Community Health in India – A study reflection and a stimulus for further study

Dr. Ravi Narayan*

1. Introduction to paper
2. Reflections
   I. Health Care in India – an historical overview
   II. Health care in post independent India – an overview
   III. Health situation in India (1990)
   IV. Community Health in India: Recognising the new paradigm
   V. Community health: the axioms of a new approach
   VI. Is community health growing as a movement in Indian?
3. Some questions and tasks

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Methodology of Use
(Alternatives)

1. The paper could be read at one sitting taking all the reflections together to get an overall understanding.

2. Each reflection could be read by a group and reflected upon. Identify group consensus on the issues raised. Also identify areas of differing opinion and newer questions/double that may arise in the group discussion.

3. If access to all the 10 key sources in made possible then members of the group could read through the original source and step 2 could be done again so that this paper and its conclusions would be supplemented by other analysis/conclusions in the sources, adding to the richness of the discussion.

COMMUNITY HEALTH IN INDIA – A Study-Reflection

INTRODUCTION

These notes are part of a background preparation that I made for a ‘reflection’ with the participants of the Community Health Forum, at Secunderabad in July 1991.

The framework given to me was
   I. A recapitulation and consolidation of the health scene in India.
   II. The evolution of the Community Health Process in India.
   III. Some reflections on the thrusts towards the 1990’s.
   IV.

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326, V Main, I block, Koramangala, Bangalore – 560 034. August 1992
After meeting, in the discussions that followed and later in correspondence with some of the members I was asked to include Health Statistics of India; the social model of health, latest trends in health care systems; NGO’s in Community Health in India in the 1980’s; different aspects of Community Health in India; new policy by government on health. I realized that putting all these together in a single article would mean writing a whole book on the subject.

However since the objective of the exercise is to inform the group about the key issues and build a framework for further study and reflection, I have decided to put-together my notes interspersed with some reflections from well known sources (books already available) hoping to stimulate the members of the forum to make a serious study of the ‘reading list’ provided and to build on the evolving reflections of a large number of individuals and groups who are recognizing and building a ‘social model’ of health. During this study they should temper the reflections with their own field experiences and those of other members of the forum, shared during the annual and regional meetings. ‘Community Health in India’ is an evolving idea, an emerging process and we all need a much deeper understanding and linkage if we wish to facilitate and or participate in Health as a movement.

I present this study – reflection in the form of short reflections and include extracts from a few of our CHC papers as well as from the 10 key sources which I recommend as ‘basic reading’ material for the group. These are

<table>
<thead>
<tr>
<th>Source</th>
<th>Name</th>
<th>Author &amp; Year</th>
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<tbody>
<tr>
<td>3.</td>
<td>Health Care Which Way to Go</td>
<td>Medico friend circle (1982)</td>
</tr>
<tr>
<td>5.</td>
<td>Rakku’s Story</td>
<td>Sheila Zurbrigg CSA (1984)</td>
</tr>
<tr>
<td>6.</td>
<td>Health and Family Planning Services in India</td>
<td>D. Banerji, Lok Paksh (1985)</td>
</tr>
<tr>
<td>10.</td>
<td>Community Health in India</td>
<td>Health Action, July 1989</td>
</tr>
</tbody>
</table>

A supplementary list of 40 titles on the Indian experience which includes the 10 above is given in the Health Action special issue (source 10)

All these books and groups do not necessarily understand and use even the term ‘Community Health’ in the same way – there are diverse interpretations but the main point which I wish to stress is that in all these groups and reflections some common thread of assumptions and perceptions are emerging. While not ignoring the differences I feel the common threads must be identified and focused so that a broader and deeper collective understanding and larger numbers of health action initiators convinced and committed to the Community Health movement in India.
N.B.

<table>
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<tr>
<th>Source 1,2,3,7</th>
<th>Available from Voluntary Health Association of India, Tong Swasthya Bhavan, 40, Institutional Area, Near Qutab Hotel, New Delhi – 110 016.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source 4,5</td>
<td>Available from Centre for Social Action, Gundappa Block, 64, Pemme Gowda Road, Bangalore – 560 006.</td>
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<tr>
<td>Source 8,9,10</td>
<td>Available from Catholic Hospital Association of India, 157/6, Staff Road, Gunrock Enclave, Secunderabad – 500 003.</td>
</tr>
<tr>
<td>Source 6</td>
<td>Available from Lok Paksh, Post Box 10517, New Delhi – 110 067.</td>
</tr>
<tr>
<td>Source 1,2,10</td>
<td>Available from Community Health Cell, 326, V Main, I Block, Koramangala, Bangalore – 560 034.</td>
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HEALTH CARE IN INDIA – AN HISTORICAL OVERVIEW
Vedic Period – to Indian Independence

*Records of Health writings and health care in India goes back in History to over 5000 years and is marked by many significant developments which include particularly

I. The concepts and ‘technology’ of Sanitation in the Indus Valley; (3000 B.C.)
II. The change from magico religious medicine to a more rational therapeutics in Vedic medicine – representing the development of Ayurveda, Siddha and Yoga;
III. The development of Social Medicine and hospitals for humans and animals during the Ashoka/Maurya Phase (279-236 B.C.).

*The growth of Ayurvedic and Siddha medicine is marked by the development of famous treatises and writings of great doctors Charaka, Susruta, Athreya, Jivaka and these traditions were very adoptive and integrative. The strengths even in these traditions available to this day are the sensitivity and closeness to local culture, the stress on healthful living and not disease, and the close links with home remedies and people’s health cultures.

The weaknesses on the other hand are that these are based on empirical logic some of which may have stood the test of time but has not been supported by experimental logic, there has been stagnation due to inadequate professional organization and some of the ills of Society be it class or gender inequality have got internalized without being reviewed from a rational standpoint.

It must be also mentioned that due to the factor of colonialism some of it which continues even today in the form of cultural colonialism, through the dominance of the western allopathic, technocentric model (that was transplanted into the developing health system especially during British rule) these traditional and indigenous systems have not been adequately studied or reviewed and have been neglected by the official health system. A serious study and research are needed to identify the strengths of the indigenous systems and integrate them with the dominant system and develop a truly National System of medicine.

*A word of caution at this stage is that efforts towards study and integration of indigenous systems should be done without undue romanticism or misplaced nationalism. At the same time care must also be taken to differentiate between People’s health culture, local remedies which are under the autonomous control of the people and the relatively more organized systems that have their own practitioners, medicines and training as well as care strategies.

*During the British Colonial phase western allopathic medicine developed greatly in India. While it had already been introduced by the Jesuits in Goa in 16th Century it did not spread till after the advent of British rule. The Health Services during this phase primarily grew with the intention of services for the army and civilian elite of the developing towns and cities in the country.
Rural areas were neglected in general though there was some missionary work that took some basic health care to many interior areas as well. People had to rely primarily on traditional health care.

It must be noted that while there was an overall neglect of the rural against urban in health service development (a fact that is as true of the situation today as in the 1850’s, the development of health services during British rule was affected by the Public Health revolution taking place in Europe at that time and inspite of the overall colonial effect there were many positive developments that must be recorded.

- Public health concepts came into the country in a big way with organization of epidemic measures and other forms of prevention on a large scale.

- The increasing focus on women and women and children and the increasing training of women for health services was another positive development. Much of the missionary work in Health was for women and children and by women.

- After some hesitation training of local doctors and nurses and pare medicals began and the state began to take growing responsibility for Public Health.

*Since there were many small and large princely kingdoms in India even at the height of British rule, these did not always keep track of the newer developments in the British presidency’s local traditional systems got patronage and some thrived. However Mysore and Travencore were two kingdoms that evolved very progressive public health and health care policies laying the foundations so to speak for the very different situation in ‘Kerala’ and ‘South kanara’ in present day India.

*In 1943 – 46 the Health and Development Committee (also known as Bhore Committee) drew up the comprehensive blue print for Health Services for India. While this was a pre-independence committee set up by the Provisional government, the recommendations were very progressive and far reaching. Three significant developments in 1920’s to 1940’s definitely inspired this committee. The influence of socialism and the health services of the socialist states, the European Public Health movement and the post world war welfare state concept as well as the growing National movement. (The Sokhey report of the Indian National Congress is a fore runner to a new vision of health/health care).

*The Bhore Committee recommendations included the following:
- Health should be an integral part of socio-economic development.
- Adequate health care for All
- Free health care for All
- Reach out to vast rural population
- Correct rural-urban imbalance
- Emphasis on prevention, promotion and education
- Key role of self help and active cooperation of people through representations and committees.
- Health as an individuals responsibility.
*The Bhore Committee evolved the concept of the Social physician - ‘Scientist and social worker…. Cooperate in team work…close touch with people…serving disinterestedly….friend and leader….protecting people and guiding them to a healthier and happier life.’

*while in retrospect we now know that there were some flaws in the expert prescription in the form of unrealistic targets, vague budget allocation and distributing, complete bypass of the indigenous systems of medicine, and the abolishment of medicine, and the abolishment of the licentiate scheme for training doctor, the Bhore report built the framework and remained the inspiration for much of the Post Independent Health Planning in India.

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**A VISIONOF Community Health CARE**

Bhore Committee, 1946

“In drawing up a Health plan certain primary conditions essential for healthful living must in the first place be ensured. Suitable housing, sanitary surroundings and a safe drinking water supply are the pre-requisites of a healthy life. The provision of adequate health protection to all covering both its curative and preventive aspects, irrespective of their ability to pay for it, the improvement of nutritional standards qualitatively and quantitatively, the elimination of unemployment, the provision of a living wage for all workers and improvement in agricultural and industrial the rural areas are all facets of a single problem and call for urgent attention. Nor can man live by bread alone. A rigorous and healthy community life in its many aspects must be suitably catered for. Recreation, mental and physical plays a large part in building up the conditions favourable to sound individual and Community Health and must receive serious consideration. Further, no lasting improvement of the public health can be achieved without arousing the living interest and enlisting the practical cooperation of the people themselves”.

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**IB - ADDITIONAL READING**

1. ‘The Traditional Systems’ and ‘The British Period’ in Chapter 1, The Historical Background. (Source 4)
2. Historical Development in Chapter III – The Care System. (Source 5)
3. Health Culture of India and the Colonial legacy in Chapter 1, Environmental Setting and Political Economy of Health and Health Services. (Source 6)
4. Health issues and the National Movement in Chapter 2, Colonialism, the National Movement and the Health Services. (Source 6)

**IC – QUESTIONS AND TASKS**

1. History teaches us a lot about the factors that have contributed to heath services development – those that have been obstacles and those that have been promoters. In your own region find out about the history of specific institutions and locate them in the context of the wider historical developments.
2. Identify all the components of Health Services currently available in your area including traditional systems of medicine. Try and build up a local history and historical context for your area.
Q. How does study of history and medical culture help?
A. The history of medicine is both history and medicine. It is a historical discipline like the history of art or the history of philosophy. It helps to give us a more complete picture of the history of civilization, because it is obviously not unimportant to know what diseases affected the people in the past, what they did to protect and restore their health and what thoughts guided their action.

But the history of medicine is also medicine. By analyzing developments and trends it permits us to understand a situation more clearly and to act more intelligently. We all know that success or failure of our medical work depend not only on the scientific knowledge we possess but also on a great variety of other non-medical factors, on economic, social, religious, philosophical, political factors that are the result of historical developments. Unless we are aware of them and understand them many of our efforts will be wasted.

- Henry E. Sigerist

**SOURCE:** Report of the Health Survey and Development Committee (Bhore Committee), Vol. III – Appendix 47.
The Constitution of India adopted in 1950 clearly recognises the government’s responsibility for the health of all the people. This commitment has led to the evolution of a large number of health programmes over the last 40 years.

**Constitutional Pledges**

The State shall regard the raising of the level of nutrition and the standard of living of its People and the improvement of Public Health as among its primary duties.

- It shall ensure that the health and strength of workers, men and women, and the tender age of children are not abused…
- That children are given opportunities and facilities to development in a healthy manner…

It shall make

- Provisions for securing just and human conditions of work and for maternity relief…
- and
- for public assistance in cases of unemployment, old age, sickness and disablement and in other cases of underserved want.

- Constitution of India

These included the

- Development of the Primary Health Centre concept for every one lakh population.
- The training of health teams including doctors, health inspectors, lady health visitors, auxiliary nurses, midwives, basic health workers, block extension educators for these health centres.
- The National programmes for communicable diseases like Tuberculosis, Leprosy, Malaria, Filaria, Plague, Cholera and so on.
- The maternal and Child Health, Nutrition and Family welfare programmes.
- Efforts at re-orienting medical and nursing education.
- Establishment of research and specialist institutions.
- The integration of programmes at PHC level, evolving the multipurpose health workers and health supervisor cadres.
- Establishment of pharmacies and training of pharmacists


**Taking Stock**

In 1972, when we celebrated the Silver Jubilee of our independence, there began a critical reflection and introspection or the preceding twenty five years of development. This was an important milestone and it became a focus to take stock of the strengths and weaknesses of our planning and development particularly in the context of the continuing poor quality of life of a large majority of Indian citizens. All aspects of national development came under scrutiny and health policy was no exception.

**Assessing achievements/failures**

A study group of the Indian Council of Medical Research and the Indian Council of Social Sciences Research in 1984 listed out the achievements and failures of the whole health care strategy.

<table>
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<tr>
<th>Achievements</th>
<th>Failures</th>
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<tr>
<td>- Life expectancy doubled                                                   - Health not integrated with Development</td>
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<td>- Health care services expanded                                              - Little dent on Malnutrition and Environmental Sanitation</td>
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<td>- Manpower training centres increased                                       - Morbidity patterns not materially changed</td>
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<td>- Small-pox was eradicated                                                   - Health Education neglected</td>
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<tr>
<td>- Plague, Cholera and Malaria controlled                                    - TB, Leprosy, Filaria yet to be controlled</td>
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<tr>
<td>- Maternal and Child Health and immunization programmes increased           - Infant and maternal mortality rates still very high</td>
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<td>- Largest Family Planning Programme in the world                            - Population stabilization – a long way to go</td>
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**Overall**

1. The model of health care was outdated and counterproductive benefitting the rich and well-to-do upper and middle classes.
2. Health was a low priority national investment.

Source: ICMR / ICSSR

**Quantitative Expansion**

We had made some rapid strides and a phenomenal quantitative expansion of health care services. This increase in manpower and infrastructure development continued into the eighties.
By 1984, we had increased the number of hospitals and dispensaries three-fold, doctors five-fold, nurses ten-fold and dental colleges seven-fold – remarkable development indeed it seemed.

However, when we compare this infrastructural development with the Bhore Committee’s long term goals enunciated in 1946 itself, we find the situation very different and the so called ‘rapid growth’ becomes questionable.

Increasing numbers with goals and base lines can be very misleading

**Critical Introspection**

In the seventies, the Government of India set up an expert group on Medical Education and Support Manpower to take stock of the situation and suggest proposals for reforms.

This is what the expert committee (Srivastava Report, 1975) had to say:

1. “A universal and egalitarian programme of efficient and effective health services cannot be developed against the background of socio-economic structure in which the largest masses of people still live below the poverty line. So long as such stark poverty persists, the creative energies of the people will not be fully released; the state will never have adequate resources to finance even minimum national programmes of education or health; and benefits of even the meagre investments made in these services will fall to reach the masses of the making a direct, sustained and vigorous attack on the problem of mass poverty and for creation of a more egalitarian society. A nationwide programme of health services should be developed side by side as it will support this major national endeavour and be supported by it in turn.”

2. “we have adopted tacitly, and rather uncritically the model of health services from the industrially advanced and consumption-oriented societies of the west. This had its own inherent fallacies; health gets wrongly defined in terms of consumption of specific goods and services; the basic values in life which essentially determine its quality get distorted; over—professionalization increases costs and reduces the autonomy of the individual; and ultimately there is an adverse effect even on the health and happiness of the people. These weaknesses of the system are now being increasingly realized in the West and attempts are a foot to remedy them. Even if the system were faultless, the huge cost of the model and its emphasis on over-professionalization is obviously unsuited to the socio-economic conditions of a developing country like ours. It is therefore a tragedy that we continue to persist with this model even when those we borrowed it from have begun to have serious misgivings about its utility and ultimate viability. It is, therefore, desirable that we take a conscious and deliberate decision to abandon this model and strive to create instead a viable and economic alternative suited to our own conditions, needs and aspirations. The new model will have to place a greater emphasis on human effort (for which we have a large potential) rather than on monetary inputs (for which we have severe constraints).”
Many other expert committee reports and policy statements of the seventies began to make critical observations about the inadequacies of the present health care model and exhorted all concerned to search for more relevant alternatives and approaches.

Prof. Banerjee of JNU (Source 6), offers a deeper social analysis to explain this growing dichotomy, his contention is that the post-independent leadership had two basic choices in front of them. Either to expand health services along the pattern set up by the Britishers choice or to introduce radical changes to answer needs of the ordinary masses. While the latter was the choice in most policy documents the class character of the leadership affected the realities in practice. The old colonial traditions were perpetuated with the focus on urban and curative. The doctors came from the privileged classes and had internalized the elitist and modernizing ethos. The humanitarian principles and socialist declarations notwithstanding, the overall focus was on a capitalist framework. Health policies of the 1950’s and 1960’s mainly answered ideals/aspirations/needs of upper and middle classes and the health professionals who belonged mainly to these classes. The focus was mainly on hospitals, medical colleges, and curative services in cities whilst rural areas got low quality curative care, some communicable disease control and more family planning services.

This basic dichotomy of needs and aspirations and class character of leadership explains the overall consistent lack of political will, the increasing dichotomy of services for the classes and the masses; the increasing urban-rural differential; the over emphasis and target orientation of Family Planning; the promotion of the health industry; the increasing corruption in the services
and growing ethos of private practice; the neglect of the indigenous systems of medicine; the populist modification of programmes; the statistical misinformation; the verticalization of programmes; the increasing neglect of public health standards and practice; the inadequate health education and awareness building strategies and the more recent glorification of technology and the promotion of privatization in health care.

Some of this is echoed in the National Health Policy of 1982 which is part of the growing rethinking on Health Care in India. ‘Community Health Action’ is therefore to be seen in this broader context.

II / B – ADDITIONAL READING

1. The Post-Independence Model in Chapter I – The Historical Background. (Source 4)
2. Towards a Proper Analysis, Chapter 4 (Source 4)
3. The Health Care System, Chapter 3. (Source 5)
4. Forces Shaping the Health System, Part III. (Source 5)
5. Health Services Since Independence, Chapter 3. (Source 6)
6. The Development of Health Services in India, Section III Chapter 1. (Source 8)

II/C – QUESTIONS AND TASKS

1. Visit the nearest Primary Health Centre and sub centres in the Taluk/Block in which you are working. From the PHC doctor and health centre staff find out about the organization and functions of the centre. What are their problems and difficulties.
2. Talk to groups of people in your community from different socio-economic and cultural groups and ask them about their experiences of health care in the government PHC or sub-centres.
3. From these two steps build up your analysis of the situation of health care in your area – the projected achievements and the actual realities.
4. Try and identify the factors that operate at the local level/district level/state level promoting or obstructing health service development, accessibility and efficiency.
The Existing Picture

In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The high rate of population growth continues to have an adverse effect on the health of our people and the quality of their lives. The mortality rates for women and children are still distressingly high; almost one third of the total deaths occur among children below the age of 5 years; infant mortality is around 129 per thousand live births. Efforts at raising the nutritional levels of our people have still to bear fruit and the extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control and eradicated. Blindness, Leprosy and TB continue to have a high incidence. Only 31% of the rural population has access to potable water supply and 0.5% enjoys basic sanitation.

1) High incidence of diarrhoeal diseases and other preventive and infectious diseases, specially amongst infants and children, lack of safe drinking water and poor environmental sanitation, poverty and ignorance are among the major contributory causes of the high incidence of disease and mortality.

2) The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and the establishment of curative centres based on the Western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based disease, and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of the health care. The existing approach instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community’s capacity to cope with its problems. The prevailing policies in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve the individuals and families in establishing a self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes.
Since independence there have been much efforts to improve the health status of the people and in the 1980’s policy statements a ‘commitment to health as a social goal with emphasis on equality of health service for all social groups in the country has emerged.

“A detailed examination of available information on mortality (death rates), morbidity (illness rates), delivery of health services and development of human power and their deployment reveals that the picture of health status in the country is not as rosy as it seems on the surface”.

**Mortality in India** (National in 1988 = 11.8 Rural 7.5 Urban)

- Rural and Urban death rates (CDR) show a continuous decline in the period studied 1971-1988.
- Rural health rates are substantially higher than urban rates in all the states with the singular exception of Kerala.
- Rural death rates in Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh are substantially higher than national average and the urban-rural differential is unacceptably high.

*Age and Sex specific death rates*

- At newborn male and female weights and heights are similar, if anything the female child is slightly better off.
- Below 10 years of age the death rates in females both in urban and rural areas is clearly higher than in males. The inference therefore is inescapable that the family and social environment in the early years is adverse for the female child.
- In 10-14 age group the rates are similar in rural areas and female is better than males in urban areas.
- In age 15-34 female death rates are higher than males, the difference being much higher in rural areas and in younger ages.
- Beyond 35 years female enjoy a lower death rate when compared to males.
- Inference: Child bearing takes a heavy toll of death in women in the country especially rural sector and reflects poorly on the Health Services.

**Infant Mortality Rates** (National in 1988 = 102 Rural, 61 Urban)

- Infant mortality rate is above 100 in Assam (101), Bihar (100), Gujarat (101), Madhya Pradesh (127), Orissa (127), Rajasthan (111), Uttar Pradesh (132) in 1988 and below 100 in all the other states. Kerala is the lowest with 30.
- In Punjab, Haryana, Himachal Pradesh and Uttar Pradesh IMR is higher in females than in males. In Assam, Andhra, Karnataka, kerala, Orissa, Jammu & Kashmir and West Bengal, IMR is lower in females than in males. In all the other states it is more or less similar.
- Rural IMR’s are substantially higher than Urban IMR with exception of Kerala.
- Neonatal and post neonatal mortality rates show a decline in all states from 1970 to 1985 except Haryana. Rural rates are substantially higher than urban rates.

*Maternal Mortality Rates (National in 1987 = 3.6)*

- One percent of all rural deaths are reported to be due to child birth and pregnancy in India.
- In 1967 the national average was calculated at 3.6/1000 live births. Uttar Pradesh (7.1), Himachal Pradesh (6.5), Bihar (6), Madhya Pradesh (6.1), Rajasthan (4.5), Orissa (4.3), Haryana (4). All the other states had lower than national average with Kerala being the lowest (0.6) and Karnataka a close second (1.0).
- Rural MMR in India is about 15 times more than what it should be for an Asian country and probably 60 to 80 times more than that in developed countries of the West.
- In a study in Anantpur District (Bhatia, J.C., IIM-Bangalore, (1984-85) MMR was higher in 15-34 age group and nearly half of all deaths in 20-24 age group was due to maternal death. 43.5% of maternal deaths was on day of delivery and 41.9% of deaths due to bleeding and infection(!).
- 70% of all births in rural India are attended to by untrained persons.
- An ICMR study on the quality of MCH services in rural India published in 1989 shows that elementary care of women during delivery is grossly inadequate in India.

*causes of Death*

- Tuberculosis, Pnemonia, Anemia, Gastro-enteritis, Dysentery and Typhoid account for 20% of all deaths in India.
- Communicable diseases account for 40% of all deaths in India.
- Diarrhoea is a major cause of illness and death in children in India.

*Nutrition Status*

- The national Nutrition Monitoring bureau monitors nutrition in the states of Kerala, Tamilnadu, Karnataka, Andhra, Maharashtra, Gujarat and Orissa.
- Barring Gujarat and Orissa all other states have shown an improvement in nutritional status from 1975 to 1989.
- The girl children have shown greater improvement than the boys!
- Moderate and severe malnutrition among tribal boys and girls is high in all these states.
- Vitamin A deficiency in pre-school children ranges from 5-10%.

Communicable and Non-communicable Diseases Mortality

- Tuberculosis, Leprosy and Malaria are still major problems. Progress in control of TB is disappointing. In leprosy with the introduction of multi drug therapy there seems more hope. Malaria has shown an increase from 1986 to 1988 (date available) in the states of Andhra, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Rajasthan and Tamilnadu.
• Goitre, Cancer and Blindness are increasingly being recognized as major problems.

Health infrastructure and health manpower

• There is growing evidence that ‘the large functional infrastructure claimed to have been created in the country only exists largely on paper.

• Official statistics indicate that the objective of having a subcentre for 5000 people in rural areas and 3000 for hilly and tribal areas and a primary health centre for every 30000 population is very nearly achieved. On the other hand, the national Institute of Health and Family Welfare’s national review of Immunization programme shows that only 45% of district have subcentre for every 5000 population.

• The ratio of male to female multipurpose worker which should be 1:1 is 1:1.6 which shows a shortage of male workers.

• The availability of all types of nurses is inadequate.

• The practitioners of the indigenous system are about 4 lakhs (registered) but are yet to be involved meaningfully by the health care system.

“...In summary, it is no exaggeration to say that the health scene in the country is really grim even after 40 years of independence. It is being increasingly realized now that the goal of good health for the people of India can only be reached through a process that is multidimensional, encompassing appropriate universal education, better environmental management both at home and outside, well integrated social services, an acceptable minimum living standard and of course health and medical care of acceptable quality!

The message from the even the limited data presented in this paper is loud and clear. The medical model of health which merely concentrates on the use of technological resources in freeing man from clinically identifiable disease or disorder is at its best an inadequate and at its worst an uneconomical and unproductive approach for the improvement of the health of a people. The medical model has to be tempered by the social model of health which as mentioned earlier approaches the goal of good health through a multi-dimensional process. Health development has to become an integral part of the socio-economic developmental process.”

(This section is principally and substantially an edited and summarized version of a recent paper (1990) on ‘Current Status of Health in India’ presented by Prof. K. Ramachandra, Professor of Epidemiology and Statistics of All India Institute of Medical Sciences, New Delhi. The original paper is 8 pages with 23 pages of tables as appendix and is available on request from CHC, Bangalore).

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III / B – ADDITIONAL READING

1. ‘The Current Health Situation’ in Chapter 1 Wanted an Alternative National Health Policy. (Source 2)
2. ‘The Post Independence Model’ in Chapter 1 The Historical Background. (Source 4)

3. The Present situation – Chapter 3. (Source 4)

4. Many interesting tables in different chapters in Dr. Banerji’s book. (Source 6)

5. The development of Health Services in India including health of children, women, adults, nutrition, Health Education and Family Planning, page 125-235. (Source 8)

III/C – SOME QUESTIONS AND TASKS

1. From all these source prepare a statistical profile of the state in which you working.

2. Compare your state’s situation with the other states. What does this exercise teach you.

3. Visit the nearest government primary health centre and or the District Health Officer and find out the latest statistics for your area/region. Reflect on these in light of some of the issues raised in the paper.

4. Send these region/district/state profile prepared by you to other forum members and resource groups to initiate a reflection on diversity of needs and local situation.

REFLECTION – IV/A

COMMUNITY HEALTH IN INDIA – RECOGNISING THE NEW PARADIGM

Since the mid-sixties there has been a growing disenchantment with the models of development including health care services, which we adopted somewhat uncritically, from Western industrialized nation. This stemmed from the growing field experience of the inadequacies of these models to meet the needs of the large majority of our people and a growing realization that “development” is a socio-economic-political-cultural process, which must evolve its own local solutions. These solutions must involve, a critical appraisal of technological packages and their adaptation to fit our own, rather different social realities.

This disenchantment took forms including the evolution of much analytical and imaginative writing, innovative field projects, ideologically based people’s movements and protests. Besides questioning and challenging the assumptions and values of borrowed models and methods, there was also a re-examination and reappraisal of the experience and thrusts of the post-independence period as well as our own cultural traditions. This quest for new values, new attitudes, new processes of social change has pervaded all aspects of development in India and Health care is no exception.

Since the early seventies a large number of initiatives and projects have been established outside the Government system by individuals and groups keen to adapt health care approaches to our social realities and this response has grown. Broadly classified as voluntary organizations or NGOs, these initiatives were predominantly rural to begin with but in recent years the focus on
tribal regions and urban slum communities has grown. Starting with illness care, most of them moved on to a whole range of activities and programmes in health and development, described later. Initially they developed independent of each other but, over the years some networking and training programmes emerged inspiring similar attempts elsewhere. As the phenomena evolved community development projects and community education experiments also began to add dimensions of health in their approaches. In more recent years further networking to share ideas and experiences, evolve some common perspectives and organize some collective action on broader health issues has taken place.

In the late 1970s I believe there were two distinct schools of thought on Community Health (refer Source 3).

- The first school of thought understood the real cause of ill health as being rooted in the present economic-political system. It believed that nothing can be done or should be done unless the present economic-political system could be changed. This generated an inactive cynicism about the health of the people. The political activists of the left parties particularly belonged to this school.

- The second school of thought believed that the panacea for all health problems had been found in the ‘alternative approach’ utilizing non-professionals and appropriate technology and some micro-level management innovation. Village Health Workers and ‘appropriate low cost technology’ was felt to be the answer. This generated an ill founded euphoria. The group evolving under the amorphous title of voluntary agencies (volags, NGO’s) belonged to this school.

- While the first school did not understand the ‘social’ meaning or potential of health the second school did not locate their action in the context of social change. Much more energy was spent attacking each other than jointly countering the medical model of health.

- In the late 1970’s – some integration began to take place through greater and deeper understanding and the more integrated concept of community health emerged as an essentially multidimensional process – including socio-political, socio-cultural, technological and managerial components (see Source 10). This generated a shift in the understanding of health from its medical technologised model to its social model-with health being seen more and more as an empowering/enabling process rather than a provision of a package of services.

Networking among individuals and groups around issues of health care began in the early seventies. The medico-friend circle – a pioneering example among these, was a loose-knit network, (of all those who shared a common conviction and understanding that the present health services and medical education system was lopsided in the interest of the large majority – the poor people of India) that began in 1974. It saw itself as a thought current upholding human values and certain new attitudes in health care and medical education (see box) and ‘offered a forum for debate and dialogue to share experiences and experiments’ and ‘for taking up issues of common concern for action’.
While the medico-friend-circle represents a network of individuals, the All India Drug Action Network which emerged in the early eighties is another pioneering example of networking around a common health policy issue. Keen to promote a rational drug policy and more rational prescribing practices in the Indian situation, this network includes a large number of health groups, and associations, consumer groups, social activists, trade unions, university departments and hospital associations. This is again a significant development since the Health for All study group had warned in its report ‘that eternal vigilance was required to ensure that the health care system does not get medicalised, that the doctor drug-producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health’.

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

The peoples science movements in Maharashtra and Kerala states (Lok Vidhyan Sanghatana and Kerala Sastra Sahitya Parishad) are prototypes of science movements that are beginning to address health issues in their campaigns. The LOCOST experiment in low cost, quality tested supplies of drugs to voluntary health organizations and small hospitals in Gujarat is another, more focused but relevant example. The inclusion of wider ‘health policy’ and social issues on the agenda of junior-doctor movements, the emergence of the socialist Health Collective, the regional or state level drug-action forums are more examples. The establishment of the Asian Community Health Action network, encompassing much of Asia, is another example of commitment to similar concerns in health care and symbolizes the fact that this trend, being described in India, is part of a much wider regional trend.
The Voluntary Health Association of India, which began in the early seventies as the coordinating Agency for Health Planning was a more formal attempt to bring together this growing commitment to alternative and community approaches to health care. As a federation of state level networks linking over 3000 health institutions and community health programmes in the country VHAI has been spearheading various aspects of a ‘health for and by the people’ approach through informal workshops and training programmes.

The Asian Community Health Action network views health as the physical, mental, social, spiritual, economic and political wholeness of the individual and the community….

It believes that health problems and priorities should be viewed in terms in which the community sees them and that the community should be actively involved in the planning, implementation, monitoring and evaluation of health care programmes…

It seeks to spread a philosophy of community based health care that envisages a process of self-reliant human development for the oppressed poor in Asian communities which will result in genuine social change.”

An introductory pamphlet of the Asian Community Health Action network, 1982.

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An introductory pamphlet of the Asian Community Health Action network, 1982.

“What is our new vision of health care?

‘Community Health’- We begin with the Community. Our goal is a healthy community. We believe in health by the people….

We promote social justice in the provision and distribution of health care…

We encourage people to demand health services as a human right…

Our old health services have been built to favour the educated, the privileged and the powerful…

We wish all goods and services to be more equally shared with the whole community….

We assist in making community health a reality for all the people of India, with priority for the less privileged millions, with their involvement and participation through the voluntary health sector.”

- Introductory pamphlet, Voluntary Health Association of India

In the early eighties two other formal coordinating agencies of hospitals and dispensaries under ‘church’ sponsorship, the Catholic Hospital Association of India (around 2000 member hospitals and dispensaries sponsored by the Catholic Church) and the Christian Medical Association of
India (around 300 protestant institutions and about 5000 individuals associated with these institutions have both begun to reflect this changing trend in policies and programme directions. (see boxes). Their policy statements illustrate their awareness of our ‘health care’ realities and their attempts to respond to these needs through a re-orientation of their earlier preoccupations.

“Health is the total well being of individuals, families and communities as a whole and not merely the absence of sickness. This demands an environment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as spiritual needs are met…

The concept of Community Health…. Should be understood as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right. Thus it is beyond mere distribution of medicines, prevention of sickness and income generating programmes.

- Policy statement of Catholic Hospital Association of India, 1983.

“A very recent addition to this trend and analysis, though more comprehensive and scholarly, is the rather voluminous ‘Epidemiological, socio cultural and political analysis’ of the health care situation in India (Banerji, 1986).

This attempts to formulate the postulates of a new theory, a new framework within which the ‘evolving health care’ ferment could be placed (refer box).

“Health service development is thus
a. A social cultural process;
b. A political process; and
c. A technological and managerial process with an epidemiological and sociological perspective.

There is often a lag between socio-cultural aspirations of the people and their articulation by the political leadership; the lag is much more between aspirations of the political leadership and the community health physicians who have the responsibility for building the needed edifice of the health services. The task is to narrow, if not totally eliminate, lags that may exist within the three tiers.

Formation of a critical mass of community health physicians and other members of the team which can take full advantage of the scope, offered by the base (i.e., the complex of ecological, epidemiological, cultural, social, political and economic factors) are needed and require a new approach to education of community health physicians and other members of the team.”

- D. Banerji (1986)
The concept of ‘Community Health’ in India must be understood as an evolving perspective that has diverse interpretations and varied formulations as the above sources exemplify but there is also an evolving common thread between these newer analysis, exhortations and actions.

(adapted from Source 10)

IV/B – ACCTIONAL READING
IV/C – SOME QUESTIONS AND TASKS

- Refer and of REFLECTION VI
- Refer end of REFLECTION V
VALUES FROM OUR TRADITION
For the Alternative Paradigm

There are five major contributions which our traditions can make to the development of values which underline the alternative model of health care:

1. The basic philosophy of our tradition, with its ashram concept of stages in life can prepare an individual better to accept life and death; he grows up as a disciplined young man (Brahmacharya); lives his life fully in adulthood (Grihastha); adjusts to old-age and begins to withdraw from active live (Vanaprastha); and finally becomes totally uninvolved and gets ready to meet death (Sanyasa). The more widespread such outlook becomes, the better will be the basis of health among the people, because it will inculcate the right attitudes to pain, to growing old, and to death.

2. Another valuable aspect of our tradition is its non-consumerist approach to life which is in total contrast to the consumerist civilization of the industrialized west. Our tradition would make health an individual responsibility and root it in simplicity and self-discipline. The concept of health in the industrial civilization is that of a commodity. This model has created its own problems even in the affluent countries and health is becoming a costlier and rarer commodity all the time. For developing countries like ours, this model can only be a disaster. A return to our own tradition in this regard is the only road to good health.

3. In our tradition, health services are essentially an individual and community responsibility; each community organized its own health services and maintained them and the state had no hand in the matter. We have now borrowed the concept of state support for health services with a vengeance. The sense of individual responsibility has thus begun to be eroded; and we are not allowing the community to undertake even those services which it alone can organize, and have created an attitude of total dependence on a state which is incapable of providing the services. What we have to do is to combine our traditional concern for community participation with discriminating but substantial state support.

4. Yoga can be a powerful instrument for physical and mental health. It needs to be popularized through the educational and health systems.

5. Our tradition places a strong emphasis on simple but effective things such as naturopathy, the use of simple medicines, the practice of growing herbs needed in day-to-day illnesses in backyards or other places in every locality; games and sports which require little equipment or space; and so on. These valuable ideas should not be allowed to die out in preference to the costly life-styles with which a profit-motivated capitalist civilization tries to encourage consumerism.

(Source: Health For All – An Alternative Strategy, ICSSR and ICMR, pages 96-97)
REFLECTION – V

THE COMMUNITY HEALTH APPROACH

In an informal study-reflection process we initiated in India over the years 1982-86 we discovered that this term means different things to different people and there are a very large range of ideas and dimensions that are included by health care action initiators when they use this term to describe their action or their approach. Our objective was not to build a single, well defined, definition acceptable to all concerned but to probe the depths of the definition and identify the richness and diversity of the possibilities. What we discovered, was a range of dimensions far beyond what we generally understand or describe as “primary health care” or “community medicine”. We outline these possibilities to help evolve the component axioms of a new approach – encompassing its philosophical assumptions, goals and methodologies.

Building on the CHAI vision of “enabling people, to exercise collectively their responsibility to their own health and to demand health as their right, we evolved a more detailed formulation of the approach.

These were –

The “Community Health” Approach
Involves the increasing of the individual, family and community autonomy over health
And Over the organizations, the means, the opportunities, the knowledge and the supportive structures that make health possible.

The ” Community Health” Approach
Includes an attempt to integrate health with development activities including education, agricultural extension and income generation programmes;

An attempt to orient existing medical programmes towards preventive, promotive and rehabilitative actions;

A search for and experimentation with low-cost, effective, appropriate technology in health care, health communications and recording systems;

A recognition and involvement of local, indigenous, health resources like traditional birth attendants (dais), traditional healers, folk-medicine practitioners, non-allopathic systems of medicine, herbal medicines and time-tested home remedies;

A training and involvement of village – based health workers;

A initiation of greater community organization through farmers, youth and women’s clubs;

An increasing involvement and participation of the community, through formal and informal organizations and health committees, in decision making for health action including planning, financing, organizing and evaluation of health actions;
A quest for generating greater community support in health action through cooperatives, health insurance and other schemes as well as tapping locally available labour, human skills and materials resources;

An organization of informal and non-formal, demystifying and conscientizing programmes of education for health.

**The Community Health approach**

Is essentially a democratic, decentralized, participatory, people building and people empowering activity and recognizes that this new value system must pervade the interaction between the community and the “health action” initiators as well as within the team of “health action” initiators themselves.

To enhance the “Community Health” approach it is therefore necessary for “health action” initiating teams to evolve a greater democratic, non-heirarchical, participatory, team building and “team empowering” ethos in their own relationships as individuals and members of a team.

**The Community Health Approach**

Recognizes that in the present inequitous and stratified social system there is no “community” in the real sense of the word and hence community health action will invariably mean, the increasing organization, involvement and participation of the large sections of the community, who do not participate adequately in decision making at present i.e., the poor, the underprivileged, the marginalized.

Such attempts will invariably be opposed by “status quo” forces and all those who draw greater advantage from the present situation.

A “Community Health Approach” will recognize the presence of these conflicts of interests and the inevitable social tensions consequent to community health action but being committed to a “community empowering” process it will support actions and struggles as they go beyond “health” issues.

**The Community Health Approach**

Recognizes that the large majority, the poor and the disadvantaged are not themselves “one community” even though they are linked by their poverty and social situation, since they have internationalized various social, cultural, religious and political differences that divide society at large.

It therefore accepts that in terms of process, efforts to imbibe the concept and the spirit of community, to improve group dynamics and group inter-relationships are preliminary to evolving community actions of any sort. Hence through all its component programmes and activities, the community building process will be promoted and enhanced.

**The Community Health Approach**

Recognizes that the present over-medicalised health care system is characterized by certain features viz., hierarchical team functioning and non-participatory decision making;
Water-tight division of responsibilities with over-emphasis on the role of doctors;

quest for specialization and compartmentalization of professional activities;

A preoccupation with the understanding of human illness in terms of an organ-centredness and at intracellular, molecular levels, forgetting the whole “being” in the process;

A clear distinction between “providers” of the service and the “users” of the service;

An overemphasis of the “physical” dimension of health and a disregard for the psychological, social, cultural, spiritual, ecological and political dimensions;

Over-professionalization, which control the spread of technical knowledge and skills to members of the health team and to the people at large;

“providing” orientation of services and action rather than the “enabling” orientation;

An over-emphasis on drugs and technology leading to a complete dis-regard for non-drug therapy and skills;

A preoccupation with the allopathic system of medicine ignoring the existence or utilization of the culture and practices of the other systems of medicine and healing.

Community Health action initiators even though they most often emerge from these medicalised environments, do not see themselves as just extensions of this medicalised system. They constantly confront these issues in their approach and actions and try to evolve new attitudes, new skills and new approaches that are people and community oriented and place medicine, professional skills and technology in their right and limited context.

The Community Health Approach
Evolves action from the community outwards and upwards confronting the various components of the existing superstructure of health services which includes
The primary health centres, dispensaries, hospitals, teaching and research institutions the medical, nursing, paramedical and public health teams and professional training centres and associations;

The health programmes and health institutions under government or non-government voluntary agency auspices.

It confronts the superstructure to become

a) More “people” oriented
   Is sensitive to the realities of the life of the large majority of people – the poor and the underprivileged,

b) More “community” oriented
I.e., understanding health in the context of the problems of the whole community and all its sections and not just as individual problems,

c) more “socio-epidemiologically” oriented
i.e., recognizing the biological, socio-economic, psychological, cultural, spiritual, political and ecological dimensions of health,

d) more “democratic”
i.e., participatory in its growth, planning and decision making processes,

e) more “accountable”
i.e., increasing the subservience of medicine, technology, structures and professional actions, to the needs and hopes of the people, the patients, the consumers, the “beneficiaries” and the community which they seek to serve.

The Community Health Approach
Is therefore not just a speciality, a new professional discipline, a new “technology fix” or a new package of actions.

It is predominantly a new vision of “health” and “health care” a new attitude of mind, a new “value orientation” in health action and a new perspective for the future linked to a new vision of society.

It must therefore existing health care systems, institutions, research efforts, training programmes, professional ethics and health planning exercises.

Community Health action
Is closely intertwined with efforts to build an alternative socio-political-economic-cultural system in which health can become a reality for all people.

The “community health approach”
Therefore recognizes that the components of actions are means and not ends and will therefore be flexible enough to reorient reprioritise, disband or change towards more relevant actions and directions as they evolve in the interactions at the community level.

(Source: Community Health; The search for an alternative process; Report of a study reflection action experiment by CHC Bangalore, Jan. 84 – June 86.)

REFLECTIONS IV & V

SOME QUESTIONS AND TASKS

1. Community Health in India is an evolving concept and all the above sources explain their understanding of it. Reflect on these and evolve a working definition for your own group action.

2. Start with the statement on Community Health in the earlier minute of the CH Forum and build on it adding points and issues from the CHC reflections and other sources mentioned.
3. Identify through reflections on your own field experiences, the factors that promote community health and those that are obstacles to it. Identify and evolve the components through practical action-reflection.

REFLECTIONS VI & A

IS ‘COMMUNITY HEALTH’ GROWING AS A MOVEMENT IN INDIA

Are there signs of such a movement 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 organizations and people’s movement to recognize the value and true meaning of health. Yet probably a beginning is being made.

The pre-requisites for the development of a Community Health movement are many:

I. Firstly there is a need for a clearer understanding among all concerned about health as a ‘social justice’ and ‘civic right’ issue.

II. Secondly more and more groups should recognize that Community Health action need not always be a providing/distributing process but can also be a enabling / empowering process.

III. Finally this understanding and dialogue must be actively initiated at the grass roots level with the people at the community level recognizing the significance of collective health action, in their daily life struggles.

Today there are positive trends supporting this possibility and negative trends which will stall such a development. What are these?

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 already been initiated.

Secondly there is a growing number of individuals – development or political activists – who are beginning to recognize the non-medical dimensions of health and ae 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 recognized. 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 organize 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 movement are definitely there but the trends opposing and most often neutralizing the gains made are equally there and probably stronger.

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

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

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

To sum up then in the early 1990’s – community health movement is far from becoming a reality. There is a potential for such an evolution but there is much more ground work to be done. The first is to recognize partners in the movement and establish linkages and interactions that go
beyond ideological debates, individual egos, and institutional/project frameworks. The second is to have a deeper study reflection on the nature of the paradigm shift that has to actively take place in the understanding of community health and community health action – from a ‘medical model’ to a ‘dynamic social model’. Thirdly is to support existing struggles and or initiate new ones all over the country, around issues related to health – be it towards a rational drug policy; towards supports to people’s health culture and traditions; against corruption, medical malpraxis and unethical practices or towards communities demanding components of primary health care as their right.

It is by this three pronged strategy that a movement can be generated, and all committed Community Health activists have to seriously face up to this challenge in the years ahead.

REFLECTIONS IV TO VI

ADDITIONAL READING

1. The Alternative Model: General Principles and Organisation, Chapter 6 & 7 (Source 2)
3. Possibilities of Relevant Action – Chapter 6 (Source 4)
4. The New Vision of CHAI – Appendix II. (Source 4)
5. Some Alternative Programmes Chapter 27 (Source 6)
6. Epilogue Postulates of a Theory Chapter 30 (Source 6)
7. Community Health: The quest for an alternative, Chapter 4 (Source 7)
8. Widening the Scope of health work, Chapter 5 (Source 8)
9. Health and Power to the People (Source 9)

SOME QUESTIONS AND TASKS (FOR VI)

1. Identify in your region of the country all the individual groups/projects/processes who are potential partners in a Community Health movement of the future. Visit them. Interact with them. Get to know their plans and perspectives. Evolve linkages and some common action for the area however limited.
2. Identify the problems that come in the way of such a ‘linking process’. Are these problems ideological, psychological, sociological or any other issue-related. Discuss in you regional and national forum meetings how to get beyond them.

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