Transformation in health: transformation in development dilemma in rural health in a village in Dindoi, Madhya Pradesh

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Introduction

When India got independence in 1947 the objective of its developmental strategy was to establish a socialistic pattern of society through economic growth with self-reliance, social justice and poverty alleviation. These goals were to be realised within a democratic political framework using the mechanism of mixed economy. Thus over the years the plans focussed on raising domestic savings for growth; industrialisation with the objective of high growth rate, national self reliance, reduction of foreign dominance, building up of indigenous capacity, encouraging small scale industries, balanced regional development and reduction of income inequalities; technological advancement and social modernization. Not denying the fact that there have been increased developmental efforts to fulfil its commitments and goals that were envisioned at the time of independence of a secular and egalitarian society free from all kinds of social, cultural, political, economic domination, it still lags behind. Vast majority of the Indian population still suffer from material and social disadvantage such as health and education.

This has been very much the case with the village Khannat- the site of my action research. But what this action research/transformation is? Coming from a conventional academic program in history and sociology, it was very difficult for me to understand question and aspect of transformation or action in what looked to be a research based MPhil program. The idea of research and transformation/action put together was unusual to a usual academic eye/gaze. However, the very few first ideas around transformative social action that I could gather through my classes and that were circulating around were as to how, I along with the community would have to conduct action research on a topic and if possible do something visible; this was indeed a significant shift; I thought research was about knowing something; how could research be about doing something; and how could one research further on the very process of doing. I then began to see myself as an agent of change and thought that my intervention would bring about change in the village. With such, what could be called naive ideas I entered my field.

The question of health in the rural: histories, institutions, schemes, practices and experience

Located in the Dindori district of Madhya Pradesh, India, Khannat is majorly inhabited by the Gond tribe. Life here is tied to the agricultural cycle. Looking at the developmental map of the village, there are various stakeholders involved in it such as the state that works through its various institutions, the panchayat, bank and block office, the Non-Governmental Organisations (NGOs) and the villagers themselves. The work carried out through various program and policies is mostly economic and infrastructural in nature such as providing livelihood options, building schools, primary healthcare facilities, digging wells, and constructing roads or micro-financing through the Self-Help Groups (SHGs), and the expected outcome of these is reflected in terms of statistical data. There is no denying these are important issues from the point of the needs of the village and the villagers but they in many ways are from the above and neglect the real needs of the people which in

Khannath is jealousy-jadoo tona-health according to the villagers themselves. As part of my first village immersion which included village stay and study, I stayed at Durga didi's house who works as a Community Resource Person (CRP) with PRADAN. First days of my stay were filled with various emotions and feelings while I was trying to locate myself in that rural space and also relate to it. In the process of staying, settling down and establishing a relationship with the village, there was also a constant thought in the mind that I have to do action research for which I needed to identify a wrong. This led me to ask didi's and bhaiya's as to what was the problem of the village which affected them the most and for which they would like to do something about. The unanimous response that came forth was surprising for me. According the villagers, it was irshiya (jealousy) that affected them the most. It was out of jealousy that people would do jadoo tona (black magic) on others that had an effect on their health.

They attribute the cause of any illness to jadoo-tona whether it is to humans, animals or even to their fields. Thus, health being affected by Jadoo tona becomes the main cause of concern for the villagers. They believed that it is good health (body free of any kind of ailment or disease) that would enable them to work hard and earn their living. According to the villagers, the people in the village are jealous of each other's good. Out of this jealousy, they do Jadoo tona over the other affecting the health in a way that would be a hindrance in their work and thus would have an effect on their growth and wellbeing.

It was only with time that the ideas of action research/transformation started to gain clarity. Though a gradual process, I realised that as action research in development practice is a research with communities or groups and not research on them, the research question or the issue to be researched had to be a community question and not merely my question. According to Anup Dhar, 'action research in development practice engages with the life of the other as one tries to figure out what is affecting the life of the other. It does not just want to know about the other, but know with the other, and put to use that knowledge to action and collaboratively work towards transforming the life of the other'. The community or the group has the ownership over the research being conducted and are involved in it throughout the research and if they wish to build on the research, then a frame of action or transformation is designed. In this process, I, the researcher is a catalyst and co-researcher with the community. Initially when I entered the village and even before going to the immersion, I always wanted to do something about the education system. However, in the course of my immersion it was jealousy-jadoo tona-health that affected me as a researcher as well as the community.

In my consequent immersions, I started to delve deeper into this issue by exploring the various facets of it. As a researcher/practitioner, it was important for me to understand community's notion of health The responses that came forth reiterated that people's lives in the village are intimately tied to their work and especially agriculture and so their concept of health is also tied with it. Being healthy for them is to be free from any kind of illness so that they are able to work and earn a living for their family which would lead to happiness. What was worth pondering was whether swaastha (health) or swastha (being healthy) are modern concepts as we understand it?

People in Khannath suffer from vast range of illnesses ranging from stomach ache to malaria to menstrual problems, problems during pregnancy to cancer. In order to cure these diseases there are three systems that exist parallel to each other. First, is the guniya or the panda (traditional healers) that does jhad phoonk to

shun away the evil spirits as they believe that the patient is affected because of spells, curses or hexes done by a tona. Secondly, the vaid gives jadi booti or the local plants, shrubs and barks having medicinal value to the patients. Third, the modern medicine practiced by the government hospitals, health workers, private doctors and jhola chhaap or Bengali doctors. People believe that all the three are equally effective.

With health and illness being crucial issue for the villagers, other associated issues are- Monetary due to high treatment costs for which they take loans, transportation, lack of information, corrupt service providers and so on and so forth. All these aspects of health intertwine and intermingle with each other and in some way are also dependent on each other. In the backdrop of the instances from the village questions of the balance between preventive medicine and curative medicine, questions of the balance between access and equality, questions of the balance between modern medicine and tradition/faith based practices continue to haunt the developmental questions or developmental practice in these villages.

Tracing developmental praxis: from growth-centric models to capabilities-functionings

The history of the development program have indicated the different strategies that have been tried with respect to healthcare have failed miserably. Public health in India has been reduced to a series of single axis vertically designed immunisation and disease eradication program in which the sick have no place (Zachariah, Srivatsan and Tharu, 2010). The poor health indicators reflect an inevitable state of disease among the poor which often are the result of broad plan priorities and indeed the development itself which has followed an economic growth centred approach in post-independent India. The limited efforts that have been made by both the government as well as the NGOs, has been on service delivery, primary health care and on the modern, scientific systems of health care and negating the traditional practices of health care. These programs have been target driven, infrastructural and demographic in nature and have not brought about any structural change, but have only been efforts at excruciating crises situations that only help postpone the crises. Government has taken measures to increase community participation in villages through Village Health and Sanitation Committee (VHSC). However, these ideas are far from reality. People in Khannat did not even know about it. The mere formation of a group or committee does not communitise it or make it a bottom up approach. The fact also remains that human existence is largely a contextualised one and it is often in the context of people lives that lay both the roots of their ill health and their wellbeing and thus the need is for a context specific notion of the health system.

In a scenario where development is economic growth induced with a limited focus on health, where even the focus of the National Health Policy (2015) is on economic growth to achieve health outcomes in order to improve productivity and equity; where there is a highly commercialised healthcare system; where even the non-governmental and non-profit organisations work towards maintaining status quo rather than bringing in change; where the country like India still lags behind in all health parameters; and where the concept of health is full of complexities, in such a situation the need of the hour is to the turn the wheel of development in the direction in which health with all its complexities becomes a developmental question right at the village level and not merely in terms of plans and policies, thus creating a space where people have the freedom to exercise their choice and decide freely between their health choices and create their own health related future.

Amartya Sen in *Development as Freedom* has argued that commodities are necessary but insufficient either for positive freedom or for human flourishing. Thus, the task of development then would be to remove various types of unfreedom such as famines, little access to health care, to sanitary arrangements or to clean water and spend their lives fighting unnecessary morbidity, that leave people with little choice and little opportunity of exercising their reasoned agency, and therefore expanding the real freedom that people enjoy (Sen, 2000). According to Sen, development as freedom involves both the processes that allow freedom of actions and decisions and actual opportunities that people have, given their personal and social circumstances. This requires expansion of the capabilities of persons to lead the kind of lives they value and have the reason to value. This kind of freedom for people to make choices has largely been missing from the Indian scenario and in the development discourse at large which has followed a top down approach.

In a scenario where livelihood, employment and other monetary benefits have become a part of development thinking and action, in such a situation raising the question of health with all its complexities becomes a challenge. Issues of health and healthcare must be brought closer to democratic politics right at the village level and make its place in public reasoning so that transformation in health policies can be brought about through informed reasoning. In such a crisis situation with respect to health, there is an urgent need to expand collective action in public health (Sen and Dreze, 2013). Thus in Sen's framework the villagers would enjoy greater freedom if they were capable of choosing a greater range of different ways of living that they value.

Engendering transformation from below

Given all its complexities, how would transformation be conceptualised, bringing together the political, social and the self was something I constantly asked myself. How would the questions of balance between preventive medicine and curative medicine, between access and equality, and between modern medicinal practices and traditional healing be addressed through this transformation? Thus in order to address these questions, I tried to organise meetings where didis could discuss these issues if nothing else.

In this endeavour, I engaged myself with the women of the village who are part of the twelve SHGs in the village that were based on saving and credit. Thus to bring these women to a platform to discuss the issue of health rather than livelihood was a difficult task. I started engaging with the Mahila Gram Sabha or the Village Level Community that comprises of women from all the SHGs and is held once in month. The initial meetings were associated with identifying the issues revolving around the health, the healthcare system and its importance. There were varied responses. For many these discussions were a matter of jokes as they would laugh it off when asked if health issues were so much a part of their lives that did not have any solution but to laugh it off and for many it left them silent. One of the responses of the didis told me to write that her hands and legs do not work as if I was only there to write about it. They have had a history where people have come and written about their problems and have done nothing about it and therefore such a response.

The discussion then moved on to the problems faced by the women. They all talked about menstrual problems, problems faced during pregnancy and child birth. Didis said that they have to face a lot of pain during the whole process. We then went on to discuss the shift to delivery in hospitals rather than at home with the help of traditional birth attendants. To this there were various replies. Rukmini didi said we now go to hospital as we get information. Before I could ask about what information she was talking about, Padma didi

said it is more convenient to deliver in hospitals as they get injections and medicines otherwise they would have to call people at home. However, Yashoda didi added the behaviour of the nurses in the hospital is very harsh towards the expecting mother. They scold the women and many times beat her. Didis further added that there is no facility for surgery to be conducted if required and they have to go to the district hospital or the nearest city that is about 250 kilometres away. Didis also added that there are no facilities for X-Ray, sonography or other tests. They said the doctor in the hospital is only for formality and there are no female doctors. They also said the ASHA in the village is inefficient. Didis said that the male health worker whom they consider a doctor that visits them in the village charges them for medicines and if they do not pay he does not treat them.

After the identification of problems, we went on to discuss as to what we could do to bring about change in the existing situation. To this Rukmini didi, a very vocal and active members of the Samiti, stated that we first need to try to change ourselves from within and then only we can change the world and the village. To this Durga didi added that this could be done by talking to each other and advising. Soon Archana didi responded and said that we cannot tell anyone as we do not know what is there in other people's mind and heart. I then asked them, knowing everything, is there any scope and possibility that we can do something together? Do they wish to do something about it? And there was silence. The silence was not merely the absence of voice but it had more to it. It raised many questions in my mind, is health really the issue? If it is then what is stopping them to do something about it? Is it fear of the evil spirit, of more illness because of it? Or is it just a waste of time because it will not give them back something substantial, something material or monetary? Then suddenly Rukmini didi said yes we can and asked didis to which they all gave a positive response. However, I was suspicious of this response. Whether it was out of courtesy towards me as I was an outsider or a guest in their village or they really felt the need. But if they would have really felt the need, they would have raised these questions earlier. Durga didi then addressed the didis saying it is important for us as it is for our benefit. If nothing else, it would at least give information about what we are unaware of. To this most of them agreed.

In the subsequent couple of meetings it was identified that lack of knowledge and information about the diseases and various facilities and services provided by the government were major concerns, and that I would tell them about their bodies, disease, their causes, symptoms and preventive measures that can be taken at home as well as the services that are provided to them by the government and work towards acquiring those later.

In the next meeting we went on to explore our bodies, what it meant to us, the body parts and the systems of our body. The idea was to have a basic understanding about the body as well as to understand its importance. Many of them laughed at it, some said we are illiterate and therefore donot know anything about it, some looked at each other with a blank face. After persuading them to speak, they identified it with diseases, pain and more importantly to their work. Sukhwati didi said, 'w'e die or we live, we only have to work. The socio-politico-economic situation of these women has denied them access to their own bodies as well as knowledge about it.

With every meeting the composition of the group kept changing which was a challenge as all the meetings were planned in a sequence and were thus inter-related in some way or the other. So the presence and absence of a member impacted the group in different ways.

In the subsequent meeting we discussed diseases, their causes and symptoms, their prevention and cure. Polluted food and water, alcohol, dirty surroundings which become breeding ground for insects, disposable syringes used by doctors again and again and so on were identified as the causes of diseases. While discussing the preventive measures to be taken at home, we discussed about clean drinking water. I suggested they should boil and drink water as their main source of drinking water was well. Interestingly didis were initially not ready to do it as boiled and cooled water did not taste well. They were ready to fall ill but not boil the water. After much discussion some of the younger didis understood and said that they would try, however the elder ones simply refused the idea.

The next meeting that was planned, did not take place as no-one turned up for the meeting despite the fact that the time and the day of the meeting were both decided by the group. It again raised the question in my mind, was health really their issue? They would never forget about their weekly SHG meetings.

Puzzled and saddened I went to the last meeting where the discussion was about the health services and the actors. Without assuming they would be remembering the meeting, I had reminded them before hand. It was important for me that all the women were there. Before starting the discussion I asked them why they did not turn up for the last meeting. Firstly as usual the didis were silent. However, they started giving reasons. Understanding their situation yet not fully satisfied, I moved on. They were unaware of the role of the service providers and that they could go to them in time of need. They lacked information regarding the services that they were entitled to. These lacks of choices as well as knowledge about them are sources of unfreedom that restricts people from making the right choices. Once I made them aware of all this they started narrating stories of how the service providers extract money from them, especially the male health worker, how they misbehaved with them and how the ASHA would never give them the right information about the entitlements or the health camps or the VHND meetings. While we were discussing the incidences, the didis said that they would go in the next VHND where the ASHA, the ANMs, the male health worker as well as their superintendant come and they would ask them as to why are they not given any information which according to them were their rights. Coincidently the VHND was to be held the very next day and so some of the didis decided that they would go and told me to accompany them.

The next day we all went to the panchayat office where the VHND took place and to our surprise there was no one. I called the ASHA to find out as to where they were and found out the VHND had been cancelled and no one knew about. Disappointed we all went to do our chores and the didis decided they would come for the next one even if I was not there and the PRADAN team member would accompany them. They wanted me or any of the PRADAN members to be there as it would give them that support to raise the voices and also that the health workers would not misbehave with them. However, there I only played the role of a facilitator and I wanted the community to take their health in their own hands and become a change agents for themselves.

Due to the limited nature of the course I had to move out of the village and planned to hand over the work to the PRADAN team until the time the community itself was ready to take over the work. However convincing

them in itself was a challenge because they mostly have project driven livelihood generation agenda. Even the issue of health specifically nutrition was related to agriculture as well as livelihood generation and promotion as means to individual wellbeing.

Conclusion: a beginning

Eight months of field immersion is a small, rather a negligible effort, to turn the wheel of development towards a kind of development that is contemporary, partial, provisional, contingent, flexible, context-specific, context-sensitive and ever evolving, in other words, open to the future (Chitranshi, 2015). The transformation that was taken up in the village was an attempt towards imagining transformation of the local, with the local, in the language of the local and for the local (Chitranshi, 2015). This transformation was an effort towards raising the question of health by making people aware and conscious of the fact that health is an equally important issue at par with employment or livelihood which would lead towards their wellbeing. However, the question that may arise here is that how was this transformation anywhere different from what the state or the non-governmental organisations do by spreading awareness about various diseases, there prevention, cure, the services and so on and so forth? The answer to this lies in the fact that even if attempts have been made both by the state and other actors, have been minimal and has not reached the grass roots. These awareness program are tailor made and designed for the whole country and thus are blind to the context that is highly complex.

The imagination and intention behind this intervention was to make the community take their health related future in their own hands. This required them to be aware of the choices available to them so they can decide based on their context and situation. Thus it became apparent to open up the available options to them so that they enjoy the freedom to choose a greater range of different ways of living that they value.

Though the transformation was co-envisioned and the problem came from within the community itself, however it has been a difficult journey to engender this transformation will be so in future in the given spread and reach of the dominant understanding of development with the focus on economic development premised on economic growth. Words such as inclusive development, participatory development, community participation, and empowerment have become an integral part of development orthodoxy. These define and design the practices. Development planning premised primarily on capitalist growth and technocratically driven, top down modernisation to facilitate growth determined the historical growth of health administration in India that has been minimal, lean and top-down with infrastructure and demography being the major focus. The complexities in health arising out of contexts have not been dealt with at all in a bid to universalise health care and specifically primary health care. Negligible effort has been made to revitalise and integrate the traditional practices especially those of the tribals.

The other push of the current developmental framework has been to bring women in development by forming SHGs where women manage their own savings and give credit to those members who are in need. This saving and credit model of SHGs has become so ingrained in the system as well as in the minds of the women that it has become difficult to raise developmental questions that are not economic in nature, for example health. Its reach can be seen from the fact that when in a meeting, while introducing themselves, the women many a time may not even tell their name, but would always identify themselves with the SHGs they belong to as if

that is the only identity they have. According to Jakimow and Kilby in their work '*Empowering Women: A Critique of Blueprint for Self Help Groups in India',* preoccupation with savings and credit has resulted in the broadening of cognitive boundaries only as far as economic activities are concerned.

There is no denying these SHGs have impacted the lives of many women and their families and have empowered them, but there is a need to examine the nature of this empowerment as well. Group formation has been incorporated into the SHG blueprint at the normative level in order to overcome internal constraints. Gender training and exposure visits also have the potential to introduce women to alternative world views, encouraging them to critically examine their own (Jakimow and Kilby, 2006). However, to what level have SHGs been able to remove the internal constraints is a big question. What needs attention is what have these SHGs done to the relationship between the women vis-à-vis those in the group and those outside it? Is it a relationship of hierarchy between literate and illiterate? Or is it of animosity and jealousy between those who save more and who save less? Or thus over time due to faulty credit or any other monetary issue, the relationship turns hostile?

The microfinance models such as the SHGs that exist in their current form are a result of a top down approach of the developmental projects undertaken by the state and the non-state actors and funded by international donor agencies, and therefore completely decontextualized, and thus do not take into account the specificity of the contexts such as the relationship between the villagers, the culture and the practices. Mayoux argues that donors emphasis on income generation and financial stability has reduced the implementation of empowering specific programs that have no financial outcome (Jakimow and Kilby, 2006). As the SHG programs have become top-down providers of services, pre-determined agency-supplied program are available in a non-negotiable format to all SHG members, regardless of any collective action. This encourages a passive acceptance of development resources and advice rather than a proactive effort to make claims and negotiate. Such is the case in Indian Villages. In the case of Khannat where there is a lack of unity amongst the villagers, when they are jealous of each others' good and do jadoo tona out of jealousy, in such a situation, do the SHGs there really form a collective to take up any kind of transformation? For me the answer is no. The internal constraints persist and the individual members of these SHGs are driven by self interest to save their own money, and not for any collective good apart from giving credit to each other in the time of need.

One of the crucial questions that arise is whether these SHGs ever become a collective to engender any kind of transformation or will transformation create a collective? From my experience in Khannat, it was always taken for granted that the meetings were organised for SHG members, and therefore, neither did the other women of the village or the men participate in these meetings. This thought has been shaped by the history of the way training programs are organised for the SHG. My position in the village also had an influence on these meetings. This was so because my entry into the village was through PRADAN so I was initially identified with them, and the relationship was formal. However, this relationship changed and became more formal and intimate, yet I remained an english-educated, city born outsider to them, having knowledge about health related issues or a doctor who had come to give them jankari (information), and that no other doctor would do it for them. What emerges out of this is the question of whether the group that I worked with was ever a collective or were they merely 20-25 individuals sitting in a room influenced by a number of factors? And will this group ever become a collective to undertake transformation in a situation where such complexities exist? It seems difficult but not impossible. But a bigger question that arises is whether these SHGs are a problem in itself or a solution to the problems?

The larger question remains as to whether health ever become a developmental question worth discussing and not be restricted to people's private lives? Despite identifying health as a problem area, jealousy-jadoo tona-health being the most important problem affecting almost everyone in the village, yet it is difficult to collectivise and engender transformation around. It is much easier to collectivise and discuss issues relating to livelihood, savings or agriculture. The question then arises as to whose problem is it? Is livelihood the only thing that requires attention just because it is material, and so visible and would lead to our wellbeing? Why is it that the things that are close to us and our bodies, such as health, are the most neglected ones? Will questions around health always need an anchor to raise them? What are we really doing in the name of development? And is it so easy to do development in a village like Khannat where so many complexities exist? Or have we just become blind and insensitive to people's needs, desires, emotions and issues especially of the marginalised for our own gains? What is the way out and for how long?

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