C. will be continued but adapted to the new organisational structure. Simultaneously the salary-security system for staff of the Society will be made more realistic in the context of longer term involvement by team members.

9. 'Learning' from the experiment:

Documentation of the 'Learning experiences' and 'perspectives gained' by the C.H.C. team during its 5 year study-reflection-action-experiment is an ongoing task. Shorter reports focussing on key themes from the wide-ranging C.H.C. initiatives are being put together and will be suitably animated as well.

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