would soon fuse into a mass movement covering the whole country. Development will only take effect, when it becomes a mass movement.

After having written at such length about the importance and the need of a non-formal education approach for critical awareness building, the temptation is rather strong to elaborate upon the process of this awareness building. But fortunately, this is done very clearly in the various case studies that follow. The methodology techniques and media they use are good models that portray the blending and assimilation of personal experience and reflection with orientations from abroad. A lot of practical lessons and orientations can be derived from a close study of these experiments.

What is common in all successful programmes is very significantly expressed in the Pauta Community Development programme. The group of three who started the work left their life-long environment and its amenities and went and lived with the people. I think that basically this is the real need of today, that those who are working to bring about a critical awareness among our people, should live with them and have a full involvement with their lives at the village level. For this is where the problems are, and it is here that we can empathise totally with the people. It is this identification that we consider a primary quality of the development worker. We hesitate to use the word 'identification' because it has not got the full meaning of what we would like to express. This full meaning is expressed by the word 'incarnation!'

4

Community Health: The Quest for an Alternative

Ravi Narayan

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

Ill health in the ultimate analysis is a direct product of an unjust socio-political system which results in poverty and inequality of resources and opportunity. An assault on ill health must, therefore, inevitably become part of a development and social change process which seeks solutions for the issues of social injustice; of which illness or disease is but a symptom. This seldom takes place in practice, for many reasons, not the least of which is the confusing of 'health' with 'medicine' and the emphasis on health care being a 'providing process' rather than an 'enabling process'.

This emphasis has its historical roots in the 'medicalisation' of health that we have witnessed over the last many decades. If health has to mean what the World Health Organisation defined it, i.e. 'as a state of complete physical, mental and social well being and not merely the absence of disease or disability' then activities and services with health as their goal must be much

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more than the prescribing of medicines; much more than the diagnosis of illness using sophisticated technology in order to prescribe more medicines. Health activities must include preventive, promotive and rehabilitative activities, health education and de-mystification of medicine, popularisation of health producing activities and attitudes, programmes to strengthen the people's traditions of self-care, attempts to increase the individual's autonomy over his own body and finally awareness building and an organisation of people and communities to get the means, the opportunities and the supportive structures that make health possible.

Medicalisation of health

What we see around us today, however, leaves little doubt that health has come to be used as synonymous with medicine and health care as synonymous with doctors, drugs and hospitals. This attitude is fostered by the established conspiracy between the medical profession, the pharmaceutical industry and the growing medical technology industry which converts 'health' into a commodity and promotes, advertises and sells it in the pursuit of a profit motive. The signs of this growing conspiracy are seen by the following trends in our society:

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

An anti-health value system

Through these trends not only does health become mistaken with medicine but institutions and teams internalise a value system which becomes counter-productive to health itself. Enough has been written on the characteristics of this value system which include among others a dependency creation, a compartmentalisation and an organ-centredness, a hierarchical decision-making, a mystification and professionalisation, an encouragement of consumerism iatrogenesis both clinical and social and ultimately a dehumanisation, all of which are patently anti-health. Medicine rather than generating health begins to generate ill health and the ultimate vicious circle is established—ill health—medicines—more ill health—more medicines. No wonder the ICSSR-ICMR report (1981: 179) warns that

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

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

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

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

> A linear expansion of this model and the consequent pumping of more funds into the system will merely add to the existing waste and make the ultimate solution of our health problems more difficult. We are also convinced that mere tinkering with the system, through well meant but misguided efforts as better training, better organisation or better administration, will also not yield satisfactory results. This is precisely what has been done during the last thirty years; and the meagre results obtained, is a strong pointer to the futility and wastefulness of continuing the same policies.

The quest for alternatives

Though this assessment of the situation is slowly becoming accepted in some of the higher decision and planning levels in

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

The component of 'alternatives'

Much has been written on many of them and hence giving a detailed list of sources would suffice (see ICMR 1976; Naik 1977; ICMR-ICSSR 1981). What is more important, however, is to identify the broad components of health care emerging in these alternatives.

1. An attempt to integrate health with development activities

Recognising ill health as the product of poor nutrition, poor

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

2. *Preventive and promotive orientation*

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

3. *Search for an appropriate technology*

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

been recognition of the usefulness of ideas that are already part of the local culture. Two additional areas of technological appropriateness which have been experimented within many of these projects are:

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

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

4. *Promotion and utilisation of local resources*

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

5. *Training of village based health cadres*

Training of local representatives of the village in basic health care activities, minor ailment treatment, recognition of illnesses needing higher levels of care, nutrition, environmental sanitation, communicable disease control, mental health and so on has

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

6. *Increasing community participation*

In addition to training village level health workers, many of these projects have attempted to involve villagers in the planning and decision-making processes through the organisation of local village health committees consisting of formal and informal leaders. Many have involved local youth groups, *mahila mandals*, teachers, religious leaders and farmers' associations and co-operatives in health work. This is a very important trend but has often become an expression of rhetoric rather than real participation. Two pre-requisites are essential if this 'community participation' has to be a genuine process of enabling people to take responsibilities for their own health services.

(i) Firstly the involvement of all sections of the community. In the stratified set-up of the village with certain groups always dominating and exploiting certain other groups

this must often mean a more purposeful and even exclusive involvement of the more disadvantaged and oppressed sections of the village.

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

7. *Initiating community organisation*

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

8. *A quest for financial self-sufficiency*

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

9. *Education for health*

Many projects have introduced health issues in their ongoing

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

10. Conscientisation and political action

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

Community health is not community medicine

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

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

One of the most important insights we got from this rich feedback was the difference between 'community health' and 'community medicine' and this was more than a matter of semantics. We understood for the first time that all these alternative health trend setters, though often labelled as 'community health projects' were not all 'community health oriented'. Most often they were extensions of the hospital system in organisation, method of functioning, team work and hence should rightly be labelled a community 'medicine' project. True to their medical roots, many of these projects for instance continued to distribute not only drugs but vitamins, vaccines and food with the same dependence creating mentality. Their teams were hierarchical and in the absence of participatory decision-making even within the teams, the claims of community participation seemed hollow. The water tight division of responsibilities, the compartmentalisation of health, development and educational activities, the professionalisation, the clear distinction between the 'providers' and the 'users', the quest for efficiency and cost-effectiveness, the pre-occupation with targets– all belied their overall commitment to health as a community building process. Consciously or unconsciously they had internalised the value system of the hospital and even though on a superficial overview they appeared to be different from hospital medicine, a deeper evaluation of the projects showed that they were just community-based extension of a medicalised form of health. Was this because most if not all the project initiators had a professional medical or nursing background and, therefore, this ingrained professionalism, superiority, sense of inborn leadership and 'know all' attitude was difficult to discard?

Due to this orientation, therefore, many projects we saw had built up highly organised systems of health care delivery – cut off from the lives of the poor people in their own communities. They were bureaucratic, project oriented, and at best no better

than government health projects except that they were more efficient, more organised and probably more cost effective, but no less irrelevant.

Towards a new value system

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

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

What then is community health?

Based on this overview, therefore, it would not be out of place to attempt a definition of what community health should be. Community health has been defined as "a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right" (CHAI 1983). This definition could be extended further by adding that the community health process would involve increasing the people and community's own autonomy over their own health and over the organisations that can prevent ill health and promote health. The process would include the concepts of present day Primary Health

Care—minor ailment treatment, village level workers' training, appropriate health technology, promotion of herbal medicine and home remedies, nutrition and environmental sanitation, community participation and organisation--but would essentially be a democratic participatory community building process.

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

Is community health possible?

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

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

> One school feels confidently that the panacea for the health problems of the people has been found. It is the alternative approach of health care delivery usually meaning utilisation of non-professionals and appropriate technology in health care. Another school is equally confident that the only real cause of ill health problems of the people is the present

economic system and nothing can be and should be done to solve these health problems unless the present economic-political system changes by revolution. The first leads to ill-founded euphoria . . . (the second) to inactive cynicism towards the burning health problems of the people.

Positive trends

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

Secondly there is a growing number of individuals—development or political activists—who are beginning to recognise the non-medical dimensions of health and are including it in their action programme. Thirdly there is a growing body of health knowledge which has become part of the syllabi of adult education and non-formal education in the country. Science education experiments have also introduced health aspects into the innovative curricula developed by them. Fourthly people-oriented science movements like the *Kerala Sastra Sahitya Parishad*, the *Lok Vigyan Sanghatana* (Maharashtra) and many other smaller forums are actively taking up health issues in their awareness building programmes, in their *Jathas* and their exhibitions.

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

Finally even expert documents on health in the country are

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

Negative factors

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

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

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

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

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

5

Social Housing as a Tool for People's Development

L.M. Menezes

The theme of social housing has been bandied about a great deal: as a means to an end, as an end in itself, as an entry point to a host of things. Inevitably, when the subject is discussed in a seminar, proceedings get stuck on definitions and semantics. What is social? What is housing? Is social housing necessarily private effort? In that case can government programmes for housing the poor be called social housing? If there is no direct participation of the people in the construction itself, then is housing no longer social? These doubts arise mainly because of the diverse levels of participation, representing a wide cross-section of experience and understanding of the subject. This is quite natural since the field is so vast, so general, so non-specialised in a way, and the problem is so colossal in India that everyone has a finger in it.

This being the case, the slogan really should be, 'Get on with it' rather than debate definitions and concepts endlessly. No doubt, not all housing efforts would stand the discriminating scrutiny of the subject's philosophers and fundamentalists—not enough people's participation, not affordable, not cost-effective, not indigenous etc. But then a few more houses would have been added to the meagre housing stock of the country anyway.