Social Dialectics of Primary Health

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This article presents some socio-psychological observations and conclusions drawn from a social study made of a limited voluntary health programme undertaken by a sinall NGO in remote rural areas of Maharashtra (Sahyadri Range). This qualitative study is concerned with health as a social process. Health practices are examined as components of over-all socio-cultural dynamics and the foundations of a people's health movement sought within the context of a wider attempt of socio-political awakening and people's organisation.

SEVERAL voices raise to draw our attention on primary health issues as components of local socio-cultural dynamics. This perception prevails, for instances, as a conclusion of the assessment of the working of the Rural Health Scheme made by the Population Research Centre of the Institute of Economic Growth: "His (Community Health Volunteer, CHV) role as a public health worker is more social than medical. It would require of him to create health consciousness within the community and to prepare and organise the community effort to carry out all the necessary steps of improving sanitation within the settlement, cleansing up the surrounding areas and imparting health education to all its members. This work within the community is in fact the fundation upon which the whole health care delivery system must rest" (Bose A, 1983: 53-80). P B Desai concludes a general evaluation of the CHV Scheme in India with the following assessment: "The most crucial shortcomings of this kind of approach is the failure to upgrade the capabilities of individuals, families and communities to take upon themselves the responsibility of attaining and maintaining conditions for healthy living within their jurisdictions. In other words, the central issue of the promotion of self-care is left unresolved" (1983: 7). He then stresses the point that the definition of the objectives drawn in the Alma Ata Declaration (1978) to resolve this central issue is 'holistic' in nature, as their formulation insists on a full community participation and a spirit of self-reliance and self-determination (WHO-UNICEF, 1978: 3), and the "task of delivering health care must begin with this non-medical, social endeavour of achieving the necessary social transformation at the grassroot level."

If such is the case, once we have acknowledged and really perceived the social role of the CHV and measured the import of the 'holistic' perspective with which we should approach primary health issues, a corollary immediately follows, that health development schemes should seek the help and the critical insights of social scientists, anthropologists and psychologists. And this is all the more necessary when we are concerned with provision of primary health education and care based on efforts of self-reliance among the most underdeveloped sections of the rural population, whether these efforts be undertaken by government agencies or NGOs. If these efforts are to be "viable, dynamic and positive instruments of social progress" (P B Desai), then primary health schemes should first of all become the subject matter of social science investigation and critical analysis.

We present here below some/socio-psychological observations and conclusions drawn from a social science study of a limited voluntary health programme undertaken by a small NGO in remote rural areas of Maharashtra. The study is not directly concerned with such objectives as the raising of health status, the planning of alternative or integrated health services among deprived rural population and the related welfare, educational or developmental issues, in a more or less static way. Health is examined here as a social process from within a marginalised population, *viz.*, as a dimension of an overall dynamics of socio-cultural and socio-political awakening and people's organisation. The study is concerned with the conditions of a possibility of an effort of health by the people which actually cares for all, based on a critical appraisal by those concerned -i e those deprived of health care facilities—of the present health system and motivated by a will to try out self-reliant ways. This case study is partial contribution towards answering some of the following questions: the need for a strategy for enlisting community participation, the task of generating social health awareness, securing of the cooperation of women more than of men, generating appropriate health practices, organising collective health actions, etc. We may even piously wish or dream that "if we succeed in organising the community for giving to itself-a primary health care system of its own choice, it may become all the more practicable to carry forward this process of self-reliant development into all fields of social and economic progress" (Desai, 1983: 8). But the crucial question remains unanswered beyond the many evaluations of the shortcomings and failures of the CHV Scheme: what does it mean methodologically to "organise the community" for enabling it to wish, to conceive, to experiment, to chalk out and to give itself a health system appropriate to its concrete needs. What does this mean in terms of strategies of social action?

Primary health care as the subject of social science research should therefore be examined and evaluated by focusing on the dialectical relation obtaining between the level of health conciousness and the forms of collective organisation on health issues on the one hand, and on the other, the local socio-cultural, administrative and power structures, including those of the public health care system itself. If health status is rightly considered as an index of social development, health consciousness—as expressed in relevant renewed perceptions and representations and consequent forms of collective action—should be rightly considered as a component and an index of the socio-cultural and politcal awakening of a given population.

The health education and care programme carried out by the voluntary organisation Village Community Development Association (VCDA) in the remote hilly areas of the talukas of Mulshi and Velhe (Sahyadri Range) was considered as providing an adequate field of observation for such a scientific investigation by the Centre for Co-operative Research in Social Sciences, Pune which conducted the study with a grant from the ICSSR. The health programme under study is part

of a wider educational programme (called "School without Walls" and comprising mainly non-conventional programmes of cultural action for children and women directed towards children's and women's organised collective action) which is itself a part of a much wider programme of "conscientisation" and organisation of the deprived sections of the population of several rural talukas around Pune. The health programme is carried out in areas deprived of any medical services. Quite recently, the government made an effort to implement its CHV Scheme. A few private practitioners sometimes visit the area to give injections and to make money from the population. Medical officers of the PHC (Velhe and Paud) do rarely visit the area, except for enlisting "cases" (tubectomy operations). Sanitary conditions are particularly bad. Animals are kept inside the houses. Many villages are cut off by the monsoon rains. In the dry season, very few villages are directly connected by a bus to the taluka centres. The scarcity of land does not permit a sufficient and balanced diet. Traditional representations about diseases and their treatment are generally prevalent.

The main aim of the study was, to document a few possible ways of reciprocal determination, among marginalised rural population deprived of elementary health services, of three series of processes:

(1) The spread of medical knowledge and the consequent improvement of health conditions among marginalised rural population;

(2) The process of socio-cultural and socio-political awakening especially with reference to the representations about health and body and the present disfunctions of the health care system, with the consequent people's collective initiatives of organisational attempts to deal with health problems as well as other related issues;

(3) Autonomous and alternative efforts to promote attitudes and concrete attempts of collective self-help in respect of primary health education and care among the same weaker sections.

The assumption underlying and motivating the study was the conviction of the necessity of such a reciprocal determination: failing this, no health development scheme—be it of a minor scale—can significantly contribute to the radical changes needed in this field. The aim of the qualitative study was to describe and establish the nature, the extent and some forms of this mutual positive correlation.

A second aim was to draw observations and conclusions relating to and bearing upon concepts and procedures of development—and especially of health development— of processes of cultural, social and political awakening and organisation of the marginalised sections of rural population. These latter processes are obviously leading towards redefining the epistemology of development. The case study sheds some light on these theoretical issues with regard to underdeveloped rural masses the health needs of which have been consistently neglected.

Three aspects characterise the methodology: The analysis is jointly and cooperatively carried out at all stages, with those concerned and involved in the scheme, resorting to methods of collective self-analysis and research-action. Such a methodological approach is expected to promote a better critical consciousness and consequently to foster the process of autonomous self-determination as well as develop the theoretical ability of the group of health workers.

The validity of in-depth studies is not to be undermined with regard to the needs of those concerned with macro-planning and large scale policies. Macro-level planning cannot with impunity overlook the conclusions of in-depth analyses. Planning remains a futile exercise whenever it does not take into account the dynamics operating at the grass-root level.

The scheme under study not being a medical care scheme, sampling methods do not suit the objectives of the investigation. The changes occuring in health preceptions, practices and conditions are evaluated by several types of qualitative procedures. One of the most significant is the so-called "sociological intervention": The sociologist and his assistants intervene at the time of seminars and analytical exercises, in-depth interviews of individuals and groups of health workers on a specific theme; personal interviews of villagers; inquiries made by some trained health workers, personnel narratives; minutes and reports of usual meetings and free discussions among the health workers; and role-plays. No questionnaire nor schedules were used; only guide-lines were always carefully prepared for conducting discussions. The study was spread over two and a half years (1983-1986) as a sort of continued analytical effort following and accompanying the evolution of the action programme.

Awareness of Identity among Health Animators (HAs)

The most decisive step consists in generating a basically new approach through a sort of cultural labour prompting the volunteers to discover their identities as HAs in a way quite different from their own expectations obviously modelled after the social patterns and the collective representations shared by the population at large.

After two to three years of health training and practice, HAs unanimously acknowledge their complete unawareness at the beginning of what health might mean. The contrast between the perceptions acquired during many months of continuous training and involvement and the remaining memories of the initial understanding leads to an evaluation of what happened at the begining. First of all, the idea, let alone the wish, of any health activity being undertaken by the population itself, did not emerge of its own from the people concerned or involved as HAs or as beneficiaries. What then was the motivating factor prompting them to undertake health tasks? People from the lower sections volunteered to undertake a health activity on account of the moral authroity that their organisation Garib Dongari Sanghatna (GDS) had acquired and of the trust they had already put on the external social agents who floated the ideal (the main animators acting as catalysts of GDS). It is obvious that without the on-going organisational process such a prompt response, would have been impossible. Without such a collective social support with its components of moral authority and confidence, neither the idea of a health task would have been effectively welcomed by a deprived population nor any man, let alone a woman, from lower sections would have dared to volunteer.

Secondly, in the absence of an awareness of the urgency

of health issues, what representations defined and accompanied the idea of a health task? The possibility of some honorarium was a very strong constituent; the vague desire of some sort of 'employment' was also there; "to become a doctor!" was a widely shared expectation; "to distrubute medicines and pills, to give injections, or to become a dai": such was the most substantial content discretly related to health; some had really no idea of what could be the task expected from them; there was a strong apprehension, especially among illiterate women, about their ability to comprehend; some daring pushed ahead all of them and some liking too. When we compare these initial representations with those brought about after three years of experience, three main shifts appeared to occur in the preceptions. Firstly, from static notions of social status and prestige position associated with the health profession and the expectation of an employment, the approach evolved towards activist attitudes, became action-oriented and conceived in terms of actual achievement. The systemic outlook was altered into a dynamic attitude. Secondly, from self-preceptions in terms of ignorance, fear and inferiority feelings, there was a shift towards self-confidence, boldness. Their ability to assimilate knowledge enhanced the self-image. Inhibition gave way to self-assertion. Thirdly, from an individualistic outlook and wishes of private profit, there was a shift towards a social understanding.

The interest was hence motivated at the start by the hope of a small honorarium (discontinued later on), by the wish to be a 'doctor', by the desire to escape deceptive practices of the private doctors, by the pleasure of getting information "when we realised that we could understand it". The interest of those who had no specific liking for the topic was raised when they learnt something new and delivered a few pills. After two or three years, four main motivations are expressed as follows at the time of health seminars: Let us give information to the people. Let us sit together and educate people. Let us organise the people. Let us be self-reliant. Later new-comers, all women, all illiterate, who joined a scheme which they had observed, give the following reasons for taking up this responsibility: to get a new education and training; if they fall sick, to be able to do something by themselves; the good results of the medicines circulated by the HAs; no money to buy medicines from private doctors, but cheap pills available from the HAs, even on credit; doctors take a lot of money and do not treat unless paid beforehand; interest in this topic; if they now learn, their children can be taught... To the question that such interest may not be sufficiently strong when male pressure is raised against women taking the lead, the answer is that: "We have been selected by a group of people during a meeting. We have the support of people".

As a matter of fact, external support is not sufficient. The female new-comers maintain their involvement out of a strong internal conviction: "We have seen the earlier ones. They committed themselves to this work. They have not eloped or have been taken away by men! The provision of a health education scheme, to succeed or fail for many reasons absolutely alien in nature to the health issues tackled by the scheme. One of them has been suggested above concerning the social factors conditioning the desire for, the access to, the sharing and circulation of medical knowledge among rural lower sections. Secondly, a health scheme is bound in the first instance to be specifically 'recognised' or understood, from a socio-psychologically point of view, through the established patterns of representation concerning doctors, health and therapies. There may be therefore some naivety on the part of action groups to resort to health as an entry point if this means that health, *as such*, on account of its urgency, is expected to easily generate radical social insights. The prevalent unawareness about health as a personal as well as social issue and the deeply imbibed pre-critical and unconscious cognitive structures in this respect make health one of the most deceptive and difficult 'entry points' if one looks forward to it as a lever for radicalising rural populations.

In such circumstances, a main concern of a health scheme consists in defining the role of the HA. This had been and remains one of the main themes of the regular and continuous training programmes of HAs in the VCDA scheme. As a result of discussions among all those concerned by the scheme, doctor, activists and mainly HAs, the following write up was prepared as a basic chart of the HA's role, as an operational model.

Our Health Work: Why and How?

—We and our children fall sick every now and then.
—When we fall sick, we never get medicines soon, nor do we get good medicines.

1. Why do we fall sick so often?

The reasons are that:

1 We do not get enough to eat nor is the food good. Then, as a result, we become weak.

2 We do not get enough of water, nor clean and pure water. As a result in the dry season, scabies increase and in the rainy season, diarrhoeas increase.

3 Our living quarters are small and not clean. We keep our cattle inside our houses.

4 During the rainy season, we work exposed to cold winds and we have not enough clothes to put on.

5 Our work is dangerous, instruments are primitive and insufficient. As a result, accidents occur; we are overworked; we quickly tire and we do not pay attention to our health condtion.

6 Many times, we are overwhelmed by difficulties: as a consequence, our mind does not remain sane. The pressure of the male domination upon women is epecially heavy.

7 The government has no money the government people do not give us information. But it takes great care of a handful of privileged people.

8 Bad habits: alcoholism, tobacco etc.

9 Frequent pregnancies.

10 No vaccination.

If we could get rid of these difficulties, then we would not fall sick so often. But, today, these difficulties cannot be removed. As a consequence, the frequency of diseases cannot immediately come down.

2. Why do we not get proper medicines when we fall sick?

1 There are no doctors in our area; the 'medicine men' are many, they deceive us.

2 The doctors who come into our area, behave like 'medicine men'; for instance, for no reason, they put on a very serious face, use difficult words which they pronounce like mantras and create an atmosphere of mystery. Although there is no need, they give injections and prescribe useless medicines. The medical profession is being converted in to a business like any other business. It is a profession consisting of selling medicines. The more money you give, the better treatment you will receive. A doctor is no different from an agent of a drug company. Doctors behave like dealers: they store the knowledge as shopkeepers

store the commodities and make us more expensive. There is a competition for consumers, (as among dealers) to obtain more consumers and gain more money.
Where is 'humanity'?

3 *What is clear about today's doctors*?

Doctors do just sell treatments. Moreover, on account of the doctors' behaviour, some ideas are firmly embedded in our minds, for example: money is everything; the knowledge of the doctor is very complicated. We shall never be able to understand anything of it; Our health depends upon doctors; Doctors' work is intellectual and of a much higher grade than our labour in the fields.

4 *What is the use of our health work*?

We cannot bring about important changes in our condition, so exposed to diseases with our health activities. The reasons are as follows: Our health condition depends much more on many other factors of our whole environment than on medical factors; the knowledge that we can get about health as health animators is limited. The pills and medicines that we give are simple and not many.
What then is the use of our health work?

We want to bring, at this primary level, a new concrete way of undertaking health work. An example will make it clear. What is the difference in the health work, between the method that is usually followed today, and our method? This will be clearly understood from the following example.

Let us suppose that a lady health animator from our group attends a child suffering from summer diarrhoea, what will she be able to achieve?

Change in the body: We shall be able to win over the disease which affects the body of the child.

Change at the economic level: A good treatment can be given at a very small cost. We can demonstrate it.

At the level of health consciousness: The health animator can change the ideas of the people. What will she/he tell them?

1 Why diarrhoea occurs, what is the treatment, and if it can be prevented. This *techincal* knowledge about diarrhoea will be given.

2 Why diarrhoea occurs much more often among the poor and in the villages. How the proper preventive treatment of diarrhoea depends upon a proper water supply. Why today's doctors and drug companies take pleasure in treating diarrhoea with very expensive medicines. This is *social* knowledge that the health animator is giving.

3 How there is no need for a doctor to treat simple and minor ailments and what is the opposition of the private doctors to this statement:

4 How we can deliver people from the exploitation of private doctors.

5 How in our health work there is no domination of the doctor. We don't give him undue importance.

6 Why, despite so many promises and announcements on the part of the government, this latter cannot seriously undertake genuine health work of that sort.

7 This health work is going on in a nice way, because we are awakened, organised. Our health work will progress to the extent our awakening and our organisation will grow.

8 Still, as long as food, water, shelter, education, cloth, etc. are not available, we shall not stop falling sick time and again.

This definition of the HA's role tries to give a concrete design to a specific concept of health work among and by marginalised rural population. This concept ought to be made explicit. The health work in such a context is conceived as aiming 1) at forging a collective health consciousness based on a critical perception of the relation obtaining between people of lower social strata and their actual physical environment and specific social constraints; 2) at making experimental attempts which constitute *per se* a practical critique of the prevailing methods and structures of the health care system; 3) at projecting in an embryonic form a sort of miniature model revealing the feasibility conditions of alternative values, norms, organisational patterns and practices of medical care; 4) at raising the level of socio-political awareness of the whole population in this respect through health education, self-reliant practices and collective health action as levers, thus contributing, in its own way, to strengthen the overall health movement; 5) at resorting to operational concepts and criteria of evaluation of a social and cultural nature instead of giving priority to and taking only as operative norms the quantitative medical improvements in the health status of a given population, objective that at any rate the NGOs are unable to achieve—particularly the small ones—on a suficiently large scale.

Selection of HAs

A general model remains futile without its operational concepts. The selection of HAs is one of them. With rare exceptions of selection being made by the external main animators of GDS, the HAs of VCDA were regularly selected by local groups of GDS during their meetings (with the 'permission' of the husband or parents for the female HAs). A few women were selected at the start on account of their activity as teachers in a voluntary nursery school of GDS. Sometimes special meetings were called to deal with this issue and several meetings were necessary to make a selection. In the course of time, when new volunteers joined, they were all co-opted by the local groups of GDS. The selection was not a sort of casual appointment but the result of group discussion and exchanges among the assembled people.

When the health workers look back and consider the procedures of their initial selection, they come to the following conclusions.

At the beginning, without any experience of procedures of collective determination, "We had no idea of the method followed, and we did not understand its importance", confess all of them. The cooptation process from within a group for a task to be carried out in the name of a group or mass organisation was a procedure absolutely unknown. They did not realise the meaning of this process. Three years later in 1984, all of them except one woman who dropped out express the firm conviction that it is proper to make the selection from within a group of assembled people taking a common decision.

The reason are the following:

The selection should be made according to the ideas that the people have about it. Their ideas should be taken into consideration; A private selection is a mistake; when there is a decision of a group, the selected person feels responsible to the group and the group responsible to the individual. This is bound to generate a reciprocal questioning of both of them. And such habit should exist; in the case of a private selection, people will not feel like cooperating with the one selected, nor give him/her their support. When a meeting is called, everbody will find an excuse for remaining absent.

The model to be followed in the future is as follows: "In a new village or a hamlet, we shall hold a meeting on health and give some information about it. Then, we should tell the people: "To tackle your problems in this respect you should select your own man/woman for that".

Why should this procedure be followed? This process induces the awareness of a reciprocal responsibility; It avoids the danger of pressures of vested interest and the criticism

or the mockery against the one who is chosen; this process assures cooperation, support and participation; there cannot be any real work by an individual alone.

What do these procedures aim at?

These procedures impart information to the people (doctors never impart information about health and thrive upon the ignorance in which they keep the patients; people get a chance to assemble, exchange and make an effort to solve their own difficulties; the objective is to become self-reliant, "to stand on our own feet"; this helps to strengthen and spread the organisation GDS; the intention is to put an end to the deceptive practices of doctors and of the local miscreants who act hand in hand with the doctors; this brings a health knowledge to the village level; this develops a health consciousness; this gives the women an opportunity of having some role and stand in society; this offers a chance to everybody of speaking out.

Let us draw one clear operational conclusion from these data: the perception of health as a collective issue that confronts the whole community is generated here through a social process of cooperation, by the group, of a volunteer. It is not the perceptions of health as a community problem which comes first and leads to a renewed social practice. It is a renewed social practice which helps developing a new approach towards health, as it could have been with any other issue. There cannot be any real consciousness of collective responsibility unless it takes the form of an appropriate pattern of social relation or a cooperative social formation.

How Villagers Perceive Health Animator

Another determining factor, mainly at the initial stage, is the perception of the beneficiaries and their expectations. Four types of reaction characterise these attitudes, in the perception of HAs, which symbolise four cognitive structures through which villagers spontaneously approach this health experiment.

1 "The village has got a big 'doctorin'!" This derogatory remark related to the women health animators. It points out firstly, that the health worker is considered as a 'doctor'! And secondly, that the prestige and honour implied in this image serve conversely, to ridicule people—, especially the women, or the illiterate workers—volunteering for the scheme being projected so suddenly to such a high position! People did not react mainly in terms of the concrete advantages of the scheme, but with regard to the social image of the doctor and to the concept of health as a doctor's commodity both of them turned into arguments meant to throw discredit upon ignorant people pretending to be more clever than they were to involve themselves in these tasks!

2 This work was looked at as sort of employment for the volunteers. As the possibility of an initial honorarium of Rs 50 was known, the task was considered as resorted to by the volunteers under the motivation of this material incentive. The women would then be able to bring their contribution to the maintainance of their husband and children, as they are the *dhana* of the house, its source of wealth, its *lakshmi*.

3 The third understanding is that this task was just a chance offered to the women's eagerness for being 'set free', abandoning the household duties under the pretext of attending training course in health or undertaking health tasks. Only women upon whom husbands and family could not keep a firm control were so allured. Their volunteering showed their lack of social restraint and fear. "Men and women sit together!" "Women just like to follow their whims!" It was almost out of lust that they had volunteered!

4 The fourth image was that through this scheme, a dispensary would be set up, medicines and pills would be made available. In this respect, as people were saying that "an educated man is needed to give medicines", women had doubts about their ability to prescribe medicines, as they were conscious of their ignorance and absence of education.

These data show that two main and anti-thetic socio-cultural cognitive structures gave readymade referential yardsticks to understand and evaluate the event. The first reference relates to the women's roles and image: a woman should never go outside of the home where she is confined to subordinate and non-prestigious tasks. The second reference relates to the prestigious function and role of a doctor as a supplier of medicines and health services. As the health animators were considered as doctors, these two referential factors clashed and as a consequence, the women were derided, for assuming a role of high rank and superior knowledge!

The basic and spontaneous point of view was not a technical or practical approach, but a social reading; and this reading was no conceptual insight nor analytical apprehension. It was a judgement. The cognitive structures worked, as a judicial recognition, not as an act of cognition. If this is likely to be the case in any transfer, its sucess depends upon the will and the ability to develop a conceptual understanding and to refrain from any hasty and spontaneous interpretation by referring to the in-built structures of recognition which can lead nowhere but to a judgement which is only a reduction to the same. This seals the impossibility of any progress.

This is obvious in our case. If the judicial recognition turns into a judgement against illiterate women and ignorant men taking up the role of a 'doctor', as this is simply a contradiction, still a women may be considered as positively motivated to take up this task for the reason that she wants to bring home some income, for the benefit of her husband and her children, as the source of wealth of the house (*dhana*). This is also a very clear cognitive structure regarding the role of a woman. The understanding of her desire to become a health animator is therefore either, negatively, a will to escape her duties at home and the control of her husband, or positively a justifiable intention of bringing home (to her owner, for the benefit of her house) some wealth, as she is a *lakshmi*.

One operational conclusion can be drawn from this. If a health scheme aims at engineering a process of social change, *viz*, a transformation in the patterns of relationship and values, it should and it could boldly create a situation which will directly challenge the cognitive structures mentioned. For that purpose a health scheme should not start with doctors and medical services run by doctors: health should not firstly be looked at as a technical task. Secondly, the leading role in the implementation of the health activities should be given to those women whose health is the most affected by the present health system. These activities should mainly and

basically consist in imparting elementary health education to women and more technical knowledge should come as a secondary dimension. A health animation activity undertaken by women of the lower social sections, taking the initiative of visiting and educating village population is likely to prove one of the most effective levers of social change in the rural areas, as this practice breaks off strongly built-in cognitive structures which have a definitive repressive role and are very significantly responsible for the perpetuation of a particularly degraded health status among women: the partiarchal patterns of relationship and values, and the undue prestigious status of the (male) doctors as the only ones capable of dealing with health and medicines.

Socio-cultural Pressures Against Health Animation

Between 1981 and 1984, out of an initial group of 30 HAs (14 men, 16 women), 17 dropped out (6 men, 11 women), while 18 new comers volunteered (1 man, 17 women). Those who remained involved had collectively analysed the reasons why so many dropped out—26 answers could be specifically given for the defection of 17 HAs. These answers are classified into 9 categories as follows:

1:3 male and 3 female HAs abandoned as they did not obtain the expected financial profit. The honorarium was considered too meagre; even this was discontinued and substituted by small help given on the basis of the days spent on house visits and meetings held, etc. Motivations were put to the test.

2:5 female HAs left under the social repression obtaining against women's assertiveness.

3:2 men and 1 women left for reasons of economic pressure and poverty.

4:3 men left out of diffidence about their own ability and social inhibition.

5:1 man and 1 woman were frustrated in their expectation of a higher status sought through this activity.

6:3 left on account of personal reprehensible behaviour.

7:2 women left because they could not cope up with the task.

8:1 woman could not bear the clash between the knowledge received and her traditional beliefs.

9:1 woman left out of lack of proper motivation.

These reasons are indicative of the difficulties and of the nature of the psycho-social determination of those who maintain their involvement with a renewed conciousness. It is obvious that almost all HAs joined the scheme with the thought that they would get a sort of paid employment thus improving their low social status. As a matter of fact, if all of them could secure through this programme somehow better social position, a qualified social recognition and some social respect—and self-respect—, paradoxically would remain more involved in the scheme than those who were usually deprived of such social respect, often denied the right to talk in the open and assert themselves, while those who already enjoyed some social prestige left an activity which appeared to them as not enhancing their dominant social position, or even countering it.

One should be fully aware of the basic difficulties which any attempt of popular health movement among underdeveloped rural population has to overcome before becoming a strength. If we are convined that there is no alternative to such a movement for bringing about significant structural changes in the health care system, we ought to be still more aware of the socio-cultural challenges this implies in the first instance. Two testimonies may convey the magnitude of the challenge. The first one is the testimony of a woman HA whose potentialities as organiser are totally repressed by her husband.

> I was conducting a balwadi under the sponsorship of VCDA since one year. On this account, I was, therefore, going from house to house to fetch the children. I found many people sick during the monsoon. Althogh they were suffering from simple ailments they were going to the doctors and taking injections. Doctors were coming from outside and knew how to take advantage of this situation; they collected and lot of money from the population for this. I thought: let us do something about these minor ailments, through health education. Then I volunteered to become a health animator
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> Private doctors do not give information on about diseases, they just give medicines. They come to our villages only to raise money from the population. I started telling people thus and trying to convince them. Six women came together and, through the Association, we requested Dr. Phadke to come and impart health education. The doctor used to come twice a month in the beginning and gave us information about the children's and women's health. We were getting Rs 50 as honorarium.
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> In the beginning, women called me names. But, later on, opposition become less. People trusted the information that we were giving them and followed our prescriptions. Similarly, they could observe by themselves how the government doctors functioned.
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> When I had to go and attend a meeting (training camp) and spend one night outside, my husband would object. "Who will look after our daughter who has reached the age of marriage? The younger children are going to school: who would look after them?"
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> I have now after three year accepted the job of becaning health worker of the government so that the health education that I received during these years is not wasted. They organise only one meeting per month. When VCDA stopped giving the Rs 50 honorarium for the health work, my husband became completely opposed to my participation in these activities. This is the reason I accepted government work. And I continued this health activity with the same motivations that I got from VCDA training
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> With the government we do not have the freedom to function as we think right; we have to do the work only in a very particular way. Although I have accepted the work of the government I like to attend the meetings and the camps for women of the VCDA. My experience with the government is very different. People get absolutely no health education from them. Only one thing matters: to distribute pills, and to keep monthly records. This is what the health officers consider good and important health work.
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> Still, one should be able to study as we were doing which questions the women should think over and take up. For instance, women started a movement for clean drinking water, as a result of that education.

The second testimony is the account of the difficulties faced at the start by the group of HAs from Panshet whose level of deprivation makes difficulties more acute. 1) The first crucial question was a doubt about one's own ability to follow the teaching of the doctor. "We shall not be able to learn and study." We were not educated: "We did not know anything about health, dispensary, medicines..." There was no conviction of one's ability to repeat correctly the lessons of the doctor. None of the HAs had ever previously attended any meeting or expressed himself in a group. "For three months I just kept silent in the meetings!"

"We did not realise that we were human beings, as much as any one else. We did not know anything about government officers... We were only busy with our house, fields

and cattle. Where is the government? How to go and meet them? We did not have any idea about it. We had no idea that we had also rights. HAs were requested to commit themselves to assume a social role when they had hardly a clear consciousness of their own identity of social beings.

No wonder this generates a strong feeling of self-diffidence. "I am afraid that people will not come and attend our meetings, nor listen to us." Still, "I am convinced that going out to attend meetings, I shall learn something. How long should we continue to submit and surrender to the leaders?"

Going alone from house to house to give information about health was seen as a great difficulty by some. Some felt it was easier to impart health education in a meeting, with a group, when people are assembled together, because there can be exchanges and discussions, and those who understand can help others to learn.

There was the reluctance to listen to women: "They cannot even behave themselves in the society and look after themselves! How should they come and teach us! Men teased the female HAs, especially after having had their drink, "We shall, all of us, now, become doctors!" "Why make everyone a doctor also like you!"

The pressure of the authority of elders especially upon women makes these latter still more shy and inhibited to undertake something new and unusual. Men complain against women that they attend meetings and report there about the drunkards of the village and all their stupid and bad behaviour, and first of all about their insults against the HAs. The pressure of the more influential male leaders was and remains a serious difficulty for the women who volunteer or would like to volunteer.

The countter propaganda objected that outsiders had come and trained HAs who immediately listen to them and follow them, falling a prey to them. "We should only look after our fields, eat peacefully our pancakes of millet. Women should just go to the fields or to the forest for their tasks, earn a few rupees for the house; this is better than attending meeting and roaming about, everywhere, doing nothing, whiling the time in useless activities which do not yield any income. What will you get (money) from this work? What will these people give you?" Aren't they already 'social workers' in our village? (leaders who are supposed to care for the welfare of the community). Local leaders do often call women names because they follow people from outside instead of going to work to bring home a few rupees, listening only to them and keeping a submissive attitude towards them.

Another type of counter-propaganda says: "What did you obtain and what did you give us after three years?" The understanding behind the objection is that the organisation should immediately bring in some material improvements to show its credentials, to the population, free of charge and without any effort on their part. The reason motivating the objection is also that the organisation "of the poor of the mountain" is approaching directly the administration and demanding the implementation of the government schemes for the benefits of the needy, independently of the local leaders who have a vested interest in the poor depending upon them.

HAs insist upon the reactions of the local leaders who see in the HAs and in the organisation a direct challenge to their authority. "They are not Dhanagars (in one area, many HAs were from this caste), they are foreigners: they come to collect girls and send them abroad where there is a want of girls. One should not vote for them. If they can get four votes, we can still have ten of them... Listen to the head-men of the village. This is not proper. Our women should not talk with men from outside!" "The HAs get plenty of money: this is the reason why they roam about". "They get medicines free of charge and take money from us!" As expected, the same leaders make capital of caste feelings to object to the fact that HAs of different castes assemble together, and do not listen to the caste elders.

A few drunkards come to disturb the meetings, teasing, shouting, raising their voices with the result that people cannot express freely their difficulties, despite their genuine desire to do so. In the beginning we did not know how to handle these trouble makers".

Dynamics of Self-Assertion

The interviews of the new-comers—all women who happen to join the existing groups of HAs reveal the following processes:

1)Personal acquaintanees and a prolonged time of "wait and see" attitude preceded any decision. The example and the concrete testimony of some one else are necessary as a preliminary step.

2) A clear invitation to join was made, not to elicit a purely individual move but a commitment to participate in a collective effort.

3) The initial step were met with laughter, counter-propaganda, lack of appreciation on the part of the population.

4) The decision to join was personal and motivated by a will to achieve something and dedicate oneself to a task whose relevance was understood.

5) This understanding increaseed the strength of the personal motivation and developed progressively a wider and realistic social consciousness.

6) The motivation takes momentum, against objections, out of one's own effective commitment to tasks which are experienced as beneficial. Action generates self-assertion.

7) The group proves to be the best support for the personal efforts and commitment: A small group of like-minded people is the essential structural factor.

8) The elements of general personality development (self assertion, ability to express oneself and talk in front of a group, capability to understand a knowledge considered as difficult, etc,...) work as an encouragement.

9) When money is seen as the main motivating factor, no effective health animation can be sustained. Monetary compensation may not go against a real interest in health and health education, but once such an interest is maintained by monetary incentive only, we cannot expect it to develop into a social concern and commitment for health animation and community organisation on health issues.

Antagonistic Perceptions and Conflicting Practices

HAs wished to co-operate with the government health services rather than compete with them. A voluntary scheme is no substitute to public health sevices. The several attempts made by VCDA to operate jointly with the government services met with only a little success. As our concern here is with the local socio-cultural processes, we shall consider only the psycho-sociological dynamics obtaining between HAs and PHC personnel rather than the possible forms of co-operation. Let us give due attention to the perceptions of HAs concerning the behaviour and the attitudes of the government personnel, as articulated in health seminars by HAs.

1. Government doctors are to be seen at the taluka centre and in the villages only in the specific plaees where commodities and facilities are available. Government doctors will always be seen in the company of a limited, restricted and specific category of people: with the sarpanch, the patil, the teachers, and sometimes the talathi and the kotwal. Their social place is with the leaders, the rich, the notables, "with those who talk". They will behave with them with civility. They will be attentive and considerate with the established notables and leaders. They will be seen in their home places. They will accomodate them immediately when these latter come to meet tham and they will attend to them without delay, and show them small courtseys. The government accordingly behave also as local leaders.

2. The attitudes which motivate their way of talking and their behaviour lead them to make a show of their superiority and importance. Their arrogance is resented by the people; they do not let others talk and express themselves. They speak fast and loudly over the voice of others as to frighten the people. Their manners show that others are not worth attention, being all ignorant people. "They consider the poor as stupid and childish". With the poor, they are, insulting and offending their feelings; they do not give answer if poor people ask questions.

3. A few features characterise their language and ways of addressing the common people. They often use words (some special or English words) that people cannot understand, with the purpose of not being understood. This language shows their superiority and "if we ask, we are left with the following answer: "You are ignorant! What can you understand! Don't you have confidence in me?... I told you once, I shall not repeat... and so on they simply do not care for whether we understand or not: nor why we cannot understand.

A second feature consists in not giving information about any disease: they would just hand over medicines. They never impart nor show any readiness to impart knowledge about health and disease. Mainly concerned with cases of family planning, they do not give due attention to the sick. Expectations regarding money are another main feature of their behaviour. The question may often be raised, from the start. If there is no money, the patient may be sent back or adviced to come later, or another day... Money and injections are two main aspects of the doctors' behaviour.

The doctors would also easily entrench themselves behind the laws and rules of the government. They do not appear as responsible towards the population; they are not answerable to the people.

These frustrations and clashes with regard to the medical practices of the government personnel lead to conclusions already often drawn but naturally stressed by HAs in their analysis.

1) The doctor's services are alien to the needs themselves. "Our main expectations is that the government doctors reach us, the poor, who need them. They don't. They never come to the houses of the rural poor". "We don't know what the word nurse mean. If it a thing to be eaten, or an animal?" "We asked the PHC officer to send us a nurse: he just promises but nobody has ever come". Once, at Sakhari, thanks to the firm insistance of HAs, doctors came and HAs helped them to vaccinate the children. HAs motivated and assembled the people. Then the doctors promised to come to another village, Dudhavan, under the pressure of the HAs. But they never did. The false promises of doctors to the HAs are a permanent matter of tension, diffidence and disgust about the government health care system, and its personnel. Another area of tension is the insistance of the government personnel that HAs should bring to them women for being sterilised. The government CHV are supposed to do it, why should the HAs not give priority to this too? HAs answer:

Chart

We HAs	The Government Health Personnel
— We go and visit the poor at home	— They enter only in the house of important people
— We arrange for few cheap and good medicines being supplied to people	— They give importance to medicines
— We give priority to the people	— They give importance to money
—We educate people	— They just distribute medicines
— We look at the patient and give the appropriate medicine	— They don't give all the medicines required to cure the patient
— We think of the whole environment and situation	— They don't bother for the whole environment
— We select HAs taking into account the ideas of the people	— They make private choices
— We organise people for collecting action on health problem	— They don't try to assemble the people
— We promote health consciousness	- They don't bother about health awareness
— Health is a public issue and a political question	— Health is a private problem to be solved by doctors

"You don't give any protection to our childre. Four live and four die. First come and attend to our children, save them and we shall bring you plenty of cases. Otherwise, why should we undergo operations?"

2) The health system is not directed towards the people. Those HAs who were absorbed in the government scheme: "During the training meeting organised by the government every month, doctors and their CHV pretend that doctors are ready to go anywhere. If HAs protest that they have never seen them, that doctors make promises which they never keep... Government doctors and their CHVs look down upon us, repress us as women who talk too much and had better shut up in front of them! When we asked the doctors: "Why do you take money from people, regularly, although you are paid by the government?", doctors reply angrily: "Why don't you take money yourself also from the people?" Doctors insisted and added, addressing a *dai* "before doing any delivery, you must first ask for money from the people". Doctors advise their CHV: "You had better stay at home. Do not visit houses." We, HAs, tell the people: "Go and see the CHV of the government." People reply: "They do nothing. They do not inform us. They do not come and attend us. They tell us nothing, they just give a pill". We tell people: "It is your right to go and meet them and avail from them their services. It is a government service." People reply: "We prefer to come and see you. No improvement is gained from them. They are of no use". Doctors tell us: "You want conflict... You organise demonstrations... We shall also organise such demonstrations... You cannot even sign your name and you immediately strongly reply and object to what we say!"

3) The selection of CHV serves vested interests. In Panshet area, when the CHV scheme started, HAs insisted that women should also be taken, and not only men, and even illiterate women. Some were appointed but no further co-operation could materialise in other places, despite the readiness of the HAs to help goverment officers in the selection and implementation of the scheme.

Conclusion

Strategies of "Health For All" will prove effective when we succeed in translating them into alternative social practices of "Health by the People". The chart on p 50 is an attempt made by HAs of VCDA, on the basis of their experience, to define antithetically, these alternative health practices required as a foundation of a people's health movement among rural marginalised population.

In view of the magnitude of countervailing forces, there is little likelihood of such alternative health practices gaining *on their own* a significantly large and lasting momentum unless (1) they are locally part and parcel of an appropriate wider peasant movement putting out similar roots, (2) externally backed by and related to, other branches and forces of the national health movement and (3) internally born by a permanent self-learning exercise addressing the anthropological, socio-cultural and ideological dimensions of the primary health issues. For lack of space, we did not deal here with these pedagogical, anthropological and ideological components as essential to any effort towards health by the people.

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